**Breaking Barriers: Addressing No Shows to Improve Access to Care**

**Year 2**

# What is Breaking Barriers?

Breaking Barriers is a national Quality Improvement Project sponsored by ACS Cancer Programs that seeks to understand how reducing missed radiation therapy appointment (“no-show”) rates can support access to high quality oncology care for all patients in diverse communities and care settings.

**The goal of this project is to:**

-Build program capacity to identify barriers to cancer patients receiving timely and complete radiation therapy and then implement sustainable solutions to address the identified barriers.

-By the end of the improvement period, reduce the rate of “no-shows” to radiation therapy appointments by at least 20% relative to each participating program’s individual baseline (example 20% reduced to 15%)

-Build and continually expand partnerships with local, regional, and state organizations that address social related health needs impacting access to healthcare

-Build a repository of best practices for addressing barriers to care that may serve as exemplars to other programs that could be adapted to varied practice environments beyond radiation oncology.

**Year 2** will focus on selecting one or two concrete reasons for missed appointments and implementing interventions (including community-based referrals) to sustainability mitigate the impact of that barrier on patients. Scalability and sustainability will also be a focus.

For more information on year 1, please see the project website “Year 1” tab.

 **The remainder of this document outlines the activities and requirements for year 2.**

# Why is this important?

Barriers to care exist in cancer treatments for various reasons (physical, emotional, psychological, social, financial, ethnic, geographic, spiritual, cultural, etc.) Some of these are anticipated barriers (e.g. toxicity from chemo XRT in head and neck cancer), and some are not (DVT/PE in LC patient). Some barriers are modifiable while others are not.

Breaks in (Radiation) therapy can be potentially detrimental to outcomes and often relate to both predictable and unpredictable factors. These breaks to planned therapy can be systemic and indicate a need for larger reform (e.g. overall better supportive care), or they can be unique to a program. Breaks can be measured, and unplanned breaks can become data for programs to help improve outcomes through shared quality initiatives. Radiation Therapy is a good model in which to measure barriers to care as it involves daily treatments over a period of weeks and is usually consecutive over the course of a standard week, Monday- Friday. Additionally, all RT facilities use record-and-verify systems that log treatment delivery and number of elapsed days for planned and actual treatment completion.

# Who should participate?

Programs interested in improving systems and workflows and building internal and community partnerships to implement innovative solutions in reducing barriers that cause cancer patients to miss and/or not complete recommended radiation treatment may be interested in participating.

We strongly recommend you form a core QI team that fulfills the following roles:

* Physician champion: serves as a conduit between leadership and frontline staff
* Clinician project leader: supports the day to day activities of the QI project
* A member of the radiation clinic team: grounds the team in the day-to-day processes of the radiation clinic
* Data analyst/data support: a dedicated person to analyze, interpret, and submit data
* Nurse navigator, social worker, behavioral health clinician: facilitates internal and external referrals, can provide behavioral counseling, and is familiar with local, state, and national resources
* Community outreach person
* When possible, an individual with lived experience (i.e. a current or former patient): this person will be invaluable to helping shape systems for outreach and informing interventions

\*Note: one person may serve in more than one role, but a minimum of 3 people on the core QI team is required.

# What will you do?

Step 1: Present project to cancer committee and radiation team. Form a core QI team and discuss participation with cancer committee. For programs new to the breaking barriers project, obtain letter of support (a template is available online) from the radiation clinic. Programs that participated in year 1 DO NOT need to provide another letter of support.

Step 2: Assess current “no-show” rate. Programs that participated in year 1 already have systems developed to outreach to patients that “no-show”. New programs must develop this system and provide no-show data, by disease site, retrospectively, as baseline data.

Step 3: Consider, or revisit, community context and local patient needs. While more information on implementable changes is listed in the Breaking Barriers Toolkit, evaluate your internal workflow and assess your information technology needs.

Step 4. Identify your barrier. Write your problem statement and your aim statement. More information on how to do this is provided in the year 2 video found on the project website.

Step 5: Select an intervention. A toolkit will be available with implementation strategy options, or you can develop your own implementation strategy. Consider the resources needed for the implementation strategy, and possible limitations of that strategy up front. Discuss with your core QI team and begin implementation.

Step 6: Meaningfully participate and engage in the QI project. Over the course of the QI project, you will be submitting data (see below) and it is strongly recommended you participate in webinars and small group cohort calls, as needed.

# What data will be collected?

Pre/post survey: Collected in April and December

Measures: Collected bimonthly; Collected via REDCap in April, June, August, and October

Include:

* **Separated by disease site:** all patients receiving between 15-45 fractions between the ages of 18-99 scheduled for radiation therapy treatment in the given time period.
* Only non-palliative radiation therapy patients

Exclude:

* SBRT and ultra-fractionation regimen patients (1-14 treatments)
* Cancelled appointments due to office systems (machine is down, short staffed, clinic closing early)
* Cancelled appointments due to environmental factors (hazardous weather, natural disasters, etc.)
1. Numerator: Number of patients who completed all scheduled visits in the time period

Numerator: Number of patients who missed 3 or more scheduled visits in the time period

Denominator: All number of patients with scheduled appointments in the time period

1. Please select all known reasons why patients did not show up for treatment (check boxes)
	1. Transportation concerns
	2. Patient sick (not due to treatment)
	3. Patient toxicity concern (due to clinical concern from treatment)
	4. Patient is hospitalized
	5. Financial concerns
	6. Psychosocial concerns (feelings of anxiety depression) about treatment
	7. Childcare cancelled or closed
	8. Conflict in appointment with another provider/appointment
	9. Patient employment
	10. Patient did not want to wait for treatment after arrival (wait time)
	11. Decided to seek treatment elsewhere
	12. Does not wish to continue treatment
	13. Does not wish to answer reason for no show
	14. Outreach attempted; unable to reach patient
	15. We do not have a system that tracks reasons
	16. Other

**Note: No patient identifying information will be collected. All metric data will be collected in aggregate via whole numbers.**

# What is the benefit of participating?

Access to asynchronous learning materials, toolkits, didactic webinars and cohort calls, and one on one coaching and technical assistance, as needed.

Bi-monthly aggregate data reports to benchmark program progress against aggregate project benchmark

Collaborate and network with peer programs and national leaders on addressing barriers to cancer care

Earn credit for CoC standards 7.3 and 8.1 or NAPBC standards 5.8 and 7.2

Opportunity to showcase innovations and learnings at future ACS conferences

# What is the time commitment?

Your team will submit baseline data and 3 rounds of data [metrics]. A brief pre/post survey, collected via an online survey tool, will also be collected in April of 2024 and December of 2024.

Didactic webinars and cohort calls will be offered. One person from each team is *strongly* encouraged to be in attendance on each call unless clinical care interferes.

We estimate approximately 12 hours of time dedicated to data entry and webinar participation over the course of one year. This does not include time spent on team meetings or huddles to discuss data and PDSA cycles.

# Timeline and Important date

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| **Tentative date** |  |
| Jan-Feb | Convene as a teamIdentify barrierRevisit community scanWrite your problem and goal statements  |
| March | Data collection for new program close March 1\*Review toolkit and develop plans to operationalize intervention |
| April 30 | First data collection due (patients seen Feb 1- March 30) |
| May  | Small group call  |
| June 30  | Data Collection (patients seen April 1-May 31) |
| July  | Small group call |
| Aug 31 | Data Collection (patients seen June 1-July 31) |
| Sept | Small group call |
| Oct | Data Collection (patients seen Aug 1-Sept 30) |
| Nov |  |
| Dec | Wrap up Webinar |