



# TCL

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## TRIALS &amp; TRIBULATIONS

# As rural cancer disparities persist, aligning policy with care delivery models can close the gap



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**A**cross the United States, rural communities bear a disproportionate and growing burden of cancer mortality.

For cancers that are preventable or highly treatable when detected early, such as cervical cancer, the disparities are stark.

In some regions, including parts of Florida, more than half of cases are diagnosed at advanced stages.

This is not a scientific failure. It is a failure of care delivery.

Patients may be screened, but often cannot access timely follow-up care. Rural clinics identify abnormalities but

lack referral pathways. And those communities face persistent shortages of specialists, nurses, and care coordinators. The result is an unfortunate and predictable progression from early disease to advanced cancer.

For decades, federal and state policies have focused on expanding access to screening. That effort has been necessary, but it is no longer sufficient. The central challenge is closing the gap between detection, diagnosis, and follow-up care.

What is missing is a system that connects these steps. There is now broad consensus among clinicians, health systems, and public health leaders that

rural cancer outcomes will not improve without structural changes in how care is organized and delivered.

Recent meetings of frontline providers and policymakers, including a symposium last year in Brooksville, FL, led by the Tampa General Hospital Cancer Institute, USF Health and the Florida Department of Health, have reinforced four priorities: sustained infrastructure, workforce development, integrated care models and technology that strengthens human care delivery.

A follow-up symposium planned for later this year is anticipated to focus on deploying these models in resource-limited settings.

The implication is straightforward. Incremental fixes will not close the rural cancer gap. The system itself must be modernized.

First, federal policy can support the development of regional hub-and-spoke cancer networks that formally link NCI-designated and academic cancer centers with rural clinics and hospitals.

While versions of this model exist, they remain fragmented and under-resourced.

A national framework, supported through Centers for Medicare & Medicaid Services demonstration models and Health Resources and Services Administration-funded programs, could standardize referral pathways, expand tele-oncology and extend specialist expertise without requiring patients to leave their communities.

Second, reimbursement policy will need to evolve to support longitudinal care coordination, not just discrete clinical encounters. The most consequential failure point in rural cancer care is the loss of patients between screening and diagnostic follow-up.

Navigation systems enabled by advanced analytics can now identify at-risk patients, flag abnormal results and coordinate care across sites, but current reimbursement structures rarely support these functions.

Expanding coverage for care navigation, remote patient management and digitally enabled coordination would allow these systems to function as intended.

Third, progress will depend on sustained investment in the rural oncology workforce, particularly in nursing and advanced practice providers. Technology can extend reach but it cannot replace the trusted relationships that underpin effective care in rural communities.

Programs that support training, retention, and placement of nurses and clinicians in rural settings remain as critical as investments in new therapeutics.

Fourth, federal and state partnerships can accelerate the deployment of infrastructure enabled by advanced analytics in safety-net and rural systems. Health systems have already demonstrated that highly developed care coordination platforms can reduce inefficiencies and improve outcomes at scale.



**What is missing is a system that connects these steps. There is now broad consensus among clinicians, health systems and public health leaders that rural cancer outcomes will not improve without structural changes in how care is organized and delivered.**



With support from the Florida Cancer Innovation Fund, an arm of the Casey DeSantis Cancer Research Program created to accelerate innovation in cancer care, our team is developing a cancer navigation platform enhanced by advanced analytics and designed for rural settings, building on proven care coordination models to identify unscreened

populations, facilitate human papillomavirus self-testing, ensure timely follow-up after abnormal results and connect patients to diagnostic services, even in counties without specialists.

Cervical cancer offers a clear test case. It is nearly 100% preventable, yet incidence is rising in many rural areas. The failure is not in understanding of the disease but in the systemic ability to deliver a complete continuum of care.

When screening, diagnostics, and follow-up are connected through coordinated systems and supported by technology and local care teams, outcomes improve. When they are not, preventable disease becomes fatal.

Patients themselves are clear about what works. In rural communities, access is not defined solely by the availability of services but by trust.

Women consistently report that while self-testing expands options, they still value the presence of a clinician for counseling and follow-up. Any policy framework that prioritizes technology without investing in local workforce capacity will fall short.

Rural Americans are not dying of cancer due to the lack of scientific breakthroughs. They are dying because of the absence of systems that deliver those breakthroughs to the people who need them.

Closing the rural cancer gap will require federal leadership, sustained investment and a willingness to rethink how cancer care is financed and delivered outside major metropolitan centers. If policy aligns with what is already working—integrated networks, a supported workforce and technology-enabled coordination—geography no longer has to determine survival.

The question is not whether rural cancer care can be improved. It is whether there is the will to do it.