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Improving CAR T Referrals for Large B-Cell Lymphoma: A Path to Better Collaboration

Announcer:
You're listening to *Project Oncology* on ReachMD, and this episode is sponsored by Kite Pharma. Here's your host, Dr. Charles Turck.

Dr. Turck:
This is *Project Oncology* on ReachMD, and I'm Dr. Charles Turck. Here with me today to discuss how we can improve collaboration between referring physicians and CAR T centers for patients with relapsed or refractory large B-cell lymphoma are Drs. Forat Lutfi and Nilanjan Ghosh. Dr. Lutfi is an Assistant Professor of Hematologic Malignancies and Cellular Therapeutics at University of Kansas Medical Center. Dr. Lutfi, welcome to the program.

Dr. Lutfi:
Thank you. Thank you very much.

Dr. Turck:
And Dr. Ghosh is a Professor of Cancer Medicine at the Wake Forest University School of Medicine in Charlotte, North Carolina. Dr. Ghosh, it's great to have you with us as well.

Dr. Ghosh:
Thank you for having me.

Dr. Turck:
So starting with you, Dr. Lutfi, would you walk us through a typical referral process for a patient with relapsed or refractory large B-cell lymphoma who's being considered for CAR T-cell therapy?

Dr. Lutfi:
Absolutely. So the standard practice which we have is through our referral base, and there's the formal referral and then also the informal referral. And a bit of that depends, of course, on the particular situation with the patient.

So typically speaking, we have a very large network here and good communication with most of our providers, particularly in Kansas. While the Kansas City metropolitan area is several million and is well-concentrated, a lot of our patients come from rural areas several hours away, and it can sometimes be a bit challenging for them to get here. But generally speaking, the referral is placed and depending on the acuity of the situation, we'll see a patient usually within a matter of days. Sometimes it can be a little bit longer than that. Other times, if there's a patient that is in a very dangerous situation, typically primary refractory or high-bulk disease, we have very good relationships with our local physicians and they just call us. And I think for patients who really need it, that makes all the difference. And I've had times where a patient is seen 24 hours after I've gotten a phone call from a provider. And I think having close, working relationships and direct contact is what's really helped us out in being able to communicate.

And then from there, we see the patients, we get them in, and we do the formal process as much as we can as far as doing the workup, which tends to be a little bit variable, I know, from center to center. But for us, we like to do a full neurologic workup, cardiac workup, etc. to really get things going.

Dr. Turck:
Turning to you now, Dr. Ghosh, what do you see as the most common communication gaps or friction points between referring physicians and CAR T centers, and how do they impact outcomes?

Dr. Ghosh:
This is a great question. There are several communication gaps and friction points which come to mind. Let's start with lack of standardized referral pathways. So there are many community oncologists that will report uncertainty about when and how to refer patients for CAR T-cell therapy because of absence of formalized referral protocols, and this may lead to delayed or missed opportunities for eligible patients.

Another one which comes to mind is limited awareness and education. Referring physicians may not be aware of all the eligibility criteria, especially how the eligibility for CAR T-cell therapy may differ from eligibility for transplant, which has been there for decades, and the logistics of CAR T-cell therapy. So this can lead to under-referral or referral of ineligible patients.

And a third one I can think of is inefficient intake and approval process, and this may be more on the side of the CAR T center. What if the CAR T center has slow intake procedures or more complex payer approval flows? It's very common for patients who are referred for CAR T-cell therapy to have financial clearance as a requirement before they are seen by a provider. And if this is delayed, it may frustrate referring physicians and delay treatment. This is particularly important for diseases like aggressive lymphoma where patients may undergo disease progression while waiting to get these approvals.

Dr. Turck:
Now, Dr. Lutfi, from your perspective, what are some effective communication strategies you've seen or implemented to ensure timely referral and seamless handoff between practices?

Dr. Lutfi:
So it's all about having the personal contact information, trust, and knowing each other. I have dozens of physicians in the community, even in other academic centers in the area, and we have a very comfortable working relationship, whether that's through texting, through talking, or even e-mail. Whatever it may be, we have a very comfortable setting. I think that's the key, so that even if it's the slightest thing, when a patient's back after 4 or 5 weeks and is still cytopenic or there's concern for infection or concern for early progression, there's that level of comfort and trust that you can call and you can reach out to us at any time—even during a busy clinic day—and we'll get things moving. And really having the infrastructure in place in our clinic to be able to get them in and get them seen.

Dr. Turck:
For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Drs. Forat Lutfi and Nilanjan Ghosh about improving communication and coordination across the CAR T-cell treatment continuum for patients with relapsed or refractory large B-cell lymphoma.

So, Dr. Ghosh, in addition to the communication strategies Dr. Lutfi just talked about, which tools, technologies, or infrastructure would you say make the biggest difference in streamlining transitions of care?

Dr. Ghosh:
Yeah, so that's obviously a great follow-up to all the barriers that can be there. So what can we do about it, right? I think establishing formal referral networks and shared care agreements with a focus on early referral and shared patient management responsibilities is very crucial to make this more streamlined.

Also, utilization of some websites to identify CAR T centers. There are some places in the country where CAR T centers are not as prevalent as some other places, but there are websites—such as Cell Therapy 360, Kite Konnect, and other independent resources from organizations like the Leukemia and Lymphoma Society or the Lymphoma Research Foundation or even plasma cell disorder and multiple myeloma foundations like IMF and others—that may help community physicians identify their nearest CAR T centers.

Another one is shared electronic health records. There are many times when the electronic health records are different between the two sites, and it can be difficult. A very commonly used electronic health record is Epic. And if the institutions are on the same records, it becomes a little bit easier in terms of a secure communication platform.

And the last one I would say is education. I think it's very important to educate our community. They have a lot to keep up with regarding the many different cancers and advances in all these different malignancies, and it's really difficult to keep up with all the details of every different disease, especially when it comes to relapsed or refractory disease. So ongoing education on CAR T indications and logistics would be very helpful.

Dr. Turck:
And Dr. Lutfi, once a patient completes CAR T-cell therapy, how do you ensure that follow-up care is communicated back to the referring provider?

Dr. Lutfi:
So we have adopted a formal and informal policy here at KU to ensure that there is nothing that's getting through the cracks, so to speak. And so we have actual information packets that include the last clinic note from the provider and we always make sure that we have an end-of-treatment and that patients are being seen by a provider. So that is sent in the packet, and we also have just a general information packet for management of any complications post CAR T.

And then in addition to that formalized process, we also have something in place where the physician will reach out to the referring physician and give them a verbal handoff, and in that way, we ensure that, again, nothing is missed. And if there's ever any concerns, again, we're building that trust with our community providers that we're always there. We're advising them on what to do and ensuring that we're reducing the mortality. Because at the end of the day, the non-relapsed mortality is what is really fearful to us. Patients, of course, are very fearful about CRS and ICANS, and that's understandable, but really long term where we're getting into trouble is the non-relapsed mortality after day 30, after patients go back. And so we think that having this formal/informal process of communication with our community providers will hopefully reduce that non-relapsed mortality.

Dr. Turck:
Well, we've certainly covered a lot today, but before we wrap up, I'd like to ask each of you to share one key takeaway with our audience. Dr. Ghosh, let's start with you.

Dr. Ghosh:
The number one thing that comes to my mind is establishing good relationships and improving communication between academic centers and referring physicians and providing the education to really discuss the benefits and eligibility of CAR T in various diseases so that patients, irrespective of geography, can get access to this life-saving therapy.

Dr. Turck:
And, Dr. Lutfi, I'll give you the final word.

Dr. Lutfi:
Thank you. I think that continuing to build communication links—both formal and informal—with our providers wherever they may be is going to be key, particularly as we go forward and try to expand care with CAR T into the community centers, even releasing them out not at the 30-day mark. And so, again, I think building those lines of communication are very important. We hope to implement more formal systems and build on what we've built with our referral system and network to also have more formalized processes so that we can ensure that patients are going and everything is squared away. And when they need to come back, we're seeing them.

Dr. Turck:
Some compelling takeaways for us to consider as we come to the end of today's program, and I want to thank my guests, Drs. Forat Lutfi and Nilanjan Ghosh, for joining me to discuss how referring physicians in CAR T treatment centers can improve communication and coordination for patients with relapsed or refractory large B-cell lymphoma. Dr. Lutfi, Dr. Ghosh, it was great having you both on the program.

Dr. Lutfi:
Thank you. Thank you.

Dr. Ghosh:
Great to be here. Thank you for having me.

Announcer:
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