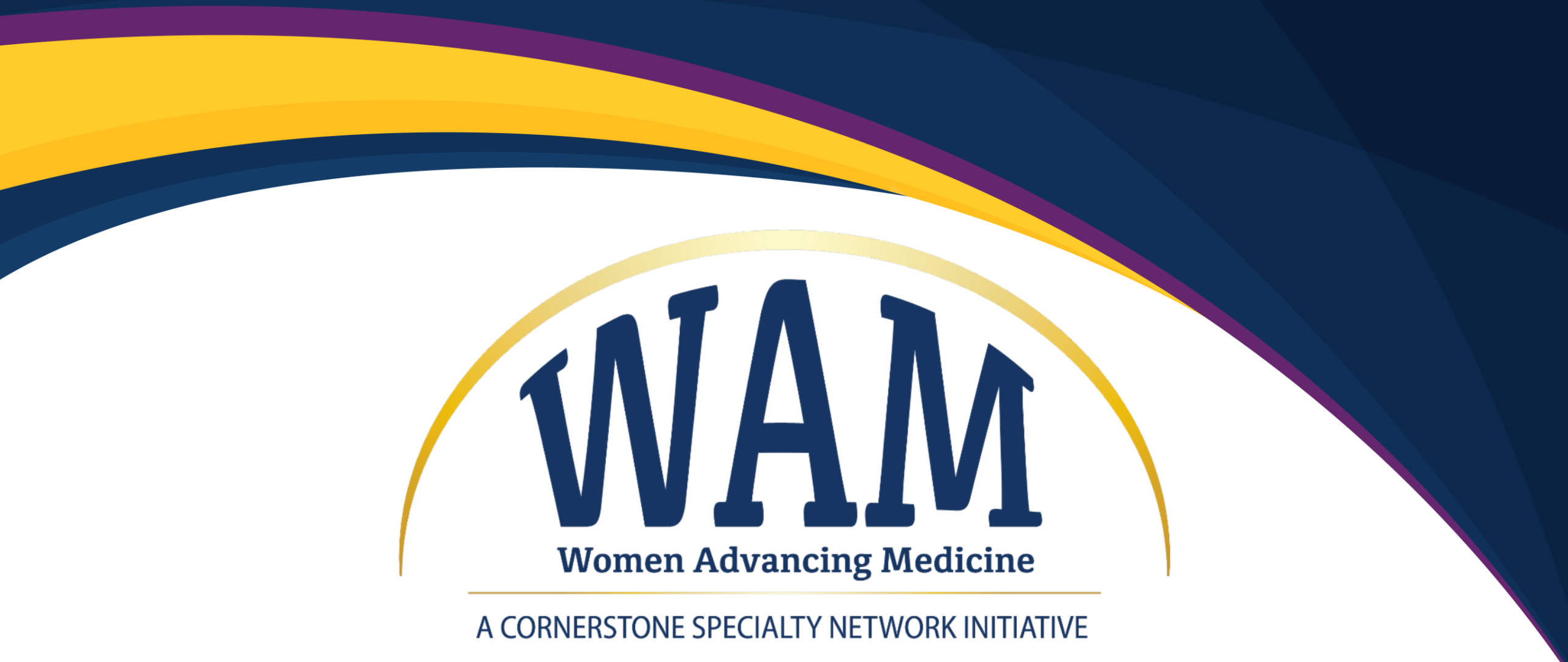




WAM

Women Advancing Medicine

A CORNERSTONE SPECIALTY NETWORK INITIATIVE

September 24, 2026

cornerstone
oncology specialty network™



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Mission

- Women Advancing Medicine (WAM) exists to cultivate, equip, and sustain women in community oncology by delivering high-impact education, leadership development, and peer connection.
- Through expert-led meetings, WAM provides women oncologists and practice leaders with practical strategies they can immediately apply to advance their careers, elevate patient care, and lead effectively within the evolving community oncology landscape.



Columbus Oncology
& Hematology

Serving Mid-Ohio Since 1987

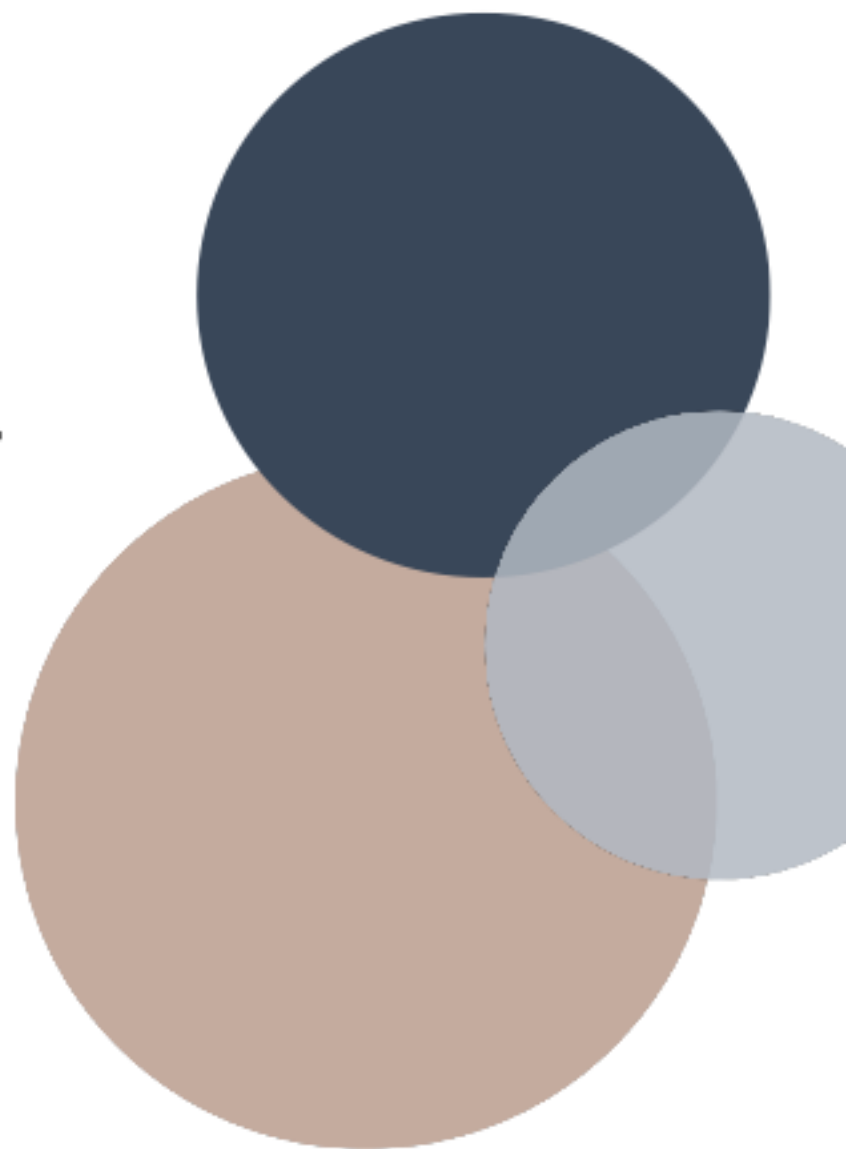
**“Know Where the Money Is Coming From —
and Where It’s Going”**

THE BUSINESS OF MEDICAL ONCOLOGY

Marlo Blazer, PharmD, BCOP

Executive Director of Clinical Strategy

Date: 9/24/2026



A Little About Our Practice & My Background

The Practice:

- (3) patient-care locations in central Ohio
- All with an infusion center, (1) houses a retail pharmacy
- Single-specialty with (16) medical oncologists
- Hospital agnostic, but strong hospital alignments
- Fully independent, physician-owned practice

Me:

- Board-certified oncology pharmacist by background
- Trained as a clinical pharmacist at an NCI-designated CCC, and served there in GI oncology for ~11 years
- From there, worked at a scientific consulting firm for ~5 years
- Joined Columbus Oncology & Hematology 6 years ago (we had [1] patient-care site at that time)
- At current, pharmacy, research, and revenue cycle reports up through me



Westerville Cancer Center

300 Polaris Parkway, Suite 330
Westerville, OH 43082

*Located on the third floor of the
OhioHealth Westerville Medical Campus
Monday, Tuesday, Wednesday, and Friday, 8 a.m. to 5 p.m.
Thursday, 9 a.m. to 5 p.m.*

Dublin Cancer Center

6700 Perimeter Drive
Dublin, OH 43016

*Monday, Tuesday, Wednesday, and Friday, 8 a.m. to 5 p.m.
Thursday, 9 a.m. to 5 p.m.*



Jasonway Cancer Center

810 Jasonway Avenue
Columbus, OH 43214

*Monday, Tuesday, Wednesday, and Friday, 8 a.m. to 5 p.m.
Thursday, 9 a.m. to 5 p.m.*



Columbus Oncology Associates Pharmacy

810 Jasonway Avenue
Columbus, OH 43214

*Located in the Jasonway Cancer Center
Monday-Friday, 8:30 a.m. to 5 p.m.
Phone: (614) 442-3342*



Understand the Business. Protect the Care.

Know the Margin to Sustain the Mission



In a single specialty practice, these account for 80-90% of monies “in” and “out”

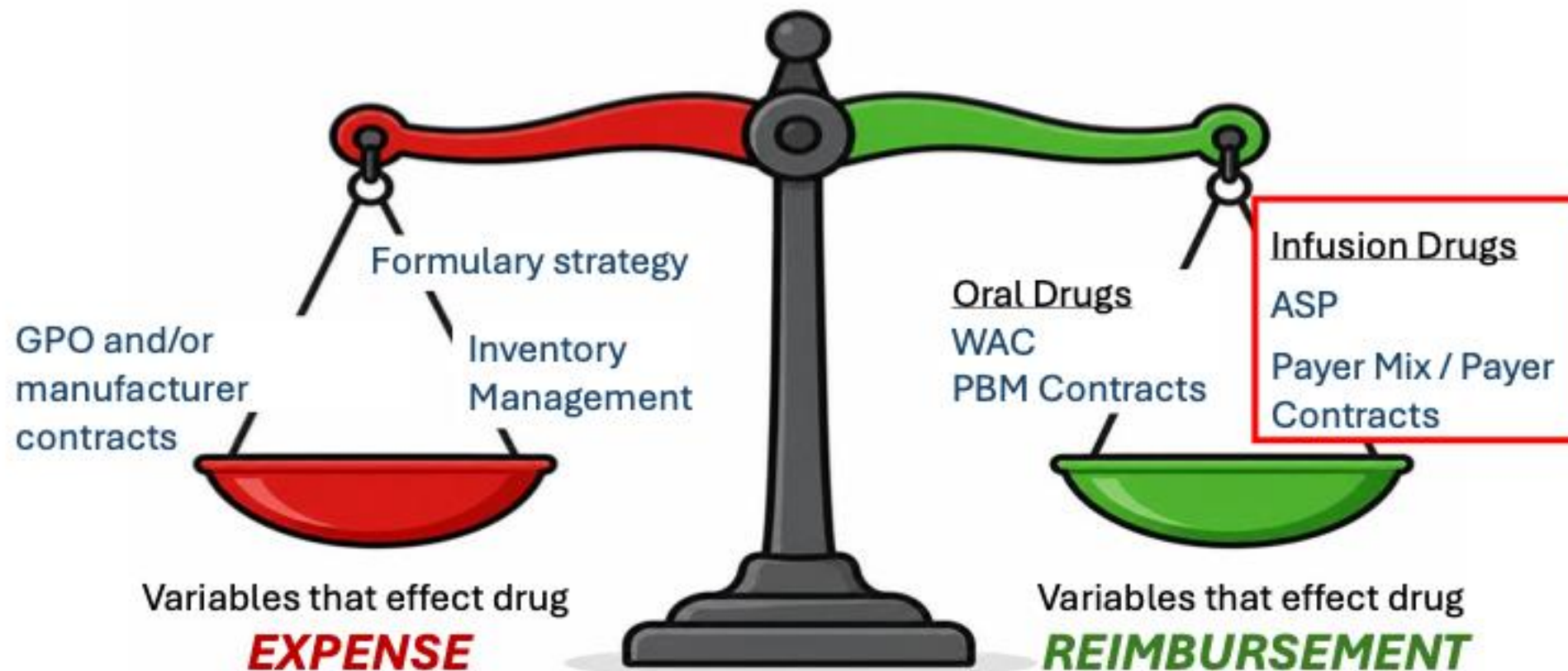
Do you know what your biggest contributors are to “Money In”?

- Infusion/Injectable Drugs
- Oral Drugs
- Drug Administration codes
- E&M codes (ie, professional services)
- Hospital Professional Service Agreements
- Research
- Value-Based Care / Payor-Incentive Programs
- Other?

What about “Money Out”?

- Drug Expense
- Staff
- Equipment Overhead
- Technology
- Denials / Uncompensated Care
- Physicians

The Economics of Drug Delivery



Average Sale Price - The Good, The Bad, and the Buffalo

$$\text{ASP} = \frac{\text{Manufacturer's net sales* revenue for a drug to all purchasers in the US in a calendar quarter}}{\text{Total number of units of drug sold by manufacturer in same quarter}}$$

**Net sales includes purchase price as well as accounted for rebates given to both practices/health systems and payers*

- Medicare (and most MA Plans) reimburse drugs at ASP + 4.3%
 - ✓ Medicare publishes these reimbursement rates based on their ASP calculation, quarterly
- Most commercial insurance plans pay at a percentage of Medicare (ie, Medicare rate + x%)
- Margin, then, is the difference between what you purchase the drug for (often times WAC-based contracts) and what Medicare pays
 - ✓ Noting – this is a worse-case scenario, and changes based on payer-mix



Easily referenced: ASP is nationally published by CMS



Volatility: When the rebates “catch-up” in the calculation, ASP for whole classes of drugs can plummet



Unknown: What happens when ASP is replaced by Maximum Fair Price (when the IRA hits Part B in 2028)?

Average Sale Price - The Good



Easily referenced: ASP is nationally published by CMS

Why is this good?

- It is administratively simplistic
 - ✓ Many-most payers utilize the ASP-based reimbursement for their contracting,
 - ✓ Readily retrievable to update contracted rates for drugs within your practice management systems
- It allows for quarter-by-quarter evaluations of formulary strategy
- The ASP sets the threshold for what a “good drug contract” may look like

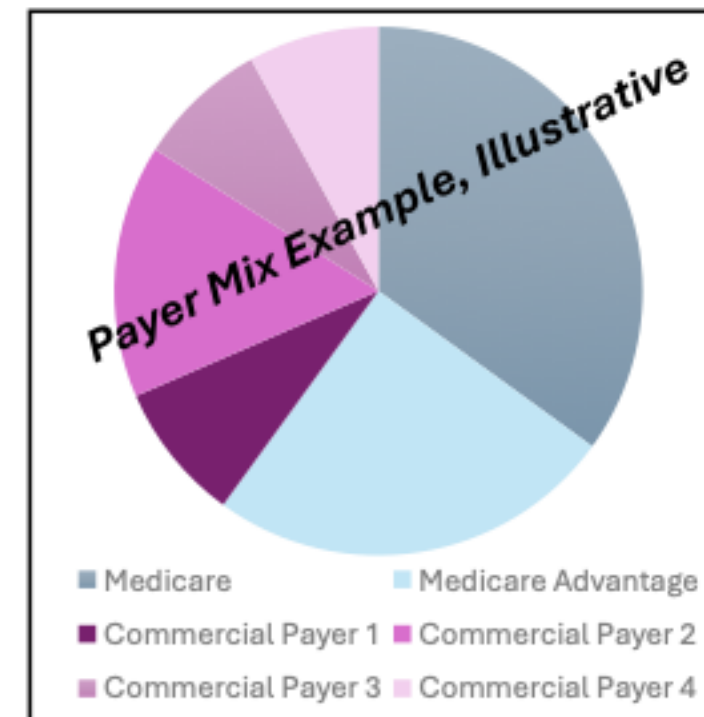


Key Need-To-Knows to Maximize the Good:

- What is your payer mix?
 - ✓ Abbreviated: Percentage of Medicare/MA to Commercial
- What is the “rough” percentage over Medicare that you get on drugs for your most prominent commercial payers
- Do you have person(s) within your organization that are managing things like pathways and biosimilar selection on a quarterly basis?
- Who advocates with your GPO for drug contracting?

Why Are the “Need-To-Knows” So Noteworthy?

- Medicare rates will give you a worse-case prognosis on impact of ASP-based reimbursement,
- Knowing your payer mix may give a more realistic range, if you know the rough contracted rate for your main commercial payers
 - ✓ Note: Medicare Advantage most typically pays at 100% of Medicare rates, but they have “preferred” formularies
 - ✓ Be wary of over-generalization (eg, Multiple Myeloma drugs – impact is more likely in the Medicare / Medicare Advantage group) based on age of the population
- Do you have person(s) within your organization that are managing things like pathways and biosimilar selection on a quarterly basis?
- Who advocates with your GPO for drug contracting?
 - ✓ Do you get quarterly updates related to preferred drugs?
 - ✓ How do you determine your pathways?

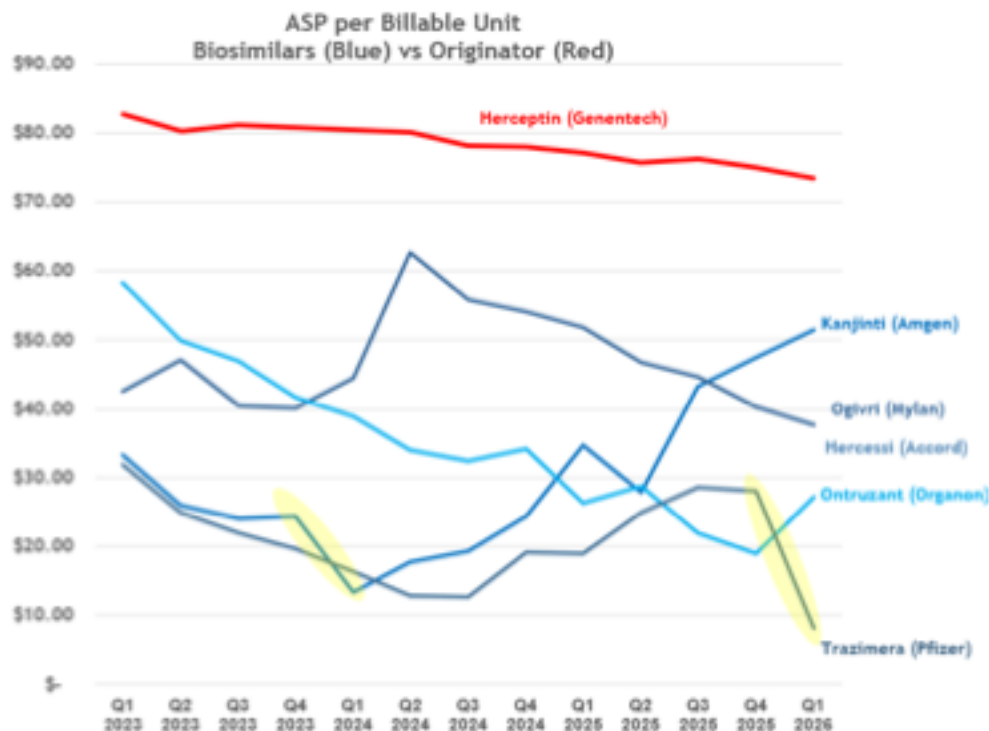




Volatility: When the rebates “catch-up” in the calculation, ASP for whole classes of drugs can plummet

Why is this bad?

- Rebates that go to payers, don't serve the patients nor the practices that serve the patients, but they DO count in the calculation



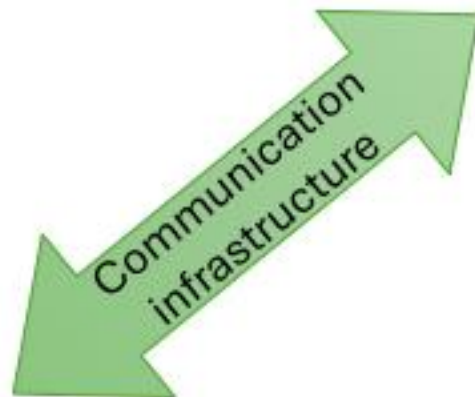
Key Need-To-Knows to Minimize the Bad:

- Who do you *need to* and who *can you* move quickly to “other drugs” that are not under water?
 - ✓ Again, here payer-mix, formulary management personnel matter
- Who manages payer contracting, and do you have contacts with your major payers that can advocate for you?
 - ✓ Do they meet with them at a regular cadence?
 - ✓ Do your major payers have restricted formularies that mandate selection of under-water drugs?
- And, again, drug contracting matters
 - ✓ Who advocates with your GPO for drug contracting?
 - ✓ And, how far in advance are you getting needed information?

Why Are the “Need-To-Knows” So Noteworthy?



Knowing what patients you can switch to alternative products, as soon as possible, helps minimize under-water dispenses, and inventory on your shelf you cannot use



The three-way handshake:

Relationships with payers can aid in advocating *against* restrictive formularies

Relationships with manufacturers and your GPO can aid in insuring timely information regarding pricing strategy



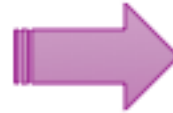
Average Sale Price - The Buffalo



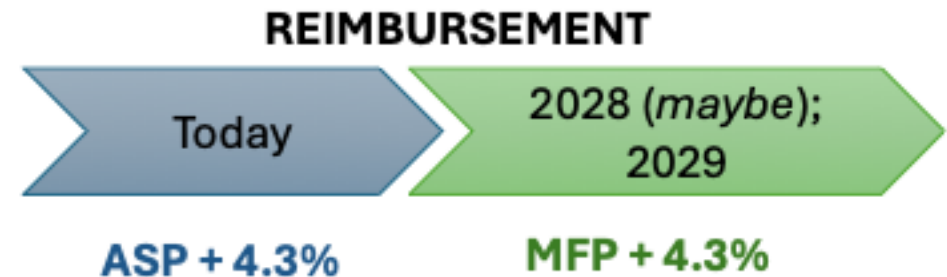
Unknown: What happens when ASP is replaced by Maximum Fair Price (when the IRA hits Part B in 2028/2029)?

What is the IRA?

- The Inflation Reduction Act was part of the Biden Administration's Healthcare, Tax, and Clean Energy Law
- How does it impact Community Oncology?
 - ✓ A list of drugs will be selected for [price negotiation](#) by Medicare
 - Eligible drugs will have been approved for at least 7 years (oral drugs) or 11 years (biologics), and cannot be drugs for an orphan disease, cannot have a biosimilar or generic, must represent a threshold of spend by Medicare
 - ✓ 10 drugs were selected in 2026; 15 drugs in 2027 & 2028, and 20 drugs will be selected in 2029 and beyond
 - ✓ Only Part D drugs (eg, orals) are eligible for 2026/2027
 - ✓ Part B drugs (eg, those given in your infusion sites) will be eligible in 2028



How will it affect my practice?



Year	Drug	WAC (last published year)	MFP	% Reduction
2026	Ibrutinib	\$15,280 (2024)	\$9,319	39%
	Palbociclib	\$15,741 (2026)	\$7,871	50%
2027	Acalabrutinib	\$14,228 (2026)	\$8,600	40%
	Enzalutamide	\$13,480 (2026)	\$7,004	48%

The IRA Technical Fix



- There doesn't appear to be major oncology revenue-generating *infusion* drugs on the 2028 list; still waiting on the 2029 list
- There are multiple groups lobbying for a technical fix which would involved leaving oncology practices at an ASP-based reimbursement, and having the drug manufactures give rebates directly to CMS for the difference between ASP and MFP



Summary:



- ✓ Understanding the economics of oncology drug delivery matters
- ✓ You don't have to be a finance expert to be financially informed
 - ✓ Ask informed questions
- ✓ Financial stewardship supports patient care
- ✓ Women leaders at these tables are necessary in order to ensure that our valuable perspectives about clinical care, operations, finances, workforce, and patient access are heard

Thank you!

Any questions:

mblazer@coainc.cc



“Above everything else I’ve done, I’ve always said I’ve had more guts than I’ve got talent.”

- Dolly Parton

“I’ve been using my torch to light other peoples’ torches. Because the whole idea that there’s only one torch is part of the reason why we’re so [messed] up. Everybody needs a torch.”

- Gloria Steinem

Emerging Trends in Patient Care

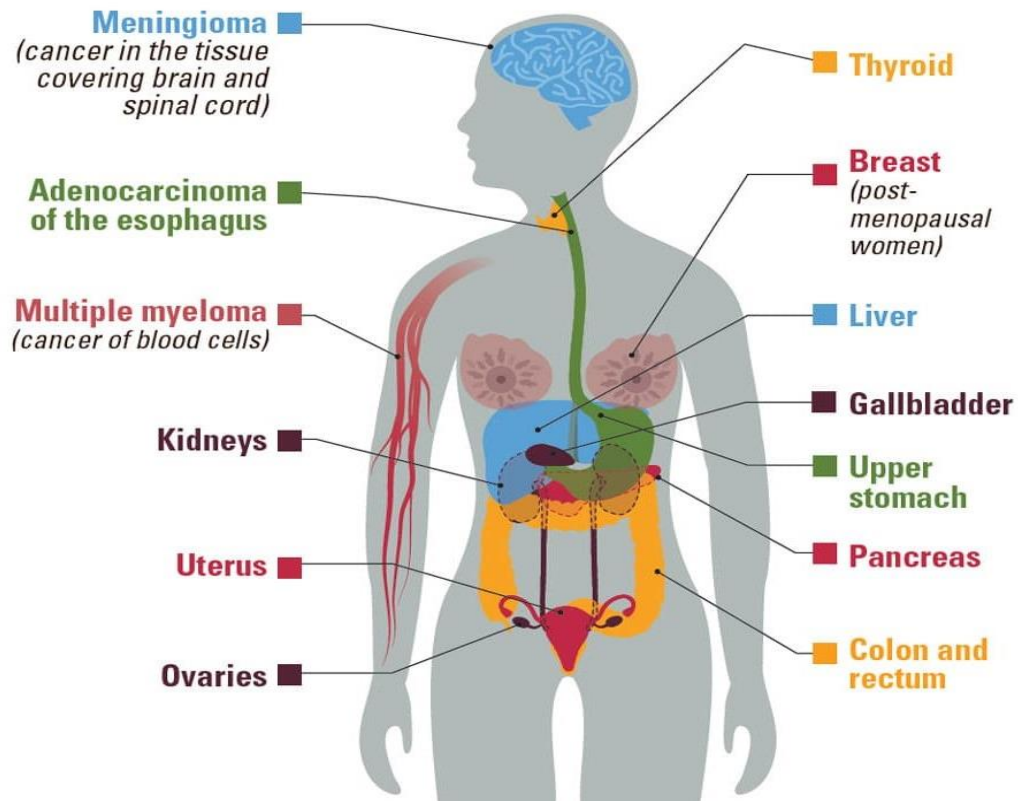
Weight, Glucagon-like Peptide-1 Receptor Agonists (GLP-1s) and Cancer

Shruti Singh, MD
Northwest Cancer Centers

Why Weight Matters in Oncology Practice?

Obesity and metabolic dysregulation are recognized as major oncogenic drivers across multiple tumor types

13 cancers are associated with overweight and obesity



More than **716,000 obesity-associated cancers** occurred in the United States in 2022

Obesity is a modifiable risk factor for development, progression, and resistance to therapy in various cancers

- Reinforces the importance of **metabolic health screening** in oncology care
- Potential discussion of **GLP-1 therapy** and cancer-risk reduction

What are GLP-1 Receptor Agonists?

GLP-1 receptor agonists (RAs) were originally developed as antidiabetic drugs that mimic the action of glucagon-like peptide-1 (GLP-1), an incretin hormone that enhances insulin secretion in response to meals

4 FDA Approvals for Chronic Weight Management

- **Wegovy (semaglutide)**
 - Initial approval (injectable) 2021
 - December 2025 as an oral
 - March 2026 as a higher dose injectable
- **Zepbound (tirzepatide)**
 - November 2023 (injectable)
- **Saxenda (liraglutide)**
 - August 2025 (injectable)
- **Foundayo (orforglipron)**
 - April 2026 as an oral

Mechanism of Action

GLP-1 RA binds to and activates GLP-1 Receptors

Enhances insulin secretion

Suppresses glucagon secretion

Delays gastric emptying and reduces appetite

Cardiovascular and renal benefits

GLP-1 Therapies: Expanding Use and Emerging Implications for Cancer Care

GROWTH · 2024 TO 2026

GLP-1 use has doubled or more on every major tracker

Share of US adults taking a GLP-1, start and end points only. No survey published the quarters in between.



KFF counts all reasons for use; Gallup counts weight loss only. The measures are not interchangeable.

The two Gallup series are drawn in the same color and separated by line style: solid for ever-use, dashed for current use.

Sources: KFF Health Tracking Poll (Oct–Nov 2025); Gallup (May–Jun 2026).

- Approximately 11-12% of adults in the US currently use GLP-1s
- Medicare's GLP-1 Bridge gives eligible beneficiaries GLP-1s for \$50 a month
- 43% of the largest US employers now cover GLP-1s for weight loss
- Direct-to-consumer out-of-pocket have fallen to \$150-350 per month
- **Implications for Community Oncology: Increased need for provider education regarding GLP-1 therapies**

[GLP-1 statistics: 65 numbers on usage, results and cost in 2026 | Pabau](#)

Why GLP-1s Matter in Oncology Practice?

GLP-1s may offer dual benefit: metabolic control and potential reduction in metastatic tumor progression in obesity related cancers

Potential mechanisms: weight loss, reduced visceral adiposity, decreased insulin/IGF-1 signaling, and modulation of tumor growth pathways

GLP-1s have **anti-inflammatory and immune-modulatory effects** beyond glucose control

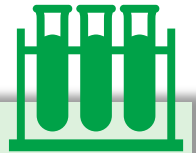
Associated with reductions in pro-inflammatory cytokines (IL-6, TNF- α , CRP) and favorable changes in the tumor microenvironment

Type 2 diabetes is associated with increased cancer risk due to metabolic dysfunction and chronic inflammation

Hyperinsulinemia, insulin resistance, and activation of pathways associated with cellular proliferation and tumor growth

GLP-1 Receptor Agonists: Expanding Evidence Across Therapeutic Areas

According to ClinicalTrials.gov (accessed September 17, 2026), **198** active and completed clinical studies are evaluating GLP-1 receptor agonists. While obesity, diabetes, and cardiovascular disease remain the primary focus areas, a growing number of studies are **examining the relationship between GLP-1-mediated weight loss and cancer incidence, cancer outcomes, treatment tolerance, and survivorship**



Select active trials in GLP-1 and cancer:

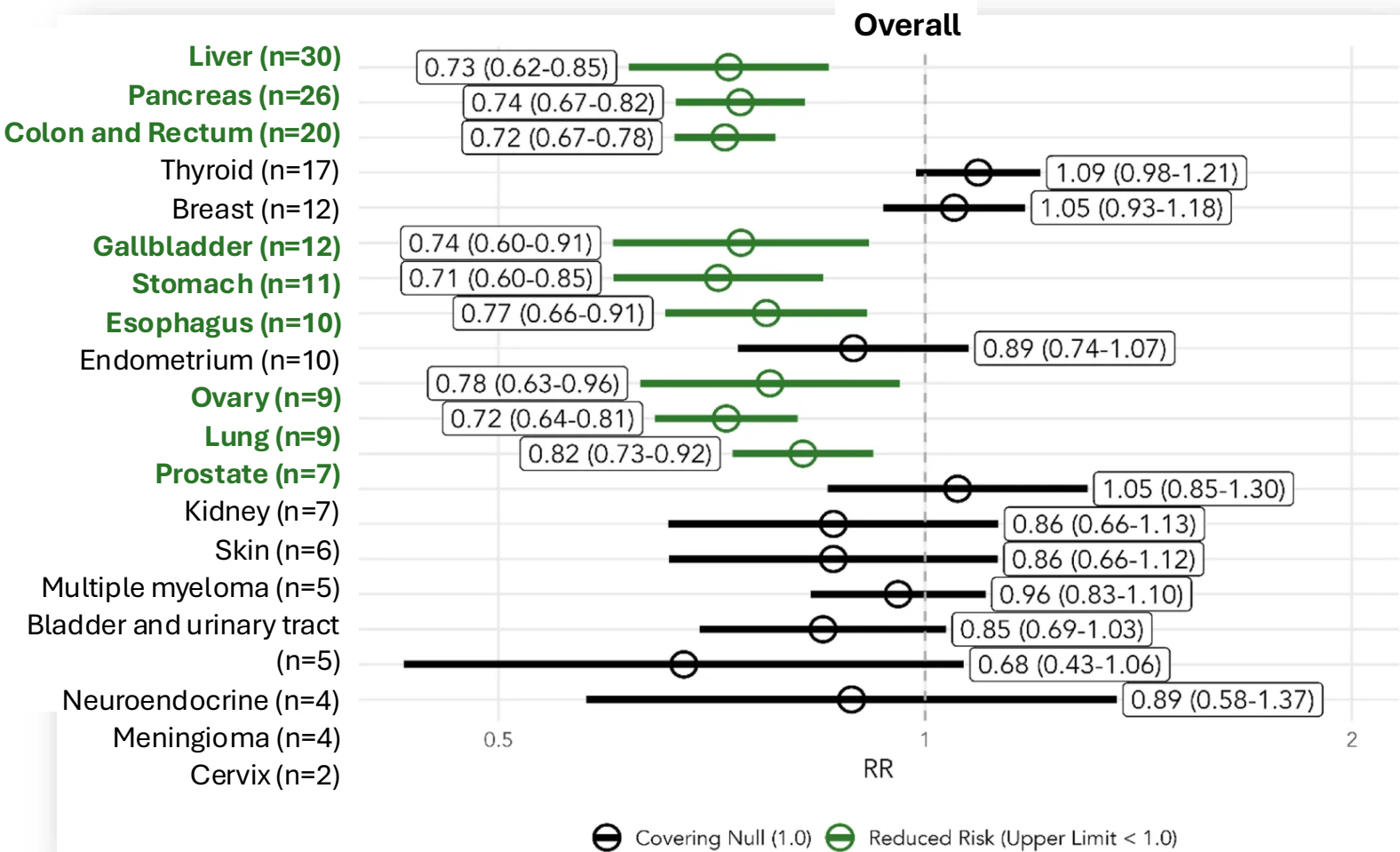
- GLP-1 RA Plus SOC Treatment in First-line, Metastatic Pancreatic, Colorectal, or Hepatocellular Cancer (NCT07627191)
- Evaluating the Impact of GLP-1 Receptor Agonists With Total Neoadjuvant Therapy in Rectal Cancer (NCT07314528)
- Investigation of GLP1-Receptor Agonists in Men With Prostate Cancer Taking Androgen Deprivation Therapy (GAINPCCONTROL) (NCT06908694)
- Clinical Study of Local and Systemic Biological Impact of GLP1/GIP-Receptor Agonists in Patients With Breast Cancer: The CLARA Trial (CLARA) (NCT07676331)

Associations Between Glucagon-Like Peptide-1 Receptor Agonists (GLP-1RAs) and Cancer Risk: A Systematic Review and Meta-Analysis



- Literature searches in MEDLINE and EMBASE databases, covering publications up to September 17th, 2025
- Included studies among adults receiving GLP-1RAs for any indication that reported effects on cancer incidence of any type.

Overall associations between GLP-1RA agents and site-specific cancer risk



Can GLP-1 receptor agonists mitigate cancer progression?

Study Design

Retrospective observational cohort

Population (n=10,225):

- Breast, Lung (NSCLC), Colorectal, Liver (HCC), Prostate, Pancreatic, Kidney (RCC)
- Patients with stage I–III cancer (TriNetX database)

Two types of antidiabetic agents, GLP-1s and gliptins, were evaluated*.

Drugs Compared (1:1):

- **GLP-1s:** liraglutide (Victoza®, Saxenda®), pramlintide (Symlin®), dulaglutide (Trulicity®), tirzepatide Mounjaro®, Zepbound®), lixisenatide (Adlyxin®), semaglutide (Ozempic®, Wegovy®, Rybelsus®)
- **DPP-4 inhibitors (gliptins):** sitagliptin (Januvia®), linagliptin (Tradjenta®), saxagliptin (Onglyza™), alogliptin (Nesina®, Vipidia®)

- These tumor types represent a large portion of community oncology volume
- Many patients already use GLP-1s for diabetes or weight management

*GLP-1s are more potent and have stronger anti-inflammatory effects than gliptins.

Can GLP-1 receptor agonists mitigate cancer progression?

Results of the retrospective comparison of GLP-1s vs. Gliptins on metastatic progression

Reduced Progression to Stage IV disease and improved survival

Cancer Type	Progression to Stage IV	Risk of Death
Lung	10% vs 22%	HR: 0.50 (0.43-0.59); <i>P</i> -value <0.001
Breast	10% vs 20%	HR: 0.57 (0.46-0.71); <i>P</i> -value <0.001
Colorectal	13% vs 22%	HR: 0.69 (0.54-0.88); <i>P</i> -value 0.003
Liver	19% vs 28%	HR: 0.62 (0.44-0.89); <i>P</i> -value 0.009

- Prostate, pancreatic, kidney: trend toward benefit but **not statistically significant**

➤ GLP-1s resulted in a meaningful reduction in cancer progression across 4 solid tumor types

- ~20 million Americans on GLP-1 receptor antagonist treatments
- Findings are immediately clinically relevant

Overlapping Side Effects between GLP-1s and Cancer Treatments

GLP-1 side-effect rates, each drug against its own placebo

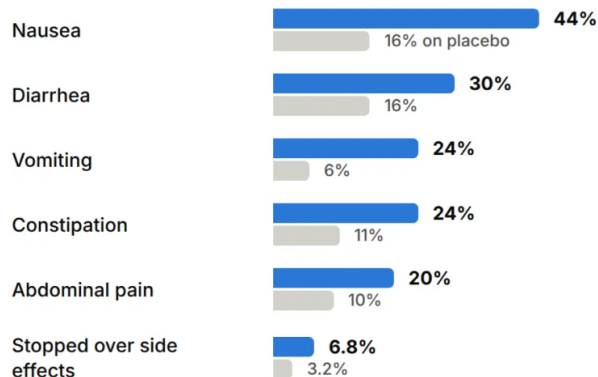
Share of trial patients reporting each effect. Both panels use the same 0–60% scale.

■ On the drug ■ On placebo ■ Range across doses

Separate trials with different populations — shown side by side, not ranked against each other.

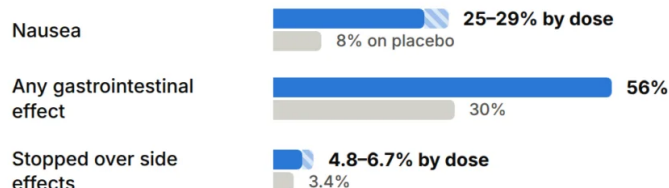
Semaglutide 2.4 mg

FDA label, pooled trials · 2,116 patients against 1,261 on placebo



Tirzepatide

Zepbound label · 2,519 adults



Nearly a third of the placebo group also reported gastrointestinal symptoms, so the share attributable to the drug is smaller than 56%.

Placebo rates are high for gastrointestinal symptoms, so the difference between the bars matters more than the height of either one.

Rates come from each drug's own FDA label and cannot be compared between drugs.

Sources: Wegovy and Zepbound FDA prescribing information.

- GLP-1 receptor agonists and cancer treatments share several gastrointestinal toxicities, including nausea, vomiting, appetite suppression, and constipation
- These **overlapping side effects** may compound nutritional risk, dehydration, weight loss, and treatment burden
- Careful monitoring is needed to distinguish treatment-related toxicities and maintain nutritional status during therapy

[GLP-1 statistics: 65 numbers on usage, results and cost in 2026 | Pabau](#)

Future Directions

- Community-based retrospective or prospective trials to validate anticancer effects of GLP-1s
- Identify if certain tumor types benefit more than others from GLP-1 therapy
- Guidance for GLP-1 continuation/discontinuation during cancer treatment
- Evaluation of GLP-1 Receptor Agonists benefits in patients without diabetes or obesity

Bottom Line: *Every oncologist should ask about GLP-1 use, document therapy in the medical record, and consider its potential impact on cancer outcomes*



Hung. ASCO 2026.

What is the greatest challenge you face when managing patients receiving GLP-1 therapies?

1. Understanding contradictions regarding GLP-1s and active cancer treatment
2. Limited oncology-specific outcomes data
3. GI side effects (nausea, vomiting, hydration, and constipation)
4. Coordination with primary care/endocrinology
5. Rapid weight loss
6. Pancreatitis Risk

Lifestyle Intervention for Optimal Oncology Care: Patients and HCPs

Priya Rudolph, MD, PhD

Georgia Cancer Specialist

Northside Hospital Cancer Institute



6 Pillars of Lifestyle Medicine

When integrated with standard treatment, lifestyle medicine plays an important role in cancer care:

- Optimizing function
- Enhancing treatment tolerance
- Improving quality of life



Which lifestyle medicine intervention do you most recommend to support patients?

1. Nutrition counseling
2. Physical activity/exercise programs
3. Behavioral health or stress management
4. Structured weight-management programs
5. Support groups
6. Referral to supportive care services
7. Unable to offer lifestyle medicine interventions

Presented Lifestyle Intervention Studies

at ASCO 2026

Effects of short-term fasting compared to free diet in ovarian cancer patients: Results from a two-arm pilot randomized trial (Abstract 5517)

YOCAS yoga, mood disturbance, and insomnia: A URCC NCORP RB nationwide, phase III, randomized, controlled trial with cancer survivors (Abstract 12004)

Effect of a weight loss intervention on quality of life and symptoms in women with breast cancer: Results from the Breast Cancer Weight Loss (BWEL) trial (Abstract 12010)

The effects of Mediterranean diet, physical activity, and vitamin D on breast cancer recurrence and cardiometabolic health: A multicenter randomized trial (Abstract 511)

Structured exercise program following adjuvant chemotherapy for colon cancer: CHALLENGE trial (Abstract 3507)

Structured exercise program following adjuvant chemotherapy for colon cancer

Study Design

Phase 3, Randomized trial

Results

Population (n=889):

- Complete resection of stage III or high-risk stage III colon cancer
- Complete adjuvant chemotherapy 2-6 months earlier

Randomized (1:1)

- Structured exercise program
- Health-education material

Primary endpoint: Disease-free survival (DFS)

Survival Rate (%)	Structured Exercise (n=445)	Health Education (n=444)	Hazard Ratio (95% CI)
Disease-free Survival	80.3 %	73.9 %	0.72 (0.55 -0.94)
Overall Survival	90.3 %	83.2 %	0.63 (0.43 – 0.94)

Median follow-up: 7.9 years

➤ A 3-year structured exercise program initiated soon after adjuvant chemotherapy for colon cancer resulted in significantly longer disease-free survival and findings consistent with longer overall survival

Lifestyle Intervention Incorporated in NCCN

Healthy lifestyle habits have been associated with **improved overall health and quality of life** in all phases of survivorship from time of diagnosis throughout cancer treatment and follow-up. For some cancers, a **healthy lifestyle** has been associated with a **reduced risk of recurrence and death**

Consider:

- Assess individual and community-level barriers to meeting the healthy lifestyle recommendations
- Support patients in developing strategies to overcome challenges throughout the continuum survivorship care
- Consider specialty referrals to support programs offered by medical centers or the community



National
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NCCN Guidelines Version 3.2026

Survivorship: Healthy Lifestyles

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GENERAL PRINCIPLES OF HEALTHY LIFESTYLES

Healthy lifestyle habits have been associated with improved overall health and quality of life in all phases of survivorship from time of diagnosis throughout cancer treatment and follow-up. For some cancers, a healthy lifestyle has been associated with a reduced risk of recurrence and death.¹

- Cancer prehabilitation^{2,3} is appropriate for many newly diagnosed survivors prior to initiating treatment with surgery or chemotherapy. Referrals to physical therapy or exercise oncology specialists should be considered.
- For optimal health, all survivors should be encouraged to set incremental as well as ultimate goals for diet, physical activity, and weight management. At a minimum all survivors should be encouraged to:
 - ▶ Achieve and maintain a healthy body weight throughout life ([SNWM-2](#)).
 - ▶ Avoid physical inactivity.
 - ▶ Engage in physical activity (eg, exercise, take the stairs, park in the back of parking lot) daily ([SPA-1](#)).
 - ▶ Maintain a healthy diet high in vegetables, fruits, beans/legumes, whole grains, nuts, and seeds.^{4,5}
 - ▶ Limit red meats to <18 oz per week. It is best to avoid processed meat.
 - ▶ Limit highly processed foods,^{a,b,6} particularly those high in fats and sugars ([SNWM-1](#)).
 - ▶ Limit sugar-sweetened beverages; consume sparingly, if at all.
 - ▶ It is best to avoid alcohol, as any consumption increases risk for several cancers ([SNWM-1](#)).^c
 - ▶ Discontinue use of cigarettes, other tobacco products (including hookah), and e-cigarettes ([NCCN Guidelines for Smoking Cessation](#)).
 - ◊ Avoid secondary exposure to cigarette smoke.
 - ▶ Practice sun safety
 - ◊ Utilize a sunscreen with an SPF of at least 30 that protects against UVA and UVB rays and is water resistant.
 - ◊ Apply sunscreen generously and reapply every 2 hours or after swimming/excessive sweating.
 - ◊ Consider using physical barriers whenever possible (ie, hats, shirts with sleeves, avoiding direct sun during peak hours).
 - ◊ Do not use tanning beds.
 - ◊ Avoid sunburns.
 - ◊ Seek shade and wear protective clothing (ie, hats and long-sleeved garments) if outside for prolonged periods of time or during peak direct sun hours.
 - ▶ Strive for sufficient sleep on a regular basis ([SSD-1](#)).⁷⁻⁹ Recommended total sleep duration:
 - ◊ Adults: 7–9 hours
 - ◊ Adolescents: 8–10 hours
 - ◊ Older adults: 7–8 hours
 - ▶ Follow up with PCP regularly.
 - ◊ Adhere to age-appropriate and treatment-associated health screening, preventive measures ([SIMIN-1](#)), and cancer screening recommendations ([NCCN Guidelines for Detection, Prevention, and Risk Reduction](#)).
 - ▶ Obtain nutrients from food sources rather than relying on dietary supplements. Routine use of dietary supplements is not recommended for the purposes of cancer control ([SSUP-1](#)).

• A multidisciplinary approach (including clinicians trained in lifestyle medicine, physical therapists, occupational therapists, dietitians, social workers, patient navigators, certified exercise professionals, health coaches, and tobacco treatment specialists) should be utilized to:
 - ▶ Assess individual and community-level barriers to meeting the healthy lifestyle recommendations.
 - ▶ Support patients in developing strategies to overcome challenges throughout the continuum of survivorship care (from diagnosis to long-term survivorship).
 - ▶ Consider specialty referrals to supportive programs offered by medical centers or the community (ie, Livestrong at the YMCA).

Note: All recommendations are category 2A unless otherwise indicated.

[Footnotes on \(HL\)](#)
[References on \(HL\)](#)

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Lifestyle Intervention ASCO Guidelines

asco special articles

Exercise, Diet, and Weight Management During Cancer Treatment: ASCO Guideline

Jennifer A. Ligibel, MD¹; Kari Bohlke, ScD²; Anne M. May, PhD³; Steven K. Clinton, MD, PhD⁴; Wendy Demark-Wahnefried, PhD, RD⁵; Susan C. Gilchrist, MD, MS⁶; Melinda L. Irwin, PhD, MPH⁷; Michele Late⁸; Sami Mansfield, BA⁹; Timothy F. Marshall, PhD, MS¹⁰; Jeffrey A. Meyerhardt, MD, MPH¹; Cynthia A. Thomson, PhD, RD¹¹; William A. Wood, MD, MPH¹²; and Catherine M. Alfano, PhD¹³



abstract

PURPOSE To provide guidance on exercise, diet, and weight management during active cancer treatment in adults.

METHODS A systematic review of the literature identified systematic reviews and randomized controlled trials evaluating the impact of aerobic and resistance exercise, specific diets and foods, and intentional weight loss and avoidance of weight gain in adults during cancer treatment, on quality of life, treatment toxicity, and cancer control. PubMed and the Cochrane Library were searched from January 2000 to May 2021. ASCO convened an Expert Panel to review the evidence and formulate recommendations.

RESULTS The evidence base consisted of 52 systematic reviews (42 for exercise, nine for diet, and one for weight management), and an additional 23 randomized controlled trials. The most commonly studied types of cancer were breast, prostate, lung, and colorectal. Exercise during cancer treatment led to improvements in cardiorespiratory fitness, strength, fatigue, and other patient-reported outcomes. Preoperative exercise in patients with lung cancer led to a reduction in postoperative length of hospital stay and complications. Neutropenic diets did not decrease risk of infection during cancer treatment.

RECOMMENDATIONS Oncology providers should recommend regular aerobic and resistance exercise during active treatment with curative intent and may recommend preoperative exercise for patients undergoing surgery for lung cancer. Neutropenic diets are not recommended to prevent infection in patients with cancer during active treatment. Evidence for other dietary and weight loss interventions during cancer treatment was very limited. The guideline discusses special considerations, such as exercise in individuals with advanced cancer, and highlights the critical need for more research in this area, particularly regarding diet and weight loss interventions during cancer treatment.

Additional information is available at www.asco.org/supportive-care-guidelines.

J Clin Oncol 40:2491-2507. © 2022 by American Society of Clinical Oncology

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Oncology providers should recommend regular aerobic and resistance exercise during active treatment with curative intent and may recommend preoperative exercise for patients undergoing surgery for lung cancer.

Implications for Practice



Routinely assess lifestyle factors as part of cancer care



Incorporate evidence-based nutrition, physical activity, sleep, and stress management counseling



Leverage referrals to dietitians, exercise specialists, and supportive care services



Align practice workflows with NCCN and ASCO supportive care recommendations



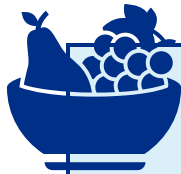
Recognize that lifestyle interventions may improve treatment tolerance, quality of life, and survivorship outcomes

Free Lifestyle Intervention Resources for Community Oncology Patients



Physical Activity

Livestrong at the YMCA:
Free 12-week exercise
program for cancer
survivors



Nutrition

Eatrightpro.org: Free
nutrition resources for
cancer treatment
journey



Psychosocial Support

CancerCare: Free
professional counseling
and support



What's good for our patients is also good for *us*...

Reduce or eliminate alcohol intake entirely due to evidence linking even low intake with increased breast, colorectal, and other cancer risks

Follow a **plant-forward diet** to support gut microbiome and reduce inflammation

Cook at home to avoid excess salt, sugar, butter, and pesticide exposure common in restaurant and processed foods

Maintain **7–9 hours of sleep** to support metabolic regulation, insulin sensitivity, appetite control, and healthy BMI

Strength train at least 2–3 times weekly to improve metabolic health and long-term resilience

Use **daily sunscreen**

Visit the **dentist twice yearly**

Act **promptly on early cancer warning** signs – e.g., colon cancer

Burnout, Leadership aspiration and organizational retention at follow up vs. baseline

Participation in a *Women Leaders in Medicine* program was associated with **reduced emotional exhaustion** and **depersonalization** and **increased leadership aspirations** among female physicians

Study Outcome	Intervention Group:		Cohort 1		Cohort 2		Cohort 3	
	BSWH Female Physicians Who Attended WLiM Events		BSWH Female Physicians Who Did Not Attend WLiM Events		BSWH Male Physician Respondents		Texas Medical Association (TMA) Physician Respondents	
	Mean (±SD)	Median (IQR)	Mean (±SD)	Median (IQR)	Mean (±SD)	Median (IQR)	Mean (±SD)	Median (IQR)
Emotional exhaustion (EE)								
• “I feel burned out from work” at baseline	2.9 (1.8)	3 (1, 4)	3.2 (1.8)	3 (1, 5)	2.6 (1.9)	2 (1, 4)	3.3 (1.9)	3 (2, 5)
• “I feel burned out from work” at follow-up	2.5 (1.8)	2 (1, 4)	3.0 (1.9)	3 (1, 5)	2.7 (1.9)	2 (1, 4)	3.2 (1.8)	3 (2, 5)
Depersonalization (DP)								
• “I’ve become more callous” at baseline	1.6 (1.7)	1 (0, 3)	1.7 (1.8)	1 (0, 3)	1.6 (1.8)	1 (0, 3)	2.0 (1.8)	1 (1, 3)
• “I’ve become more callous” at follow-up	1.3 (1.2)	1 (0, 2)	1.5 (1.7)	1 (0, 2)	1.7 (1.8)	1 (0, 3)	2.1 (1.8)	1 (2, 3)
Personal achievement (PA)								
• “accomplished many worthwhile things” at baseline	4.7 (1.5)	5 (4, 6)	4.5 (1.4)	5 (4, 6)	4.7 (1.4)	5 (4, 6)	---	---
• “accomplished many worthwhile things” at follow-up	5.1 (1.0)	5 (5, 6)	4.5 (1.5)	5 (4, 6)	4.8 (1.4)	5 (4, 6)	---	---
Leadership aspirations								
• “To what degree do you aspire to be a leader” at baseline	7.4 (2.4)	8 (6, 10)	5.3 (3.2)	5 (2, 8)	6.6 (3.1)	7 (5, 10)	6.6 (3.0)	7 (5, 10)
• “To what degree do you aspire to be a leader” at follow-up	7.8 (2.6)	8 (6.5, 10)	6.2 (3.1)	7 (4, 9)	6.4 (3.4)	7 (3, 10)	6.8 (3.2)	8 (5, 10)
Retention with Organization								
• “plan on staying in organization for 5 years?” at baseline	4.0 (1.3)	5 (3, 5)	3.7 (1.5)	4 (3, 5)	4.0 (1.4)	5 (3, 5)	3.6 (1.7)	4 (3, 5)
• “plan on staying in organization for 5 years?” at follow-up	4.1 (1.9)	4.5 (3.5, 5)	4.1 (1.4)	5 (3.5, 5)	3.8 (1.6)	5 (3, 5)	3.6 (1.6)	4 (3, 5)

The parameters of burnout and leadership aspirations improved for the women who participated in WLiM events compared to those who did not. Both control groups scored worse on some of the burnout parameters. Intention to stay remained unchanged over time for TMA women physicians and worsened from male physicians. Intention to stay improved in women who attended and did not attend WLiM events at the institution.

<https://doi.org/10.1371/journal.pone.0319895.t002>

Caring for Ourselves to Better Care for Patients

Lifestyle Medicine is for Healthcare Providers too!



Healthcare providers face increasing demands, administrative burden, and risk of burnout

The 6 pillars of lifestyle medicine can help support:

- Leadership effectiveness
- Work-life integration
- Physical and emotional well-being
- Professional fulfillment
- Prevention of burnout and compassion fatigue

Artificial Intelligence (AI) Revolution Impact on Oncology Care

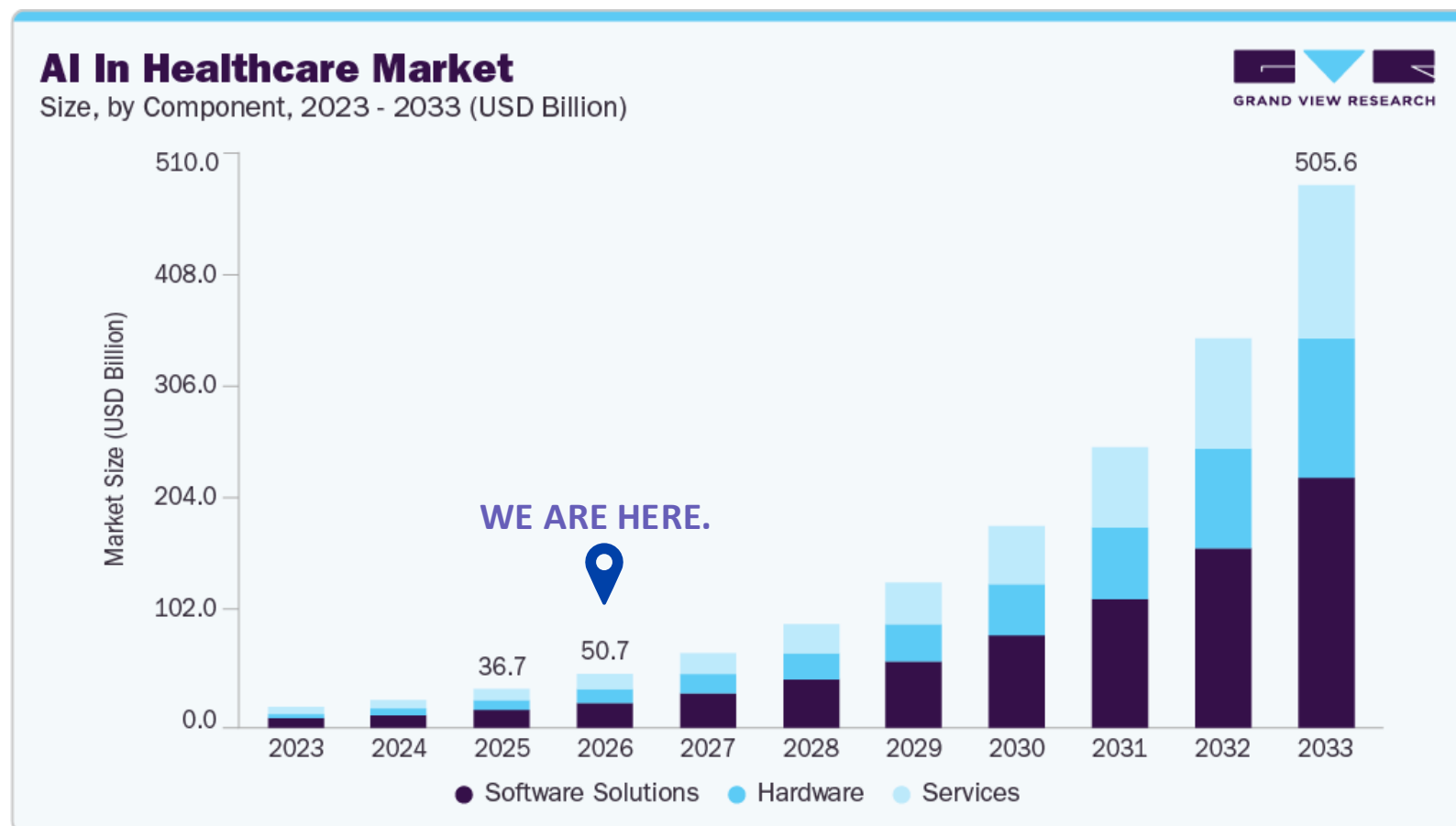
Edith A. Perez, MD

*Chief Medical Officer,
Cornerstone Specialty Network
Professor Emeritus, Mayo Clinic*



Future Tools and Innovation

We are in the *middle* of the AI boom



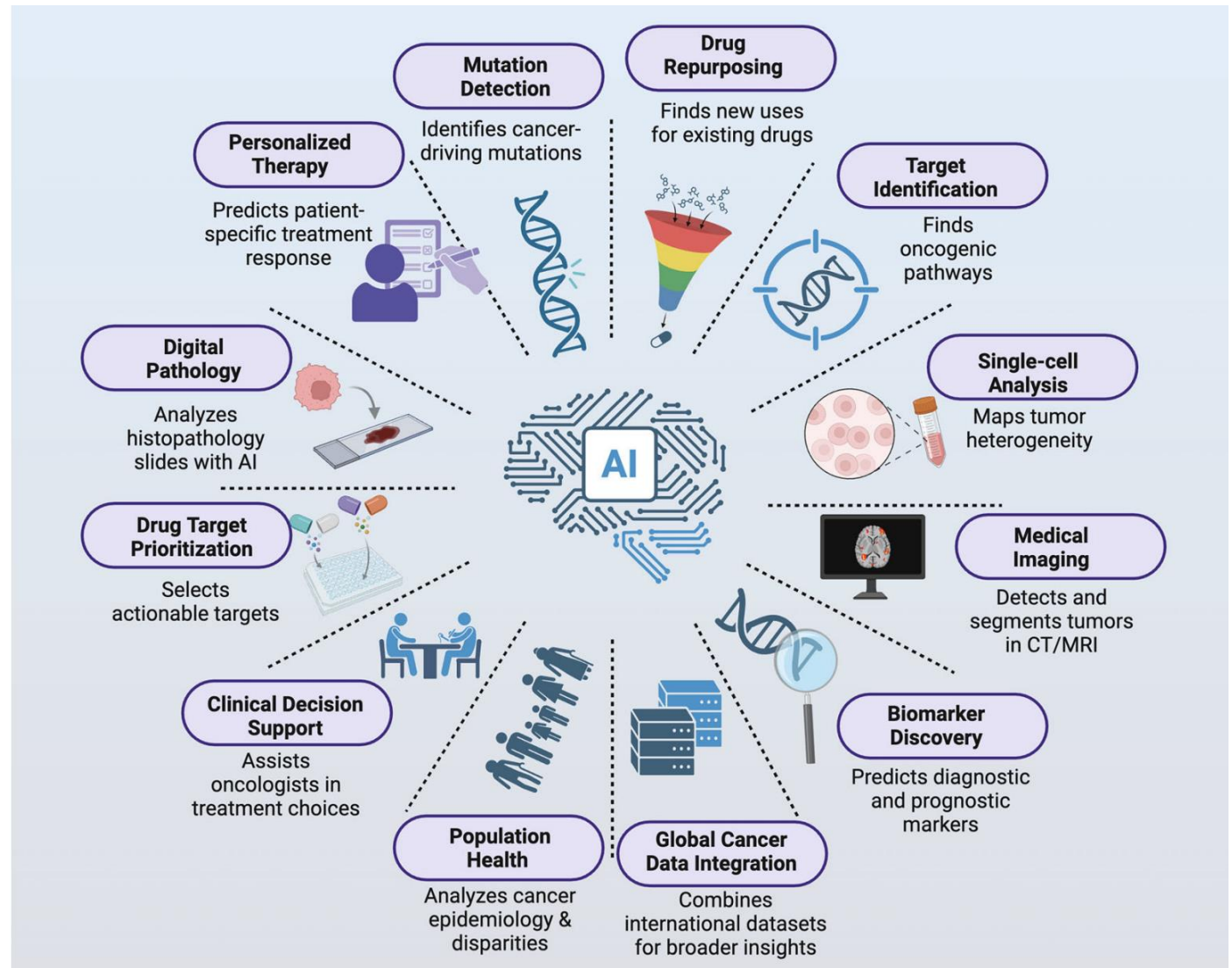
Grand View Research [AI In Healthcare Market Size, Share | Industry Report, 2030](#)

The swirl: An already dizzying array of AI - powered solutions exists and continues to proliferate.

The challenge: cut through the noise to identify and operationalize **meaningful, durable solutions.**

Impact of AI in Modern Oncology

Various areas in which AI aids in cancer research and treatment, from imaging, clinical decision support, and global data integration to mutation mapping, biomarker discovery, and treatment development



Women are Driving Both Sides of AI Adoption

Innovation happening on both Builder and Buyer domains

Builders:

Women Founders are Domain Experts

- Women-founded teams generate 2.5x revenue per dollar invested and 63% higher ROI than all-male peers (*First Round Capital*).
- Women represent 30% of U.S. data scientists and 44% of the college-education STEM workforce (*NCSES NSOG, 2021*), the technical foundation for the industries AI is reshaping
- Women lead 22.3% of health tech founding teams (*Carta, 2023*), the highest share of any sector, with rising concentration in medical devices and care operations

Buyers:

Women Operators Hold Procurement Authority

- 65% of enterprise procurement and compliance budgets are managed by women (*WEF, 2024*), and 80% of women business leaders share AI strategy (*Morningstar, 2024*).
- Enterprise AI adoption concentrates in the functions women dominate: 78.9% of healthcare employment, 54.5% of financial activities, and ~51% of compliance officers (*BLS, 2024*)
- Female procurement leaders adopt faster when automation is built by founders with firsthand workflow expertise, shortening sales cycles for women-led vendors

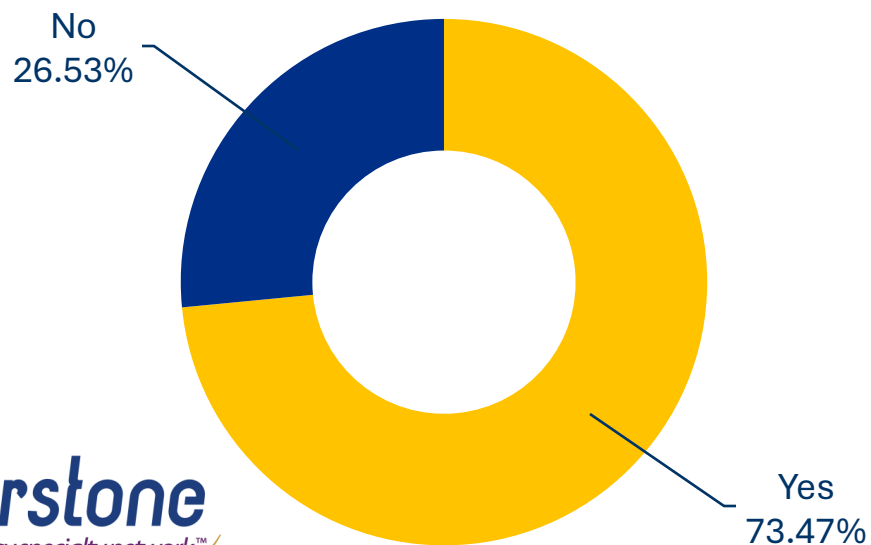
Implication for Community Oncology

- 81% of physicians now use AI professionally; daily use continues to grow
- 32% of adults use AI for health information and increasingly bring AI-generated content to clinic visits
- AI is improving documentation, research, workflow efficiency, and patient engagement
- Practices will face a growing number of AI vendors and solutions
- Success depends on selecting trusted, evidence-based partners and use cases

Cornerstone Survey of 98 Community Oncologists

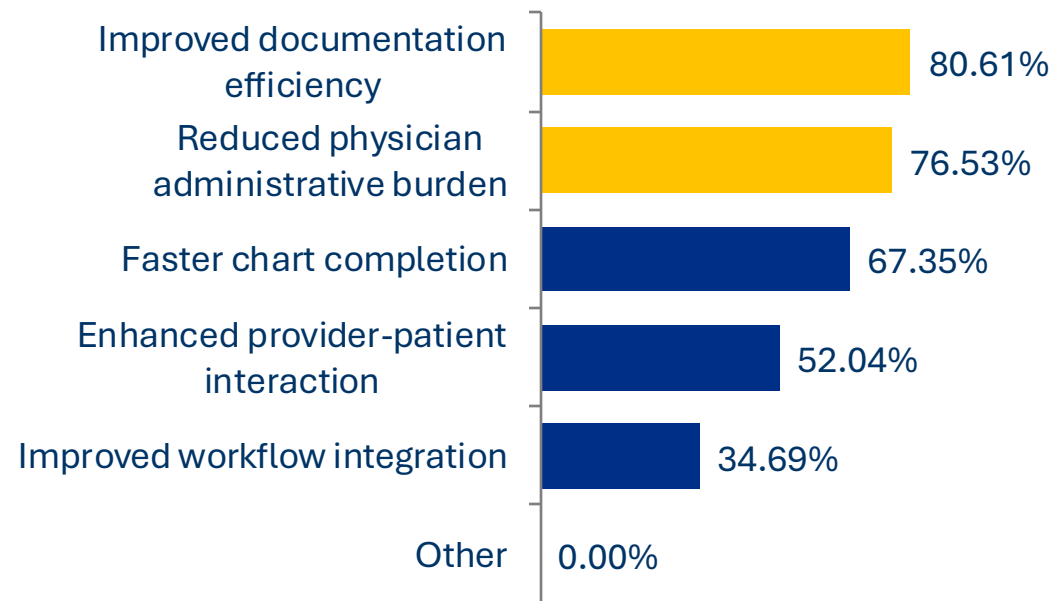
- Nearly 3 in 4 community oncology practices are utilizing AI-powered documentation tools

“Does your practice currently utilize any voice-enabled AI technology or AI-assisted clinical documentation tools?”

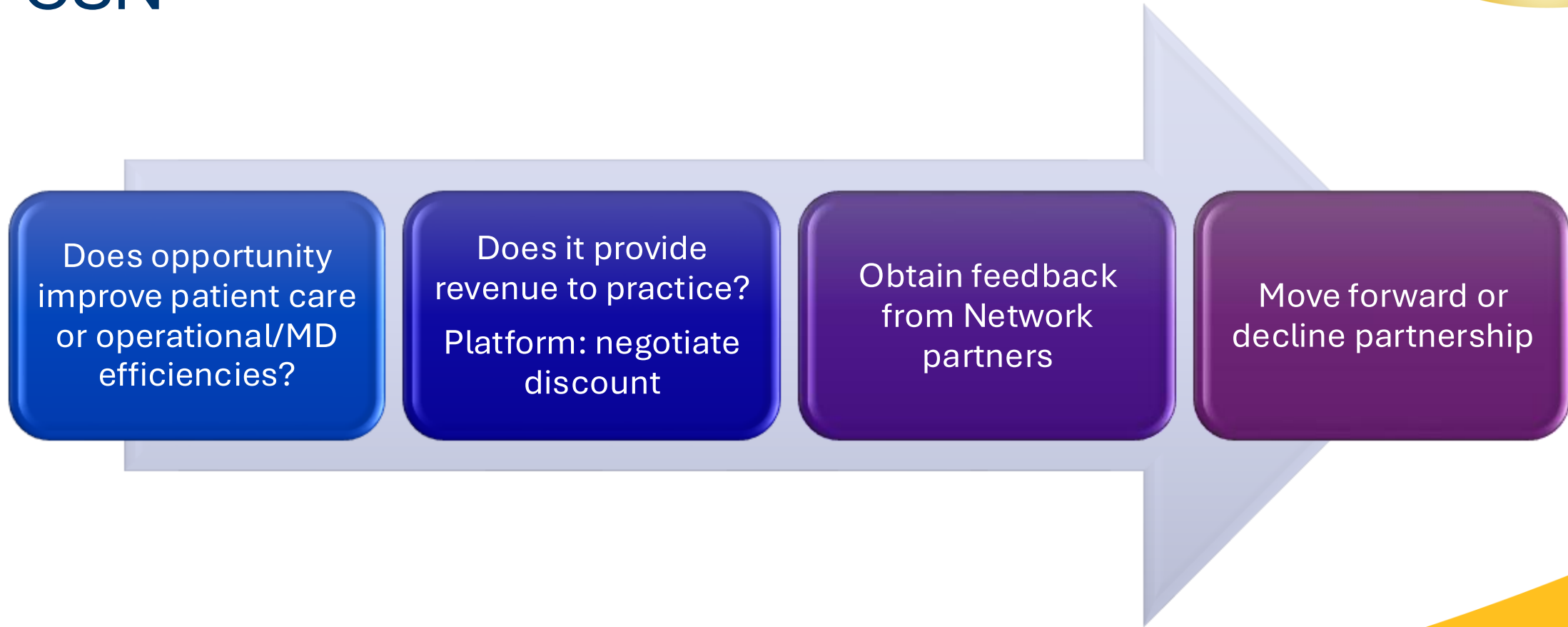


- Practices see AI as a solution to improving efficiency and reducing physician administrative burden

“Which potential benefits of AI-enabled documentation are most important to your practice? (Select all that apply)”



Evaluation of Partnership Opportunities at CSN



What Cornerstone is Doing to Support AI Incorporation to Improve Clinical Practice



Knowtex Partnership

- Knowtex's platform leverages voice-enabled artificial intelligence to automate **clinical documentation, medical coding, and deep EMR integration**
- By embedding these capabilities into everyday clinical operations, practices can expect meaningful improvements in **clinician efficiency and burnout reduction, revenue cycle performance, and patient care quality**



PulsePointAI

Platform Under Development for Oncology

- Transforms **fragmented data** into actionable insights by consolidating EMR, PM, and lab information into **one clinical command center**
- Uses NCCN Guidelines, best practices, high-level clinical input, and feedback to **identify clinical gaps, prevent missed appointments, and streamline day-to-day workflows**

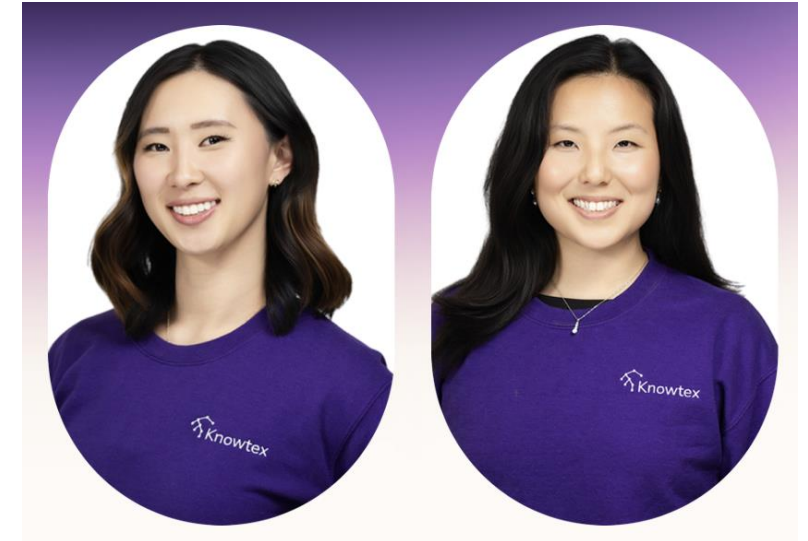
The Knowtex Team and Product

Team: Stanford scientists and clinicians with deep oncology expertise and live deployments across the U.S.

Mission: Technology should be used to enhance and empower your clinical workflows, so you can focus on patients, not paperwork.

Data: Platform is powered by a unique, custom dataset of **12 million expertly curated medical interactions**, with deep coverage of oncology and specialty care encounters.

Product: Transparent, specialized AI models that **automate end-to-end clinical workflows** — tailored to the realities of community oncology.



Caroline Zhang
Founder/CEO

Jocelyn Kang
Founder/CTO

Knowtex Offers One Platform, Built for Oncology, and Relevant to Community Practice

TIME SAVING

Ambient Documentation

Real-time note generation during visits. Specialty-tuned for oncology to capture treatment intent, staging, NCCN context, and more.

REVENUE IMPACT

AI Coding & Billing

Automated and customizable ICD-10 and E&M code suggestion from the clinical note. Reduces coder burden, improves revenue capture.

DECREASING CLICKS

AI Order Entry

Detects order intent in conversation. Stages CBC, imaging, lab orders for one-click approval. Eliminates manual EHR click burden.

CLINICAL INTELLIGENCE

Longitudinal Reasoning

Synthesizes prior visits, labs, treatment history. Surfaces relevant context at point of care.

EHR MADE EASY

EHR Summarization

Face Sheet: real-time access to full patient history during encounter. Abnormal labs, imaging, prior plans surfaced instantly.

PARTNERSHIP

Codevelopment

Premier workflow builds tailored to your digital strategy. We scope, build, and validate together — your roadmap, our engineering.

Platform capabilities are modular and can be turned on/off at a provider/specialty/group level.

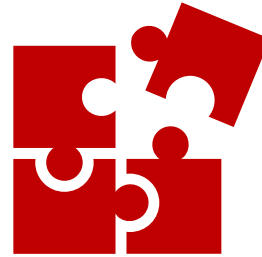
PulsePoint: From Data to Action

Building a connected intelligence layer for independent specialty practices



WHY WE BUILT IT

Practices already have the data needed to make better clinical, operational and economic decisions.



THE PROBLEM IS CONNECTION



PULSEPOINT

Connects clinical, economic, operational fragmented sources and turns them into actions a person can evaluate and use.

Built first in urology. Designed to extend beyond.

Our Custom Clinical Action is a Patient Finder

With refinement, the same capability could support oncology trial pre-screening

DEFINE STUDY-LIKE CRITERIA

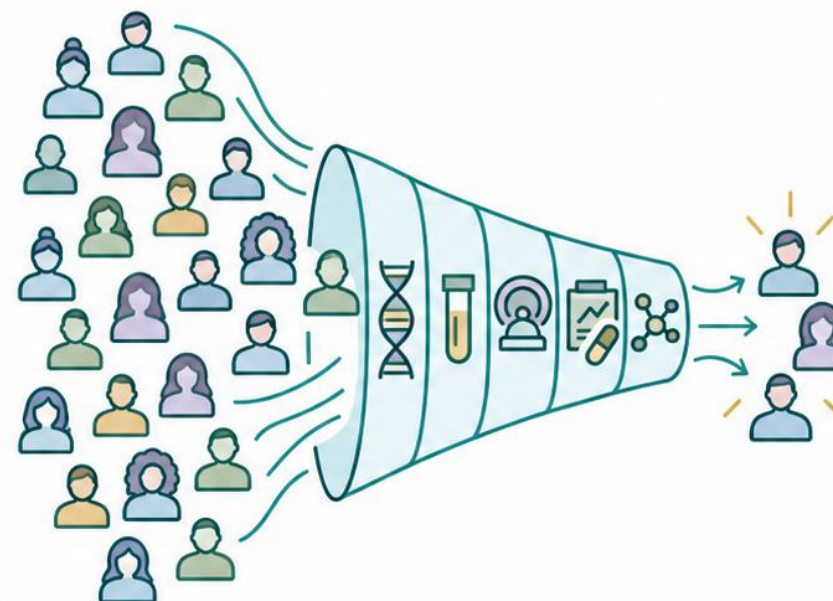


INCLUSION

- Disease state
- Biomarkers
- Prior therapy

EXCLUSION

- Contraindications
- Prior exposure
- Thresholds



SAME UNDERLYING PROBLEM | *Find the patient who fit*

Technology Finds. Humans Validate. Research Decides.

Oncology requires a deliberate clinical validation layer before research action



FIND

Criteria-driven
technology



VALIDATE

Practice or external
clinical later



DECIDE

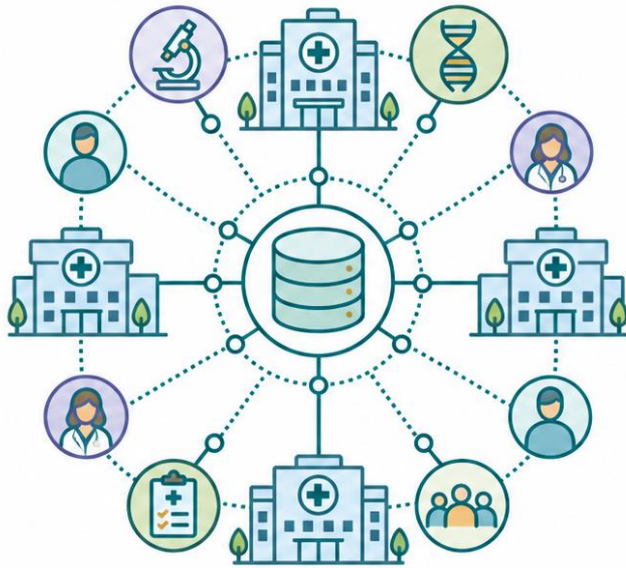
Research team /
investigator

UROLOGY USES NURSE NAGIVATORS FOR THIS VALIDATION STEP

ONCOLOGY WILL NEED ITS OWN OPERATING MODEL

The Opportunity for Cornerstone Clinical Investigation Alliance (CCIA)

A connected network can become easier to evaluate, activate and grow



POTENTIAL VALUE

Faster feasibility

Better patient identification

Stronger trial enrollment

More differentiated network data

More research + revenue opportunity

START NARROW. VALIDATE THE MODEL. SCALE WHAT WORKS.

How are you currently using AI to support oncology patient care or practice management?

1. Clinical documentation and administrative tasks
2. Patient education and communication
3. Clinical decision support
4. Research or data analysis
5. Exploring AI but not yet actively using it
6. Not currently using AI

Pathways to Leadership



Edith A. Perez, MD

*Chief Medical Officer,
Cornerstone Specialty Network
Professor Emeritus, Mayo Clinic*



Eleanor Faherty, MD

*Senior Director, US Medical
Affairs at Daiichi Sankyo*

Building the Next Generation of Women Leaders



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Eleanor Faherty, MD
*Senior Director, US Medical
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Marlo Blazer, PharmD, BCOP
*Columbus Oncology & Hematology
Columbus, OH*



Shruti Singh, MD
*Northwest Cancer Centers
Dyer, IN*



Priya Rudolph, MD, PhD
*Georgia Cancer Specialists
Northside Hospital Cancer Institute
Athens, GA*

Mentorship vs Sponsorship for Professional Development

Mentor

A trusted counselor or guide from inside or outside the workplace; someone who teaches or gives help and advice

- Experienced person who is willing to help and support you
- Builds your confidence and provides a sounding board
- Offers empathy
- Expects very little in return



Sponsor

Someone who vouches or is responsible for a person; one who makes a pledge or promise on behalf of another within the workplace

- Believes in you and your potential and is willing to bet on you
- Vested in your future progression
- Encourages you to take risks and has your back
- Expects a great deal from you (performance and loyalty)



Advice
Makes introductions
Gives feedback
Guidance

Thank you for joining Women Advancing Medicine 2026!

- Access today's slides in the Network Member Portal
- We look forward to seeing you at future Women Advancing Medicine programs in 2027!