Breaking Barriers: Looking Back on Data—Looking Ahead to What’s Next

July 28, 2023
Logistics

- All participants are muted during the webinar.
- Questions – including technical issues you may be experiencing – should be submitted through the question pane.
- Questions will be answered as time permits; additional questions and answers will be posted on the website.
- Please complete the post-webinar evaluation you will receive via email.
Introducing our Moderator and Panelists

Dr. Laurie Kirstein, MD, FACS
Attending Breast Surgeon
Memorial Sloan Kettering Cancer Center
Associate Professor
Cornell University Medical College

Lauren Janczewski, MD
ACS Cancer Program Scholar

Dr. Charles Shelton, MD
Radiation Oncology
The Outer Banks Hospital
ECU Health/Chesapeake Regional

Katie Michaud
Executive Director of Oncology
Cape Code Healthcare
Agenda for today

• Welcome
• Data Review- Baseline and June
• Breaking Barriers- A Deep Dive
• Identifying Barriers to Care: A How To
• Q and A
Baseline and June Data

Lauren Janczewski
Breaking Barriers
Data Collection Round 2
7/28/2023

The following includes data combined from both data collection periods
Participating Programs

• 354 total programs

• 322 had patients with 3 or more missed treatments (91.0%)

• Median percent of patients who missed 3 or more radiotherapy treatments = 8.0% [IQR 4.1%-13.8%]
Baseline Systems in Place

- Call: 96.9%
- Text: 3.7%
- Email: 5.7%
- Patient Portal: 9.3%
- Letter: 14.7%
- No System: 1.7%
### Missed Radiotherapy Treatments by Different Facility Types

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic</td>
<td>9.1% (5.6%-19.2%)</td>
</tr>
<tr>
<td>Community</td>
<td>7.6% (3.7%-12.5%)</td>
</tr>
<tr>
<td>Comprehensive Community</td>
<td>7.8% (4.5%-16.2%)</td>
</tr>
<tr>
<td>Integrated Network</td>
<td>7.4% (4.3%-12.5%)</td>
</tr>
<tr>
<td>Other</td>
<td>7.1% (2.4%-14.3%)</td>
</tr>
</tbody>
</table>

p=0.312
## Missed Radiotherapy Treatments by Geographic Location

<table>
<thead>
<tr>
<th>Geographic Location</th>
<th>States</th>
<th>Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>CT, MA, ME, NH, RI, VT</td>
<td>7.6% (3.4%-12.3%)</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>NJ, NY, PA</td>
<td>9.7% (5.4%-18.2%)</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>DC, DE, FL, GA, MD, NC, SC, VA, WV</td>
<td>7.0% (3.7%-13.6%)</td>
</tr>
<tr>
<td>East North Central</td>
<td>IL, IN, MI, OH, WI</td>
<td>8.7% (5.2%-15.9%)</td>
</tr>
<tr>
<td>East South Central</td>
<td>AL, KY, MS, TN</td>
<td>10.2% (7.8%-18.4%)</td>
</tr>
<tr>
<td>West North Central</td>
<td>IA, KS, MN, MO, ND, NE, SD</td>
<td>6.1% (4.0%-7.3%)</td>
</tr>
<tr>
<td>West South Central</td>
<td>AR, LA, OK, TX</td>
<td>9.5% (4.0%-17.6%)</td>
</tr>
<tr>
<td>Mountain</td>
<td>AZ, CO, ID, MT, NM, NV, UT, WY</td>
<td>2.9% (1.0%-6.4%)</td>
</tr>
<tr>
<td>Pacific</td>
<td>AK, CA, HI, OR, WA</td>
<td>6.3% (3.8%-10.0%)</td>
</tr>
</tbody>
</table>

\[ p=0.012 \]
### Missed Radiotherapy Treatments by Disease Site

Total number of patients who missed 3 or more treatments = 2,528

<table>
<thead>
<tr>
<th>Disease Site</th>
<th>Patients (N)</th>
<th>Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>647 (4.7%)</td>
<td>7.7% (4.5%-14.3%)</td>
</tr>
<tr>
<td>Upper GI</td>
<td>91 (8.3%)</td>
<td>33.3% (15.0%-50.0%)</td>
</tr>
<tr>
<td>GYN</td>
<td>118 (11.8%)</td>
<td>28.6% (14.3%-50.0%)</td>
</tr>
<tr>
<td>H&amp;N</td>
<td>489 (10.2%)</td>
<td>21.4% (12.5%-37.5%)</td>
</tr>
<tr>
<td>Prostate</td>
<td>316 (5.2%)</td>
<td>11.1% (7.1%-20.0%)</td>
</tr>
<tr>
<td>Lung</td>
<td>331 (8.5%)</td>
<td>18.5% (11.1%-33.3%)</td>
</tr>
<tr>
<td>Rectum</td>
<td>94 (14.0%)</td>
<td>40.0% (25.0%-50.0%)</td>
</tr>
<tr>
<td>Other</td>
<td>442 (4.9%)</td>
<td>12.1% (6.7%-31.7%)</td>
</tr>
</tbody>
</table>

*p=0.001*
Reasons for Missed Radiotherapy Treatments

- Illness: 52%
- Treatment Side Effects (Toxicity): 34.9%
- Hospitalized: 33.8%
- Psychosocial: 4.9%
- Transportation: 26.5%
- Housing Concerns: 1.2%
- Financial: 1.8%
- Employment: 2%
- Childcare: 1.8%
- Conflicting Appointments: 16.6%
- Wait Time: 3.2%
- Treatment Elsewhere: 1.7%
- No Longer Wants Treatment: 12.9%
Illness and Psychosocial Factors

- Illness
- No Longer Wants Treatment
- Psychosocial

<table>
<thead>
<tr>
<th>Condition</th>
<th>Illness</th>
<th>No Longer Wants Treatment</th>
<th>Psychosocial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>61.7</td>
<td>11.7</td>
<td>4.4</td>
</tr>
<tr>
<td>GI</td>
<td>43.9</td>
<td>12.3</td>
<td>1.8</td>
</tr>
<tr>
<td>GYN</td>
<td>46.7</td>
<td>9.3</td>
<td>8</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>50</td>
<td>18.5</td>
<td>5</td>
</tr>
<tr>
<td>Lung</td>
<td>50.6</td>
<td>10.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Prostate</td>
<td>49</td>
<td>11</td>
<td>5.2</td>
</tr>
<tr>
<td>Rectum</td>
<td>44</td>
<td>8</td>
<td>1.3</td>
</tr>
<tr>
<td>Other</td>
<td>52.2</td>
<td>14.9</td>
<td>4.4</td>
</tr>
</tbody>
</table>
# Healthcare Systems

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Conflicting Appointments</th>
<th>Wait time</th>
<th>Seeking Treatment Elsewhere</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>20.1</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>GI</td>
<td>10.5</td>
<td>5.3</td>
<td>0</td>
</tr>
<tr>
<td>GYN</td>
<td>20</td>
<td>4</td>
<td>1.3</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>20.2</td>
<td>3.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Lung</td>
<td>13.1</td>
<td>2.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Prostate</td>
<td>12.3</td>
<td>7.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Rectum</td>
<td>2.7</td>
<td>1.3</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>20.5</td>
<td>2.5</td>
<td>1.9</td>
</tr>
</tbody>
</table>
More on data
June Data - By the numbers

- 74% of programs reported they have identified the most common barriers for why patients miss scheduled appointments

  HOWEVER

- 33% of programs report having a plan in place to address the identified barrier

- Most commonly identified barriers include:
  - Patient sick (not due to toxicity)
  - Transportation
  - Conflicting appointments
  - Patient no longer wishes to continue treatment
1. Do you need further data support from your radiation oncology software?
   Yes, with Aria
   Yes with Mosaiq
   No, we are able to pull all data we need
Breaking Barriers: A Deep Dive

Charles Shelton, MD
Radiation Oncology, The Outer Banks Hospital
Disclosures

We are small practice on barrier island so our results may not typify your program’s results
Goals of This Discussion

Deep Dive into Barriers

1. Review our process of Data Retrieval
2. Review Results from small community hospital using criteria from *Breaking Barriers* collaborative
3. Analyze Data for Trends
4. Review our Community Map
5. Consider QI projects for Future Project(s)
1. Data Retrieval
Our Data Retrieval Process

Methods

- We retrospectively analyzed last 200 patients treated at rural cancer center:
  - 51/200 (25%) were palliative intent and excluded since goals are different
  - 149/200 (75%) met “curative” category as defined by this collaborative

- Remember curative intent is usually 15-45 treatments, includes all sites, and usually not stage IV (not bone or brain metastases)
- We excluded ultra-fast short course of RT for this study (e.g. SBRT)
Medical Chart Review

• We reviewed records in ARIA using date timeline for all curative patients, using standard Record and Verify system

• We looked for “no shows” on appointment days, correlating with the prescribed schedule for RT, and the actual treatments delivered
Example of EMR platform (ARIA)
How we defined missed appointments:

• Any appointments for RT treatments where patient was on schedule and canceled/did not show was defined as a “no-show”

• We had 42 patients who experienced at least 1 “no-show” = 28% of curative patients

• These tend to be sporadic and not a systemic problem, so for this study we discounted these patients, and considered ≥3 “no-shows” as a meaningful metric to highlight barriers
For this collaborative $\geq 3$ No-shows is significant

Results:

• We had 24 patients (16%) who experienced 3 or more “no-shows” for various reasons that form the body of this analysis for us at our hospital RT clinic. The majority of these patients completed therapy, but it was delayed due to the “no-show” rates (3 days generally translates into half a week)

• 1% of patients being treated with curative intent quit radiotherapy altogether (this is the ultimate “no-show” but not as predictable)
We looked in ARIA to find reasons

• Was there even a system in place to document reasons?
• Were the reasons documented by staff? Who? How?
• What were the various reasons?
• Did the reasons seemingly correlate with adverse outcomes (like patient not completing intended treatments)
Example of note by therapists in ARIA
2. Review Results
What we found

• Our radiation therapists/technologists were the ones to usually document this after talking with patients, since they are the ones that usually do scheduling

• They did a decent job of documenting the reasons in a note in the EMR, usually in ARIA or MOSAIQ (which is not readily available to non-RT chart reviewers)

• Reasons for missed appointments were not always obvious, and we learned we need to sometime do more asking to factor out the things we can change
Results: 3 or more missed treatments

• N= 24 patients had ≥3 “no-shows”

• 173 treatment days were missed in these 24 patients for an average of 7 missed treatment days per patient (range 3, 22)

• 173 days of scheduled treatment were missed due to repeated reasons: toxicity from therapy, unrelated illness (COVID, flu), problems with transportation, office was running late and patient did not want to wait, conflicts with other medical appointments in other offices, “did not feel well/sick”, not documented well, unable to keep appointments for other personal reasons, conflicts with out of town vacations/graduations/family needs, hospitalized for unrelated reasons, COVID quarantine, work needs outweighed treatment needs, language barriers

• 2 patients stopped their treatments altogether (1 stopped a single treatment short of planned number. The other quit due to a fall-related subdural hematoma)
We made bins for this in REDCAP for data collection purposes for this study

- Transportation barriers
- Patient illness, not related to treatments (e.g. COVID, virus)
- Toxicity from treatment (e.g. skin reactions necessitating breaks, nutrition concerns, low blood counts, etc.)
- Housing related concerns (e.g. lives far away)
- Financial concerns/barriers (Cant afford lodging or gas, or driver or Uber, have to work to pay bills)
- Psychosocial concerns (e.g. feelings of anxiety, depression about treatments, addiction issues)
- Dependent care (childcare needs, parental care, spousal care, etc.)
- Conflict in appointments with another provider/appointments (eg PEG tubes, med onc appointments, chemo, other specialists)
- Vacation plans
- Patient employment related issues (patient cannot miss work, caught at work, etc.)
- Wait time too long and patient left
- Too many treatments scheduled
- Time of day was difficult to make repeated appointments consistently
- Educational concerns- patient did not understand need to come every day/duration
- Patient sought care continuation elsewhere for various reasons
- Facility too far away/distance/time to travel issues
- No answer provided by patient or provider for missed appointments
- Outreach attempted; unable to reach patient
- We have no system in place for tracking reason
Then, we asked:

• Does the treating facility have ways to match resources with their own uniquely identified barriers?
• Are there correlations with known socioeconomic factors (examples: gender, age, race, insurance status, marital status, employment status, educational achievement, distance to treatments, distress score using NCCN screening tool?) or treatment factors (site treated, number of tx)?
• Are there potential areas of improvements for QI projects as a group or individually?
3. Analytics-Trends in Barriers
We analyzed our data for these correlates:

• By site
• By gender
• By age
• By ethnicity
• By insurance
• By marital status
• By education
• By distress score
• By Primary Language
• Other (distance to facility, number of tx, chemo+RT simultaneously)
Site of RT treatment correlation

By Site “No-shows” as a % of the total per site

<table>
<thead>
<tr>
<th>Site</th>
<th>% No-shows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>13%</td>
</tr>
<tr>
<td>Prostate</td>
<td>10%</td>
</tr>
<tr>
<td>HNC</td>
<td>10%</td>
</tr>
<tr>
<td>Thoracic (lung)</td>
<td>31%</td>
</tr>
<tr>
<td>GI</td>
<td>0%</td>
</tr>
<tr>
<td>GYN</td>
<td>50%</td>
</tr>
<tr>
<td>Skin</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
</tr>
</tbody>
</table>
Gender correlation

- Male: 11%
- Female: 20%
Age correlates

Age with 65 as cutoff

% no shows in ≤65 yrs. 11%

% >65 yrs. with no shows 20%
Ethnicity, not so much for us

Ethnic White vs Non-White

16% White

14% Non-White
Insurance status correlates

Insurance and No-Shows

- No insurance with No Shows: 40%
- % with no shows having insurance: 15%
Marital Status correlates

Not Married (D/W/S) vs Married and No-Shows

Married with No-Shows as %

- 10%

Not married and % likelihood No-Shows

- 30%
Employment status correlates

Employment (Self described) versus No-Shows

- Retired: 17%
- Employed: 10%
- Not employed: 31%
Education correlates

Educational Attainment vs No-Shows

Some college (no degree, or less) - 20%
College Degree + - 9%
Language was a barrier

<table>
<thead>
<tr>
<th>Primary Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>16%</td>
</tr>
<tr>
<td>Not English</td>
<td>33%</td>
</tr>
</tbody>
</table>
Distance to RT facility not correlating for us

Distance in Miles to RT facility

“NO shows” average 20

Yes Shows average 22
Distance further analyzed

Distance traveled versus No Show

No Show patients
Compliant pts

- <15 miles
- 15-30 miles
- >30 miles
Number of treatments did not correlate for us

Number of Treatments per Course (Median)

- "No shows" median Number of TX: 29
- Median Number of TX for those with no missed appointments: 30
Adding chemo to RT did trend towards more barriers

ChemoRT vs RT alone

- **Chemo + RT No shows**: 26%
- **RT only No-shows**: 14%
Blue scatterplot = patients with no missed appointments, and their distress screen score in RT office. In our hands patients who missed appointments (red) were NOT screened very well using the DISTRESS SCREEN by NCCN.
4. Developing Community Map
How we map resources to identified barriers

- **Patient has identified barrier(s)**
  - **Access**
  - **Lodging**
  - **Language**
  - **Insurance**
  - **Transitional Care**
  - **Spiritual**
  - **Insurance**
  - **Conflicts Medical**
  - **Financial**

**Oncology SW**
- Helps with funds through local foundations, support organizations, relief groups
- Helps with applications, Medicaid, etc.
- Offers counseling or referral

**Oncology SW helps find specialists**
- Connect with volunteers, SW, gas cards, vouchers, County transport

**Nurse Navigator Onc**
- Offers counseling or referral

**Use Martti translation services for all visits**

**Reduced rate hotels**

**Palliative care clinic**

**Integrative Med Team**

**Pastoral Services**
What we found as small rural cancer program

We want to do better

• We used NCCN screening tool (distress tool) regularly, but it does not help predict these barriers to care

• We should consider other tools (e.g. Edmonton) that screen for food insecurity, lodging, transportation, financial stress, etc. or develop tools/processes that do better predict these barriers
Exit interviews began (in 2023) with this project

• We think there are underlying issues not addressed with our screening tools in initial encounters with cancer patients so we want to dig into barriers more

• We implemented exit interviews with any patient missing an appointment in 2023 as way to gather better data so we could consider areas for improvement.

• For example, when a patient calls and says they are canceling for “being sick”, we have our staff ask more to see if there is anything we can do to better support patient and minimize “no-shows” (e.g. IVF for rehydration in patients getting chemoRT, palliative care clinic sees patients if needed, counseling for emotional support)
5. Future Directions
**Moving Forward: Potential QI projects**

1. Find or develop better tool to predict for barriers to care in this population

2. Add palliative care clinic for patients experiencing toxicity from therapy (our number one barrier) especially those getting chemoRT

3. Alert Rad Onc MD when a patients misses an appointment (we now include this in weekly chart reviews) so it can be addressed in real time

4. Track “no-shows” as a metric - we added this to quarterly CQI team in RAD ONC for 2023

5. Consider more proactive use of SW/Onc NN in these cases to immediately plug patients into resources

6. Reduce the no-show rate moving forward
Poll Question

• If you make a follow up phone call after a missed appointment, who typically reaches out?
  • Schedulers or admin staff
  • Nurses
  • Physicians
  • We do not make follow up phone calls
  • I’m not sure
  • It changes/varies day to day
Identifying Barriers to Care

Presented by: Katie Michaud, Executive Director of Oncology
Date: July 28, 2023
Annual Executive Committee Meeting:

- Cancer Committee Chair
- Executive Director of Oncology
- Marketing Director
- NAPBC Committee Chair
- Associate Director of Development and Community Benefits
- Cancer Committee Coordinators
  - Cancer Conference Coordinator
  - Quality Improvement Coordinator
  - Clinical Research Coordinator
  - Psychosocial Services Coordinator
  - Survivorship Program Coordinator
- Specific invited guest(s)
Sources of Information for Consideration

• Community Needs Assessment:
  ➢ Themes and Priority Areas
  ➢ Demographic information
    ✓ Age
    ✓ Language
    ✓ Race
    ✓ Food Security
    ✓ Insurance status
  ➢ Social Concerns (food, transportation, access to healthcare services, etc.)
  ➢ LGBTQ barriers to healthcare services by type (PCP, mental health, dental, etc.)
  ➢ Availability of different types of healthcare services and barriers to their access
  ➢ Top healthcare concerns within the community
  ➢ Mortality by cause compared to State by cancer type and race

• Cancer Registry Data:
  ➢ Rates by cancer type, gender, stage at diagnosis, and time to first treatment

• Service Line Meeting Input:
  ➢ Discussion of information from past Service Line Meetings which identified service needs by cancer type
Examples: Community Needs Assessment slides

Figure 9: Percent of Survey Respondents Identifying issue as a Top Social Concern for the Community, 2015

- Housing or Homelessness: 75.5%
- Access to healthcare services: 74.4%
- Transportation: 63.3%
- Employment: 62.9%
- Poverty: 62.2%
- Access to needed medications: 48.4%
- Community engagement: 47.2%
- Environment: 43.8%
- Discrimination based on race, ethnicity, or language: 33.0%
- Discrimination based on other characteristics: 15.9%
- Violence or Crime: 14.4%
- Education: 14.3%

Data Source: CCVC Community Health Needs Survey, 2015

Figure 10: Healthcare Services Perceived as "Very Hard" to Access, 2016

- Primary care physicians: 54.4%
- Counseling or mental health care for adults (age 18+): 46.7%
- Counseling or mental health care for children/adolescents (under 18 years): 43.5%
- Specialty care (e.g., orthopedics, cardiology, dermatology, etc.): 38.9%
- Alcohol or drug treatment services for youth (under age 18): 37.7%
- Alcohol or drug treatment services for adults (under age 18): 36.8%
- Dental or oral health services: 24.8%
- Health or medical services for seniors (Age 65+)

Data Source: CCVC Community Health Needs Survey, 2015

Also observed, larger percentages of LGBTQI respondents and other Cape residents identified each of the healthcare services on the list as "very hard" to access compared to the overall sample, suggesting some systemic issues related to access may be occurring for these populations.

Figure 11: Healthcare Services Perceived as "Very Hard" to Access, 2015

- Pharmacy and medication services: 46.7%
- Emergency department services: 42.7%
- Urgent care services: 35.4%
- Implied medications: 35.0%
- Outpatient services such as lab work or radiology: 43.7%
- Dental or oral health services: 36.3%
- Hospital services: 43.9%
- Vision services: 36.9%
- Cancer screening: 34.4%
- Physical therapy: 26.0%
- Caregiver/care/treatment: 27.9%
- Health or medical services for seniors: 20.9%
- Health or medical services for women: 15.6%

Data Source: CCVC Community Health Needs Survey, 2015

Also observed, larger percentages of LGBTQI respondents and other Cape residents identified each of the healthcare services on the list as "very hard" to access compared to the overall sample, suggesting some systemic issues related to access may be occurring for these populations.

Figure 12: Top Barriers Experienced when Accessing Healthcare in prior 12 Months, 2016

- None of the situations have made it hard to access healthcare: 24.8%
- Long waits for appointments: 60.2%
- Difficulty scheduling appointments: 54.5%
- Cost of care (such as prescriptions, co-pays, etc.): 23.8%
- Lack of evening and weekend hours: 21.3%
- Poor customer service of provider or office staff: 20.5%
- Difficulty coordinating care between different healthcare providers: 13.6%
- Insurance problems/lack of coverage: 18.5%
- Distance to closest provider: 18.4%
- Do not have access to regular provider: 15.0%

Data Source: CCVC Community Health Needs Survey, 2015

©2015 Cape Cod Healthcare Inc.
Examples: Community Needs Assessment slides
Example: Cancer Registry Data

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Total %</th>
<th>Male %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTAL, ORAL CAVITY &amp; PHARYNX</td>
<td>35 2.6%</td>
<td>31 4.4%</td>
<td>8 1.6%</td>
</tr>
<tr>
<td>Tongue</td>
<td>14 0.9%</td>
<td>13 1.9%</td>
<td>1 0.2%</td>
</tr>
<tr>
<td>Salivary Glands</td>
<td>6 0.4%</td>
<td>3 0.4%</td>
<td>3 0.6%</td>
</tr>
<tr>
<td>Floor of Mouth</td>
<td>1 0.1%</td>
<td>1 0.1%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Gum &amp; Other Mouth</td>
<td>4 0.3%</td>
<td>4 0.6%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Tongue</td>
<td>12 0.9%</td>
<td>9 1.3%</td>
<td>3 0.5%</td>
</tr>
<tr>
<td>Oropharynx</td>
<td>2 0.1%</td>
<td>1 0.1%</td>
<td>1 0.2%</td>
</tr>
<tr>
<td>DIGESTIVE SYSTEM</td>
<td>237 16.9%</td>
<td>130 18.7%</td>
<td>107 15.3%</td>
</tr>
<tr>
<td>Esophagus</td>
<td>22 1.5%</td>
<td>15 2.2%</td>
<td>7 0.9%</td>
</tr>
<tr>
<td>Stomach</td>
<td>12 0.8%</td>
<td>8 1.1%</td>
<td>4 0.6%</td>
</tr>
<tr>
<td>Small Intestine</td>
<td>3 0.2%</td>
<td>2 0.3%</td>
<td>1 0.1%</td>
</tr>
<tr>
<td>Colon Excluding Rectum</td>
<td>85 5.7%</td>
<td>45 6.5%</td>
<td>40 5.1%</td>
</tr>
<tr>
<td>Cecum</td>
<td>21 1.5%</td>
<td>11 1.6%</td>
<td>7 1.1%</td>
</tr>
<tr>
<td>Appendix</td>
<td>6 0.4%</td>
<td>4 0.6%</td>
<td>2 0.3%</td>
</tr>
<tr>
<td>Ascending Colon</td>
<td>20 1.3%</td>
<td>12 1.7%</td>
<td>8 1.1%</td>
</tr>
<tr>
<td>Hepatic Flexure</td>
<td>5 0.4%</td>
<td>3 0.5%</td>
<td>2 0.3%</td>
</tr>
<tr>
<td>Transverse Colon</td>
<td>5 0.3%</td>
<td>3 0.5%</td>
<td>2 0.3%</td>
</tr>
<tr>
<td>Splenic Flexure</td>
<td>4 0.3%</td>
<td>1 0.1%</td>
<td>3 0.5%</td>
</tr>
<tr>
<td>Descending Colon</td>
<td>5 0.3%</td>
<td>2 0.3%</td>
<td>3 0.5%</td>
</tr>
<tr>
<td>Sigmoid Colon</td>
<td>16 1.1%</td>
<td>10 1.4%</td>
<td>6 0.9%</td>
</tr>
<tr>
<td>Large Intestine, Nos</td>
<td>10 0.7%</td>
<td>6 0.9%</td>
<td>4 0.6%</td>
</tr>
<tr>
<td>Rectum &amp; Rectosigmoid</td>
<td>38 2.6%</td>
<td>23 3.3%</td>
<td>15 2.0%</td>
</tr>
<tr>
<td>Rectum</td>
<td>34 2.4%</td>
<td>19 2.8%</td>
<td>15 2.0%</td>
</tr>
<tr>
<td>Anus, Anal Canal &amp; Anorectal</td>
<td>17 1.1%</td>
<td>8 1.1%</td>
<td>9 1.1%</td>
</tr>
<tr>
<td>Liver &amp; Intrahepatic Bile Duct</td>
<td>19 1.3%</td>
<td>11 1.6%</td>
<td>8 1.0%</td>
</tr>
<tr>
<td>Liver</td>
<td>13 0.9%</td>
<td>9 1.3%</td>
<td>4 0.6%</td>
</tr>
<tr>
<td>Intrahepatic Bile Duct</td>
<td>6 0.4%</td>
<td>1 0.1%</td>
<td>5 0.7%</td>
</tr>
<tr>
<td>Gallbladder</td>
<td>1 0.1%</td>
<td>0 0%</td>
<td>1 0.2%</td>
</tr>
<tr>
<td>Other Intestine</td>
<td>2 0.1%</td>
<td>0 0%</td>
<td>2 0.3%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>38 2.6%</td>
<td>24 3.3%</td>
<td>14 2.0%</td>
</tr>
<tr>
<td>RESPIRATORY SYSTEM</td>
<td>201 13.6%</td>
<td>101 14.5%</td>
<td>100 12.7%</td>
</tr>
<tr>
<td>Larynx</td>
<td>7 0.5%</td>
<td>5 0.7%</td>
<td>2 0.3%</td>
</tr>
<tr>
<td>Lung &amp; Bronchus</td>
<td>194 13.1%</td>
<td>95 13.6%</td>
<td>99 13.6%</td>
</tr>
<tr>
<td>BONES &amp; JOINTS</td>
<td>3 0.2%</td>
<td>1 0.1%</td>
<td>2 0.3%</td>
</tr>
<tr>
<td>Bones &amp; Joints</td>
<td>1 0.1%</td>
<td>1 0.1%</td>
<td>0 0%</td>
</tr>
<tr>
<td>SOFT TISSUE</td>
<td>2 0.1%</td>
<td>1 0.1%</td>
<td>1 0.1%</td>
</tr>
<tr>
<td>Soft Tissue (including Heart)</td>
<td>2 0.1%</td>
<td>1 0.1%</td>
<td>1 0.1%</td>
</tr>
<tr>
<td>SKIN EXCLUDING SITAL &amp; SQUAM</td>
<td>45 3.2%</td>
<td>23 3.3%</td>
<td>22 3.0%</td>
</tr>
<tr>
<td>Melanoma – Skin</td>
<td>43 2.9%</td>
<td>21 3.0%</td>
<td>22 2.8%</td>
</tr>
<tr>
<td>Other Non-Epithelial Skin</td>
<td>2 0.1%</td>
<td>2 0.3%</td>
<td>0 0%</td>
</tr>
</tbody>
</table>

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Example: Issues Identify at Service Line Meetings
And of course, the Breaking Barriers Opportunity

### STANDARD 8.1: Addressing Barriers to Care:
Each facility within the network must address barriers to care in their demographic and geographic area and individually fulfills the specifics outlined in Standard 8.1. This can be a network-wide identified barrier to be addressed within each facility.

<table>
<thead>
<tr>
<th>Recommended Options for System-based Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breaking Barriers: An ACS Cancer Programs National QI Project</strong></td>
</tr>
<tr>
<td><strong>Breaking Barriers Details</strong></td>
</tr>
<tr>
<td>Who can participate?</td>
</tr>
<tr>
<td>What standards will you receive credit for?</td>
</tr>
<tr>
<td>How long is this project?</td>
</tr>
<tr>
<td>Participants: 1 year + credit for 1 year. You do not need to participate in both years</td>
</tr>
</tbody>
</table>

*NOTE: Will need to have at least 1 update on roll-over Barrier to Care from 2022: Access to Nutritional Food*
Who might we partner with?

Provided is a list of organizations who received financial support from the CCHC Foundation for 2023.

Are there any that we might want to approach to partner with this year?
The Overall Process

Executive Committee Reviews Information

Committee Discusses Info and makes recommendations to take forward to Full Cancer Committee

Full Cancer Committee is presented with ALL information, in addition to the conclusions & recommendations made by the Executive Committee

Cancer Committee identifies both “formal” (CoC documented) and “informal” recommendations for the year.

As areas of potential work are identified, resource needs, feasibility and potential partners are discussed

Full Cancer Committee discusses recommendations and are asked to provide other barriers to care that they have identified that may not be included in the Executive Committee proposal
Roll-over from 2022 fully underway in cooperation with Cape Wellness Collaborative

We will roll-over the 2022 Barrier for resolution: access to fresh fruits and vegetables. A small team is continuing to work with the CCHC Foundation and the Cape Wellness Collaborative and hope to have a program ready for implementation by the time farmers’ markets start this spring. The team will provide an update at that time.

Several barriers to care were brought forward for consideration for 2023:

- Participation in the Breaking Barriers PI
- Prevention and screening activities for minority populations was identified as an opportunity for improvement in our recent Community Needs Assessment
- Mental Health access for cancer patients was raised as an issue by physicians
- Dental care for uninsured H&N cancer patients was identified as a need and a possible addition to our new H&N Cancer Clinic.
- Treatment options for neuropathy (especially in the Falmouth area) was a noted need.

The committee agreed to pursue the Breaking Barriers PI to meet this standard requirement. However, there was considerable discussion about the other options. Several might be rolled into outreach activities. Others need more system structure to pursue. We will continue considering these areas this year and next.

“Formal” Barrier was agreed to be participation in the Breaking Barriers initiation from the Commission on Cancer

“Informal” Barriers to care that have received attention YTD include:

- Exploration into See-Test-Treat possibility in 2024/25 based on community request
- Placed money in FY24 budget for community outreach on prostate cancer based on CNA, cancer registry data and physician input
- New collaboration with CCHC Behavioral Health – group therapy and limited on-site crisis intervention
- Identification of therapy resource for neuropathy within VNA (Neuro-Go)
Looking Ahead: What to Expect
Upcoming Data Collection

Released August 15-Due August 30
Patients seen June 15-August 15
Questions about progress with Community Map

October 15 data collection
More in depth questions about barriers
• Transportation
• Conflicting appointments
• Does not wish to continue treatment
• Patient Sick
Beginning in 2024

Expectations in 2024

• Identify at least one barrier
• Develop a problem statement and goal
• Implement toolkit
• Report Data
• Meet with small group cohort based on barrier
Reminders
ACS Cancer Conference 2024

February 22-24, 2024 | Austin, TX

Save the Date

facs.org/cancerconference
Breaking Barriers: Important Dates

Ongoing: Continue to work on your community asset map

August 15: Data metrics released; will include questions about progress of Community Asset Map

Sept 22 at 12pm CT-Webinar

• If you need to change your primary contact: email cancerqi@facs.org
Q and A

Reach out to cancerqi@facs.org