

# Generating Team-Based Strategies to Reduce Health Inequity in Cancer Care

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## ABSTRACT

**Purpose/Objectives:** Despite increased emphases on reducing racial disparities in the U.S. health care system, interprofessional care teams may inadvertently perpetuate health disparities through lack of awareness or experience in supporting individualized, patient-centered goals of care. Racial disparities can lead to health inequity. Persistent health disparity gaps exist among Black patients with multiple myeloma (MM) when compared with non-Black patients. Black patients experience a two-fold increase in MM risk and earlier age of onset compared with non-Black patients. Black patients are also less likely to receive timely access to some therapies, undergo autologous stem cell transplant, or enroll in clinical trials. This article describes a large-scale, equity-focused implementation science initiative aimed at identifying and overcoming racial disparities and health inequity among patients with MM through quality improvement goals identified by each of the interprofessional cancer care teams.

**Primary Practice Settings:** Interprofessional cancer care teams in two large oncology systems as well as four community clinics were engaged in this study along with their patients with MM. Geographic areas included the following: Chicago, IL; Washington, DC; Charlotte, NC; Columbus, OH; Denver, CO; and Indianapolis, IN. Interprofessional teams included hematologists/oncologists, primary care physicians, nurse practitioners/physician assistants, and case managers/nurse navigators. Teams collectively examined and compared their own beliefs and attitudes about their patients' goals for MM treatment and management versus those of their patients to uncover and address discordances. Medical records from the clinics were audited to evaluate disparities in treatment and practice at the point of care. Live, team-based audit-feedback sessions were implemented among teams to examine data sets, as well as utilize the data to address interprofessional factors that could enhance more equitable care.

**Findings/Conclusions:** Data from comparative surveys between patients and interprofessional team members revealed significant discordances that enabled health care teams to recognize gaps and identify ways to improve patient-centered care, such as shared decision-making. Through audit-feedback sessions, interprofessional teams were able to collaboratively meet and discuss methods to improve access to care coordination services and other strategies aimed at alleviating disparities. Baseline chart audits revealed and confirmed disparities of care including patient/disease characteristics, treatment history, clinical practice metrics, and patient-centered measures. Follow-up chart audits conducted 6 months later measured changes in documented practice behavior. Action plans developed by the interprofessional teams as a result of this study intend to address sustainable reductions in health disparities among patients with MM to improve health equity and overall care.

**Implications for Case Management Practice:** This implementation science initiative and data results have several implications for case managers caring for diverse patients with MM in both large health systems and smaller community practices. Results punctuate the importance of identifying and supporting diverse patients' individualized goals and preferences in their care journey to mitigate health inequity and maximize health outcomes. The value of working collaboratively as an interprofessional team is evident in the study results, as is the role of the case manager in appropriate resource allocation to mitigate health disparities. Lessons learned from this initiative may also be applied to other case management settings where complex care delivery and interprofessional teams are at work.

**Key words:** *audit-feedback, health disparities, health equity, implementation science, interprofessional health teams, quality improvement, shared decision-making*

Racial disparities often lead to health inequity among vulnerable populations (Centers for Disease Control and Prevention, 2022; Cogburn, 2019). The Centers for Medicare & Medicaid Services (CMS) has released the CMS Framework for Health Equity 2022–2032 to address health inequity across Medicare and Medicaid populations. This plan includes a priority to support health care teams that provide care and services to

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**Disclosure:** The study sponsors did not play a role in the design, execution, or analysis of the study or in the development of this article. The authors did not receive an honorarium.

The authors report no conflicts of interest.

DOI: 10.1097/NCM.0000000000000657

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underserved communities (CMS, 2022). The CMS proposes to build capacity of health systems and their workforces to achieve appropriate resource allocation decisions that can improve the needs of the communities they serve. A key role of case managers is to identify and implement appropriate resource allocation decisions (Case Management Society of America [CMSA], 2022), and these decisions can mitigate racial and other social risk factors leading to health inequity (CMS, 2022).

Racial and health disparities have been documented in the literature to affect patients across a myriad of diseases, including cancer (Lett et al., 2022; Lin et al., 2021). Multiple myeloma (MM) is the most common hematological malignancy among Black patients, who experience a two-fold increase in MM risk as well as an earlier age of onset compared with non-Black patients. Yet, Black patients are less likely to receive timely access to novel therapies, such as proteasome inhibitors and immunomodulatory drugs, or to be enrolled in clinical trials or undergo autologous stem cell transplant than non-Black patients (Ailawadhi et al., 2019). Members of the health care team have been called to action to confront health inequity in cancer care (American Association for Cancer Research [AACR], 2022; Patel et al., 2020). Case managers can implement appropriate resource allocation decisions that may deter health inequity through collaboration with other members of the interprofessional health care team. Root causes can be uncovered and patient-specific disparities addressed by examining data-driven patterns of health determinants and health outcomes in cancer care (Kamstra & Huntington, 2017).

## **STUDY DESIGN**

This article describes a large-scale, equity-focused implementation science initiative aimed at identifying and overcoming racial and health disparities in the interprofessional care of patients with MM. This study was conducted at two large health systems, followed by four community-based clinics, with patient and provider surveys to assess beliefs and experiences with MM care. Patients and their providers completed 35-item and 30-item surveys, respectively. Surveys were designed to examine alignments and discordances in the attitudes, values, beliefs, and delivery of MM care perceived by interprofessional team

members and by their cancer patients. The surveys included questions validated to assess racial differences among oncology patients in adherence, cancer beliefs, patient-provider communication, and awareness of health disparities. Following survey collection, each clinic participated in an audit-feedback assembly to review survey results unique to each clinic and to prompt an individualized team-based action plan. A Plan-Do-Study-Act (PDSA) method was applied to the audit-feedback sessions to support team-based changes in practice behavior. This program was part of a larger quality improvement initiative exempt from institutional review board oversight.

Through use of data analyses and the team-based audit-feedback sessions examining racial disparities in care delivery among patients with relapsed/refractory MM, case managers and other members of interprofessional cancer care teams were able to identify and address discordances in care and develop strategies to improve health outcomes for Black and other minority MM populations.

Data captured from patient and provider surveys included the race/ethnicity not only of patients but also of their health care teams delivering care in both large oncology systems and smaller community practices (see Tables 1 and 2). These were relevant data when considering attitudes, values, and beliefs captured by the health care team as well as by their patients. Representation of interprofessional team members for the surveys included a balanced mix of specialists (hematologists, oncologists), primary care physicians, advanced practice providers (nurse practitioners, physician assistants), and care coordinators (case managers, nurse navigators) (see Table 1). Likewise, there was broad representation of the cancer care team during the scheduled audit-feedback sessions, including diversity in race/ethnicity (see Table 3).

To uncover objective data aimed at potential health care disparities, baseline and follow-up chart audits of patients' electronic medical records (EMR) were conducted, working backward in time from the index date to identify the most recently seen patients who met the inclusion criteria until the cohort was generated. Inclusion criteria for the EMR audit included patients 18 years or older with a confirmed diagnosis of relapsed/refractory MM and a minimum of two clinic visits within the previous 12 months. Extracted data measured patient and disease characteristics, treatment history, clinical

**TABLE 1**  
Interprofessional Care Team Demographics for Surveys

	Providers	
	n	%
Role		
Hematologist/oncologists	17	29%
Primary care physician/other physician	8	14%
Case manager/nurse navigator	19	32%
Nurse practitioner/physician assistant	13	22%
Other	2	3%
Race/ethnicity		
Black	5	8%
White/Non-Hispanic	44	75%
Asian/Pacific Islander	10	17%
	Mean	
MM patients		
MM patients per month	49	
Years caring for MM patients	9	

Note. MM = multiple myeloma. From "Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers," by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/curroncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.

**TABLE 3**  
Interprofessional Care Team Demographics for Audit-Feedback Sessions

	Providers	
	n	%
Role		
Hematologist/oncologists	17	29%
Primary care physician/other physician	8	14%
Case manager/nurse navigator	18	31%
Nurse practitioner/physician assistant	13	22%
Other	3	5%
Race/ethnicity		
Black	10	3%
Caucasian/White	18	60%
Hispanic/Latino	7	23%
Asian/Pacific Islander	2	7%
	Mean	
MM patients		
MM patients per month	118	
Years caring for MM patients	17	

Note. MM = multiple myeloma. From "Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers," by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/curroncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.

practice metrics, and patient-centered interventions by the interprofessional team.

## STUDY FINDINGS

Using the survey tools, patients ranked the top reported challenges they faced in MM care, and their responses were different from what their cancer care teams predicted. Many (32%;  $n = 59$ ) of the health

care team members predicted that patients' biggest challenge in MM care is dealing with the cost of treatments, whereas only 9% of patients ( $n = 100$ ) selected this answer. Rather, the majority (32%;  $n = 100$ ) of patients reported that their biggest challenge is feeling confident that their cancer treatment plan is the best plan for their care, whereas only 18% of care team members ( $n = 59$ ) predicted this answer (see Figure 1).

Likewise, there were discordances between patients and providers in identifying their goals for MM treatment, and these disparities were even greater when data among patients' responses were further subdivided to associate Black/Hispanic patients versus White patients. Although 63% of the interprofessional care team members ( $n = 59$ ) predicted that length of survival was the most important goal of care for patients with MM, and the majority (47%;  $n = 100$ ) of their patients agreed, perspectives changed when the data were drilled down to associate results between Black/Hispanic patients ( $n = 50$ ) and White patients ( $n = 50$ ). Only 38% ( $n = 50$ ) of Black/Hispanic patients selected length of survival as the most important goal of MM treatment, whereas the majority (56%;  $n = 50$ ) of White patients selected length of survival as a top goal of MM treatment. Among Black/Hispanic patients, 46% ( $n = 50$ )

**TABLE 2**  
Patient Demographics for Surveys

	Patients	
	n	%
Race/ethnicity		
Black	41	47%
White/Non-Hispanic	50	50%
Asian/Pacific Islander	3	3%
	Mean	
MM care		
Time attending current clinic	5 years 5 months	

Note. MM = multiple myeloma. From "Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers," by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/curroncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.

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responded that improvement in quality of life was their top goal for MM treatment, with only 28% (n = 50) of White patients selecting quality of life (see Figure 2).

There were also distinct disparities between Black/Hispanic and White patients related to shared decision-making. Shared decision-making is a hallmark of optimal cancer care (Katz et al., 2014). Yet, when patients were asked to respond to the statement, "I feel that I am completely involved in my treatment decision-making," 54% of White patients (n = 50) agreed with this statement, whereas only 14% of Black/Hispanic patients (n = 50) concurred (see Figure 3).

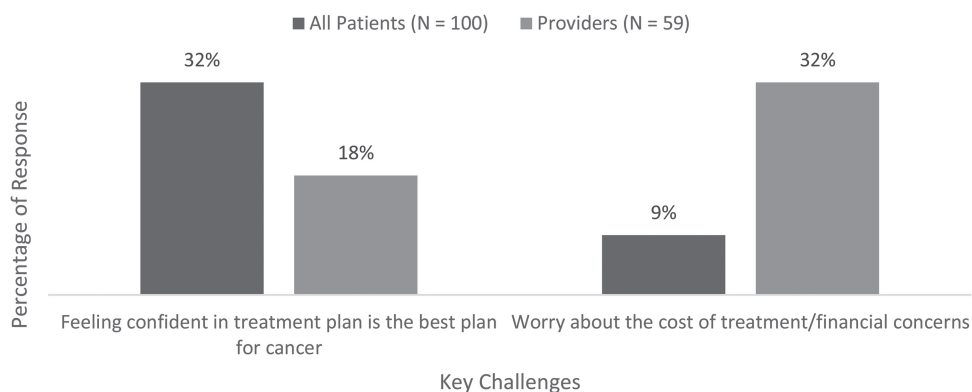
Although it is important to increase patient involvement in shared decision-making, it is equally important to share information that is most relevant to the patient. The majority of providers (57%; n = 59) overestimated that their patients' biggest concern in selecting treatment would be related to risks, complications, and side effects of therapy, whereas only 29% (n = 100) of their patients felt this was the most important decision factor in treatment selection (see Figure 4).

This discordance was also evident in the results of the chart audits, where 41% of providers (n = 82) documented in the EMRs that they discussed the pros

and cons of treatment options, whereas only 29% of providers (n = 58) documented in the EMRs that they discussed patient/caregiver concerns and fears with their patients (see Table 4). In fact, objective chart audits revealed that providers scored under 40% in performing every other aspect of shared decision-making with their patients related to treatments (see Table 4). These data allowed providers to uncover unknown biases in their approaches to care and to appreciate how these biases were affecting the quality of their communications with their patients.

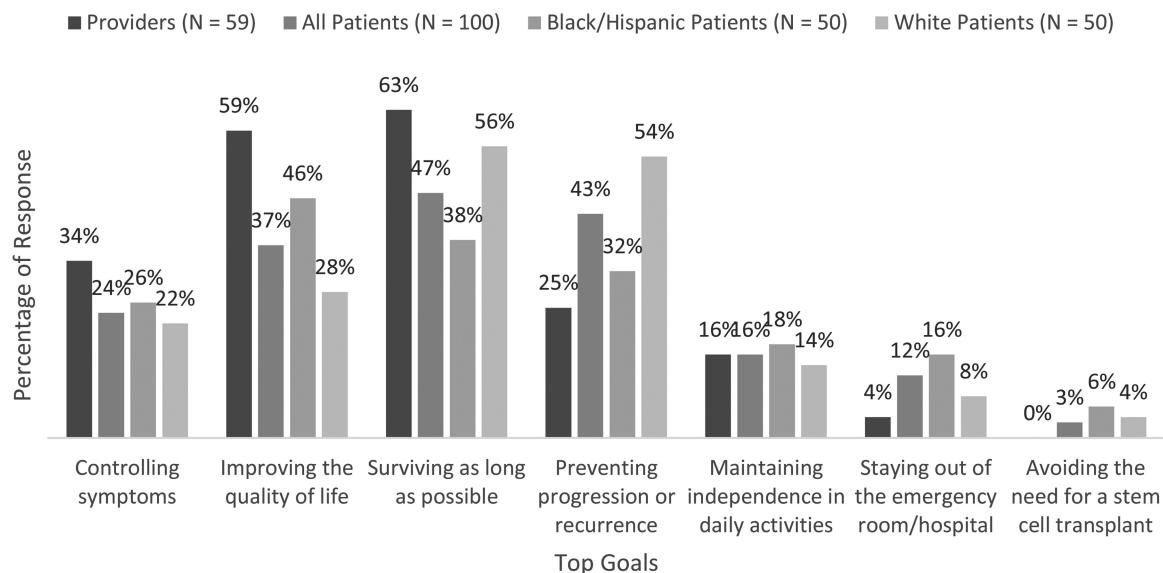
## DISCUSSION

Considering the importance of relevant shared decision-making, and the value proposition for team members to understand their patients' primary challenges and goals of cancer care, these data provided interprofessional care team members with poignant insights. Team members were able to identify unrecognized biases that can perpetuate health disparities, and these insights provided teams with a basis for identifying individualized action plans for change. Proposed methods for change included such interventions as a check and a check-again system to ensure minority patients understand and can verbalize treatment options available to them. Team members also considered ideas to improve shared



**FIGURE 1**

The top reported challenges faced by patients in multiple myeloma care. From "Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers," by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/curroncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.

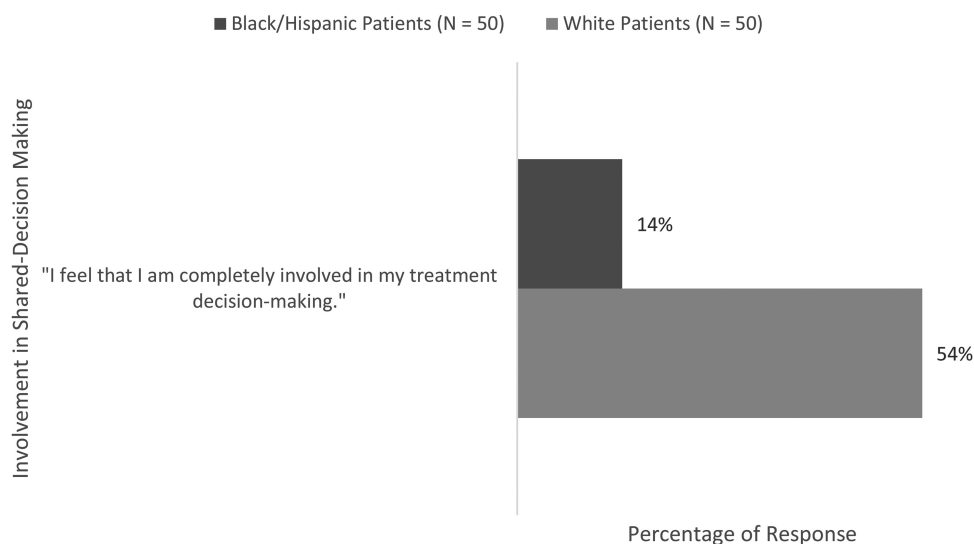


**FIGURE 2**

Disparities in the top two goals for multiple myeloma treatment reported by health care providers and patients. Statistical significance identified in the following: Improving quality life: Providers,  $p = .006$ ; Improving quality life: Black/Hispanic patients,  $p = .062$ ; Surviving as long as possible: Providers,  $p = .055$ ; Surviving as long as possible: White patients,  $p = .071$ ; Preventing progression or recurrence: All patients,  $p = .026$ ; Preventing progression or recurrence: White patients,  $p = .026$ . From "Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers," by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/curroncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.

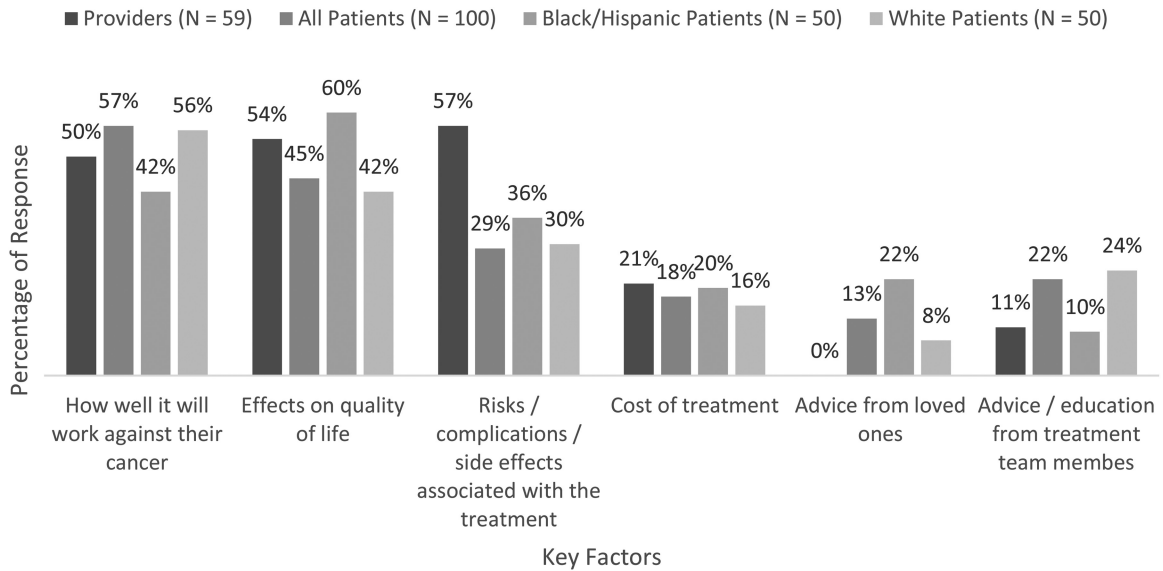
decision-making. Recognizing that different members of the health care team can engage patients in shared

decision-making, such as the physician assistant or the case manager, may help the time-strapped provider.



**FIGURE 3**

Disparities in shared decision-making. Statistical significance identified in the following: White patients,  $p = .021$ . From "Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers," by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/curroncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.



**FIGURE 4**

Key factors in treatment decision-making reported by providers and patients. From “Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers,” by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/curroncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.

Effective shared decision-making can help overcome health literacy issues in discussing available treatment options or to what extent the patient would like to be involved in those decisions.

Finding extra time in a clinic day to assemble the health care team is no easy feat and should provide value in order to justify additional time and resources. To gauge the relevance and impact of the audit-feedback sessions, self-reported surveys were completed by all health team members both

before and after the audit-feedback sessions. These surveys were designed to assess health team members’ confidence in recognizing and mitigating potential health disparities in patient encounters and to promote improved communication and collaboration among health team members caring for patients with MM. As identified in Figure 5, interprofessional team members reported improved confidence in recognizing barriers to equitable MM care as measured in the pre- and post-session surveys.

Although the audit-feedback sessions were individualized to the needs and issues of each clinic, foci on ways to improve patient engagement were a discussion point in all the audit-feedback sessions, as well as methods to improve documentation of shared decision-making in the EMRs. The structure of the audit-feedback sessions was particularly useful in allowing different members of the interprofessional care team to hear each other’s ideas and concerns related to overcoming clinic-specific disparities of care. Often, patient caseloads and time restrictions in specialty cancer care prevent effective or ongoing communication among health team members.

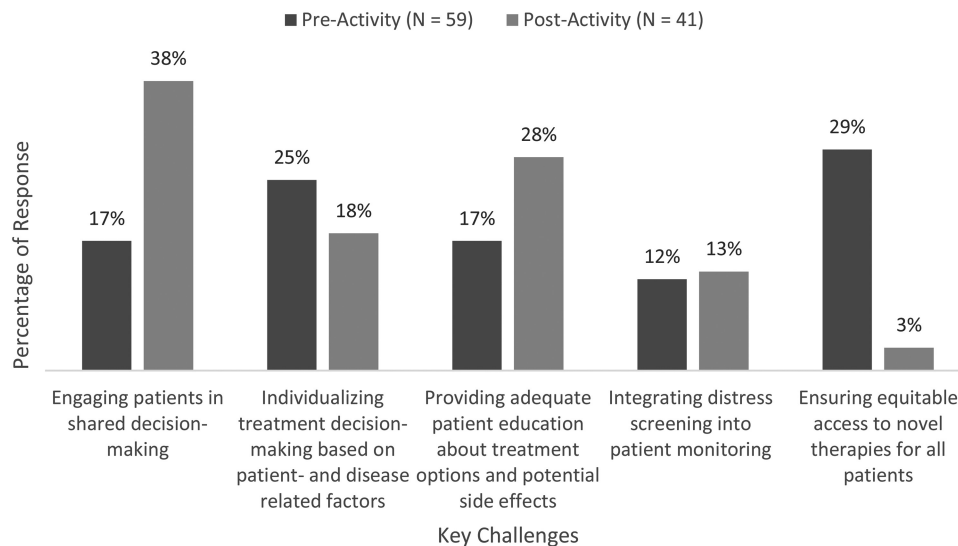
## CASE MANAGEMENT INTERVENTIONS

The audit-feedback sessions created a unique opportunity for case managers and nurse navigators to build awareness among their teams for the value of resource management as a deterrent of actual and potential racial disparities. The sessions allowed

**TABLE 4**  
Chart-Documented Shared Decision-Making Practices

Role	n	%
Checking for the patient/caregiver understanding of treatment options	52	26%
Exploring patient/caregiver expectations for treatment outcomes	52	26%
Ask a patient or caregiver about treatment goals	60	30%
Exploring patient/caregiver concerns and fears	58	29%
Explaining pros and cons of treatment options	82	41%
Providing treatment options	74	37%
Providing opportunities for patient or caregiver to ask questions	70	35%

Note. From “Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers,” by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/curroncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.



**FIGURE 5**

Interprofessional care teams' identified key challenges to equitable care. From "Multisite Quality Improvement Initiative to Identify and Address Racial Disparities and Deficiencies in Delivering Equitable, Patient-Centered Care for Multiple Myeloma—Exploring the Differences Between Academic and Community Oncology Centers," by J. R. Mikhael, S. L. Sullivan, J. D. Carter, C. L. Heggen, and L. M. Gurska, 2023, *Current Oncology*, 30(2), pp. 1598–1613 (<https://doi.org/10.3390/currncol30020123>). Copyright 2023 by the authors. Licensee MDPI, Basel, Switzerland.

the case managers and nurse navigators to identify resources available through the clinic or accessible through the larger health system or the community that may be utilized to assist underserved patient populations in their own clinics. Common resource needs included transportation issues, coordination of health care benefits, drug assistance programs, reminders for clinic appointments, and assistance preparing questions and concerns meant for clinic providers.

Overall, the sessions illuminated the need for patient-specific resources that can overcome health inequity and provided a forum to maximize approaches to patient-centered care. Because resource management is a key role of case management (CMSA, 2022), the sessions provided a good opportunity for health care team members to understand how case management interventions can be applied to improve patient outcomes in the clinic setting. The data identified the need for improved communication with patients. Case managers can develop a rapport with patients with MM through effective communication strategies that express empathy while demonstrating self-efficacy for the patient during a difficult and often overwhelming cancer journey. Health literacy is an important component of effective communication among minority patients, as is active listening. By actively listening to the patient and developing a comfortable rapport, case managers can build a trusting relationship to break down barriers in health disparities.

Effective communication within and among the interprofessional team can also improve patient care. When all team members are stretched for time, communication can break down. Case managers can take a lead role in ensuring all members of the team are current with the patient's plan of care and that patient-specific goals of care continue to be met. The study results from this initiative highlighted the value of working collaboratively as an interprofessional team, but that is only plausible if the team is communicating. Case managers are also uniquely positioned to promote effective communication within the larger health system as well as with outside service providers when coordinating patient services so that delays in treatment and care can be avoided.

## IMPLICATIONS FOR CASE MANAGEMENT

Case managers are a vital and effective part of interprofessional cancer care teams (Wang et al., 2022). Appropriate resource allocation decisions can mitigate social risk factors leading to health disparities among these patients (CMS, 2022). Because resource allocation is a key function of case management (CMSA, 2022), case managers are uniquely positioned to positively impact reduction of health disparities among patients and families in the health care system. Among Black and other minority patients with MM, case managers have an opportunity to reduce disparities affecting whether, when, and how cancer care is delivered, as well as to advocate for patient-centered

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*Interprofessional cancer care teams are dedicated to giving their complex cancer patients the best available care. However, care teams may inadvertently perpetuate health inequity among underserved populations through lack of awareness or experience in supporting patient-centered goals of care.*

goals of care, which can reduce root causes of health inequity in this population.

This study and data results exposed needs among patients with MM and areas where case management can have a positive impact. Patient education can be an effective strategy, especially when it focuses on patient literacy. Educating patients about different treatment plans in MM care and speaking with them about their individualized goals of care and treatment preferences can help ensure that patients and the care team are aligned on the goals of care and subsequent treatment decisions. This can ameliorate discordances in treatment goals such as those identified in the data.

Case managers can counsel patients about methods to improve their quality of life while undergoing difficult treatment regimens. Helping the patient consider when to engage family members and friends in errands and chores can go a long way toward improved quality of life during periods of extreme fatigue. Recognition by the case manager that underserved patients may have difficulties with everyday issues, such as transportation to the clinic or child-care challenges or inability to maintain independence in activities of daily living, can be a first step for identifying needed resources and initiating effective resource allocation.

## CONCLUSION

Interprofessional cancer care teams are dedicated to giving their complex cancer patients the best available care. However, care teams may inadvertently perpetuate health inequity among underserved populations through lack of awareness or experience in supporting patient-centered goals of care. Persistent, documented health disparity gaps exist among Black patients with MM when compared with non-Black patients (Ailawadhi et al., 2019). Case managers working collaboratively with other members of the interprofessional care team have an opportunity to recognize and address health disparities among their underserved populations. Using patient data as well

as team-driven data to identify problems and inform strategies for change can assist clinics and their teams in mitigating health disparities, which can improve patient outcomes at the point of care. Lessons learned from the objective and subjective data associated with this implementation science initiative may be applied to improve recognition and resolution of racial disparities and health inequity across other cancer conditions.

## ACKNOWLEDGMENTS

This implementation science study was funded through education grants to PRIME Education, LLC, from AbbVie, Inc., Bristol-Myers Squibb, and Janssen Biotech Inc.

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## INSTRUCTIONS

### Generating Team-Based Strategies to Reduce Health Inequity in Cancer Care

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- Read the article. The test for this CE activity can only be taken online at [www.nursingcenter.com/ce/PCM](http://www.nursingcenter.com/ce/PCM).
- You will need to create (its free!) and login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CE activities for you.
- There is only one correct answer for each question. A passing score for this test is 7 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.

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Registration Deadline: September 1, 2024

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#### Disclosure Statement:

This implementation science study was funded through education grants to PRIME Education, LLC from AbbVie, Inc., Bristol-Myers Squibb, and Janssen Biotech Inc. The study sponsors did not play a role in the design, execution, or analysis of the study or in the development of this article. The authors did not receive an honorarium. This module has been reviewed and all potential or actual relevant financial relationships have been mitigated. The planners have disclosed no potential relevant financial relationships or otherwise.

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DOI: 10.1097/NCM.0000000000000677