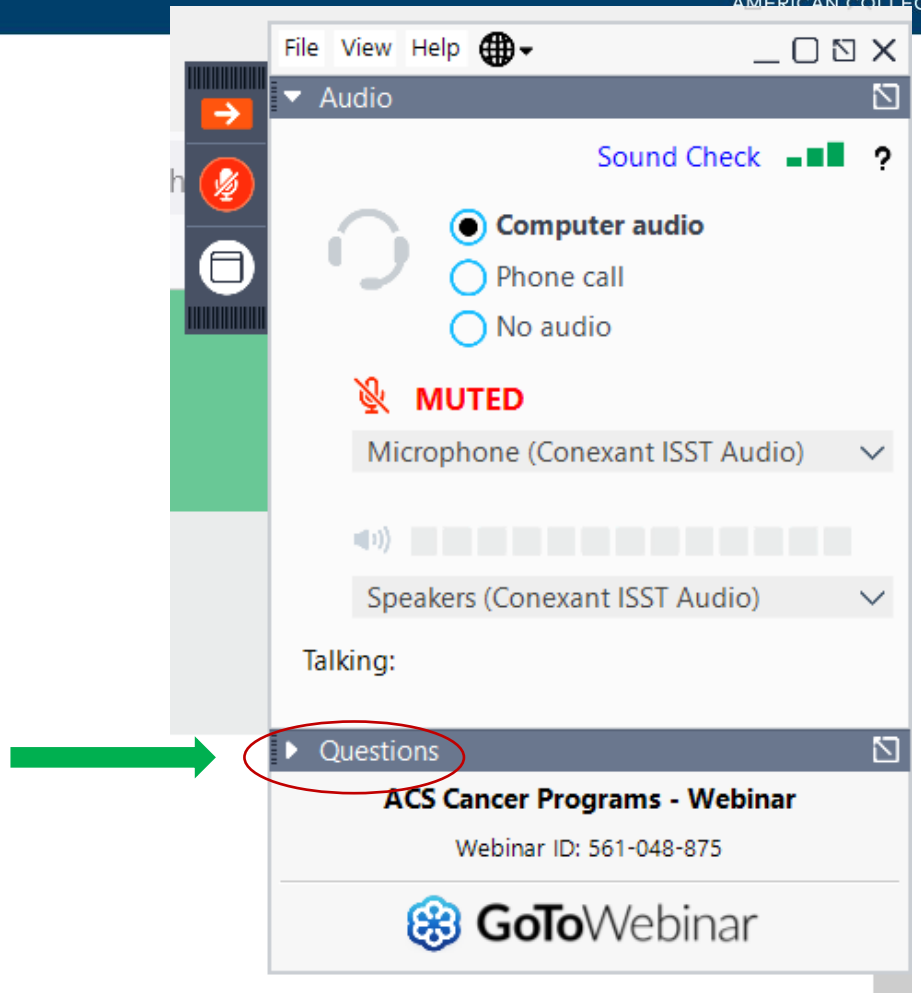
Commission on Cancer
American College of Surgeons

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

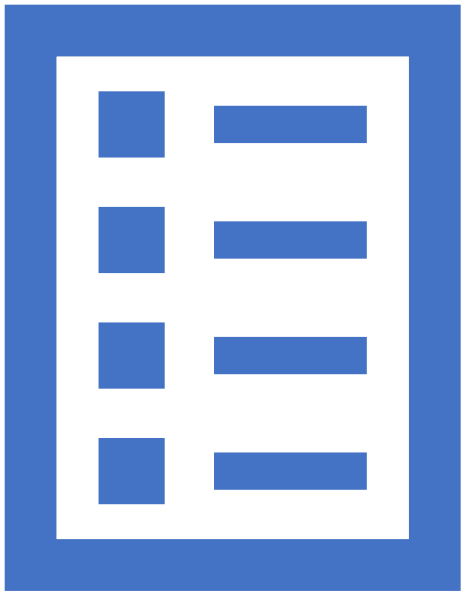
Lauren Janczewski, MD
ACS Cancer Program Scholar

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



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Baseline and June Data

Lauren Janczewski

Breaking Barriers

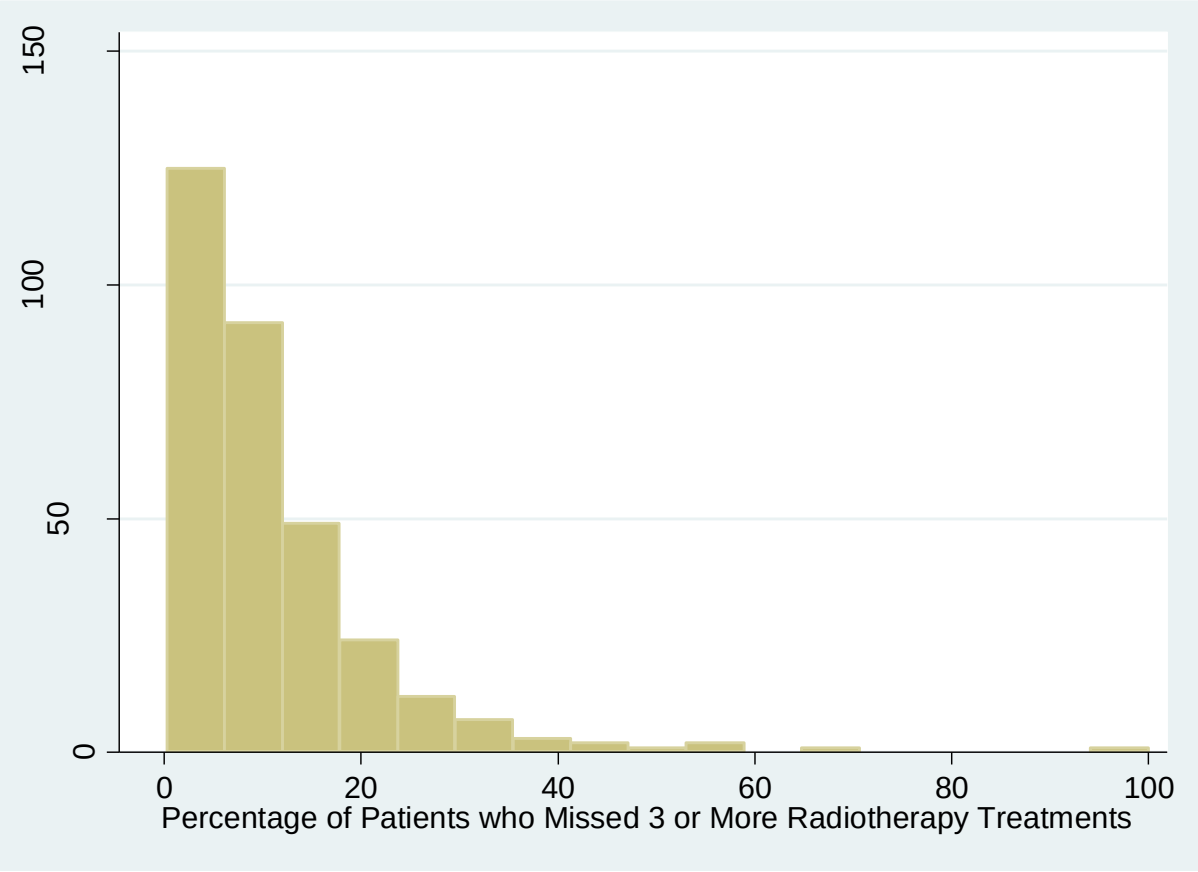
Data Collection Round 2

7/28/2023

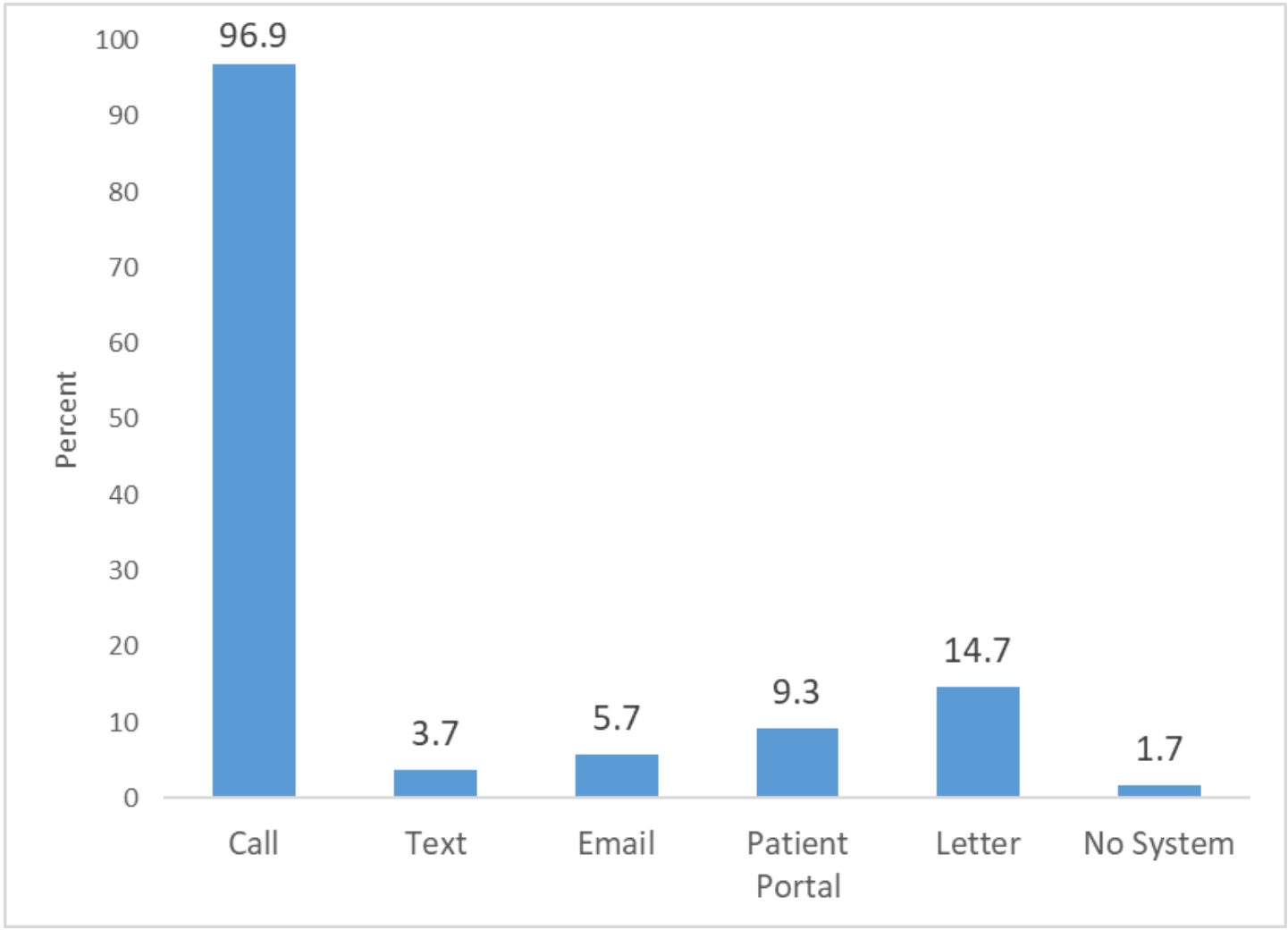
The following includes data combined from both data collection periods

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



Missed Radiotherapy Treatments by Different Facility Types

Facility Type	Median (IQR)
Academic	9.1% (5.6%-19.2%)
Community	7.6% (3.7%-12.5%)
Comprehensive Community	7.8% (4.5%-16.2%)
Integrated Network	7.4% (4.3%-12.5%)
Other	7.1% (2.4%-14.3%)

p=0.312

Missed Radiotherapy Treatments by Geographic Location

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

p=0.012

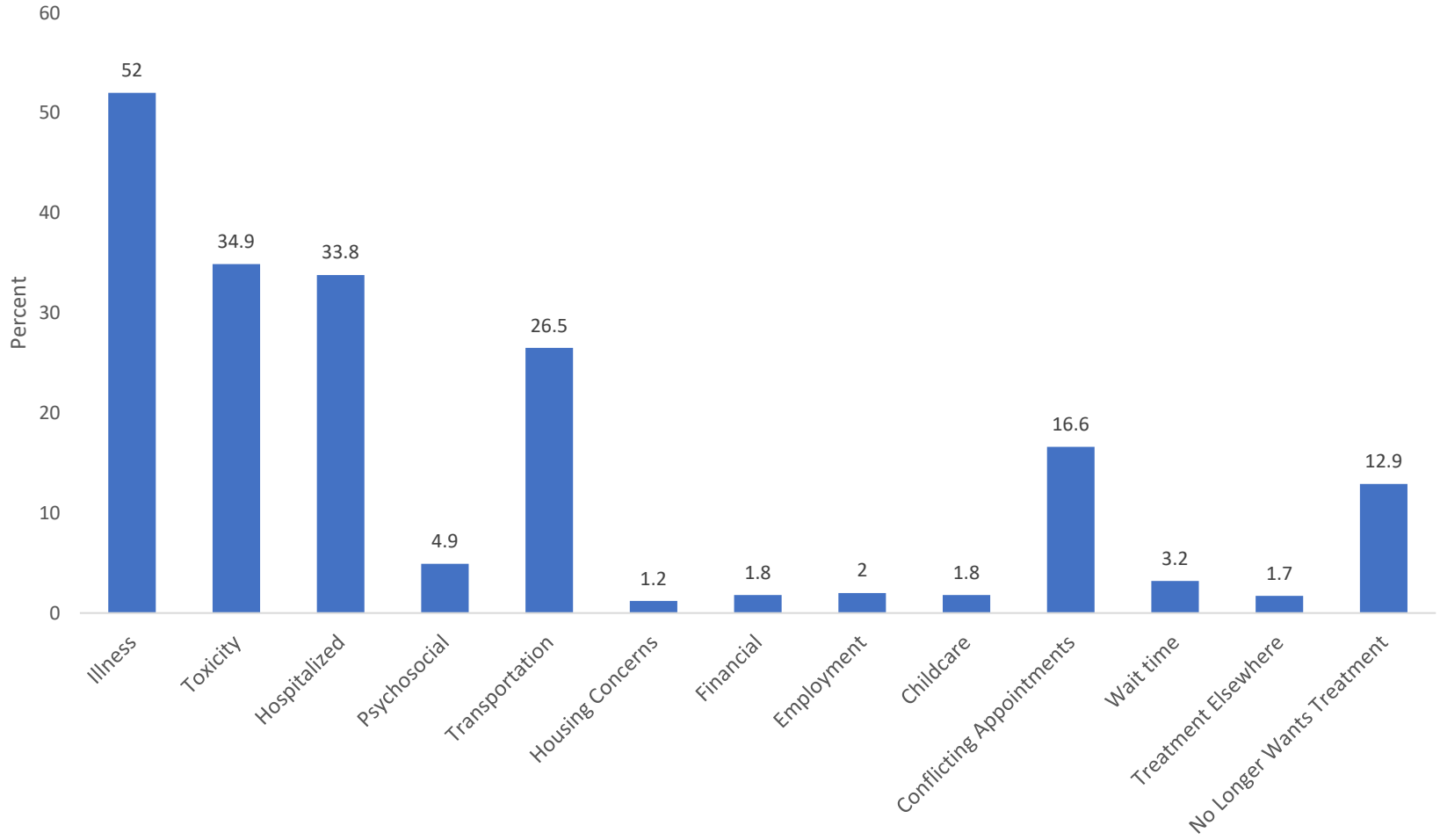
Missed Radiotherapy Treatments by Disease Site

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

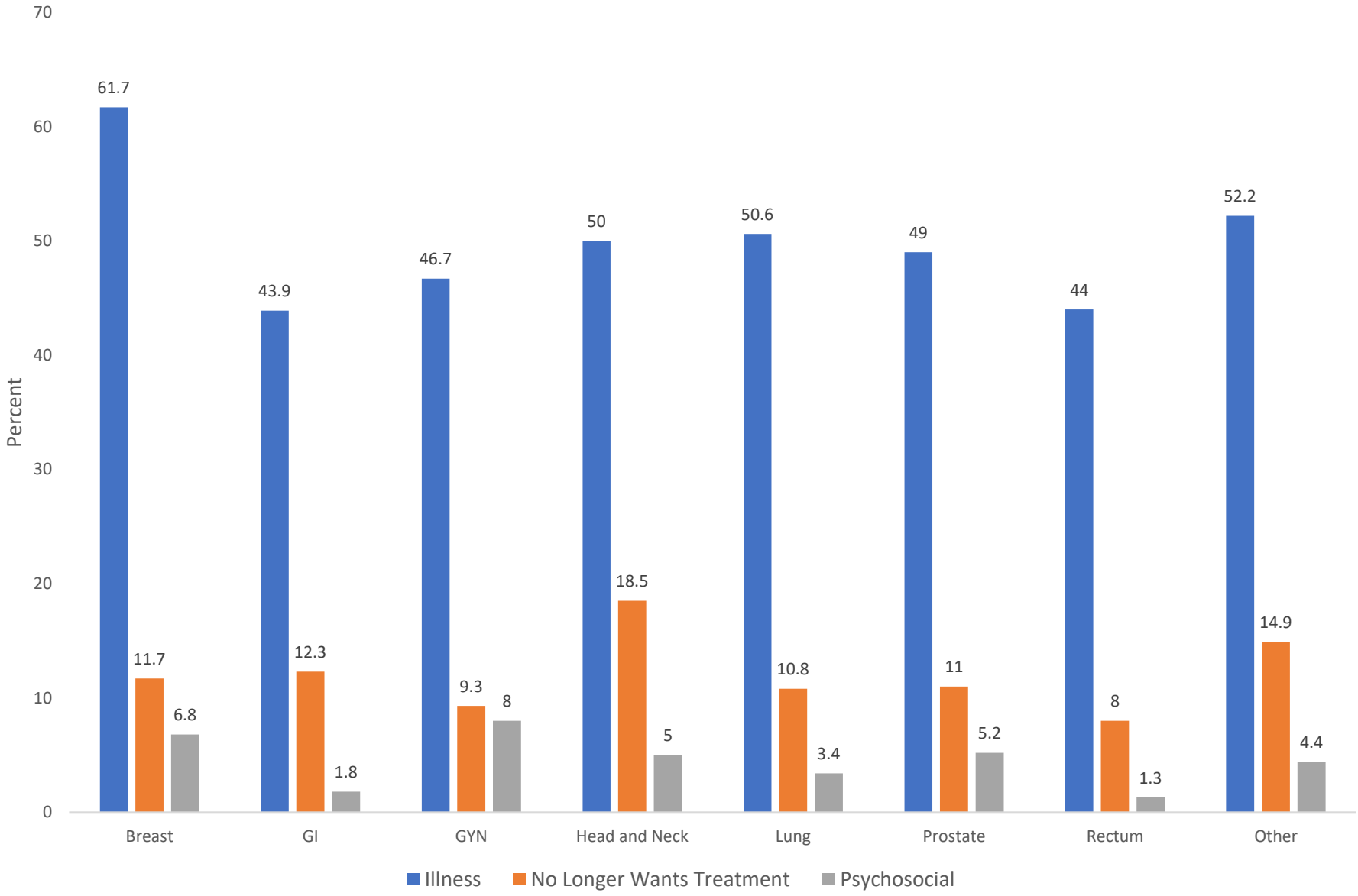
Disease Site	Patients (N)	Median (IQR)
Breast	647 (4.7%)	7.7% (4.5%-14.3%)
Upper GI	91 (8.3%)	33.3% (15.0%-50.0%)
GYN	118 (11.8%)	28.6% (14.3%-50.0%)
H&N	489 (10.2%)	21.4% (12.5%-37.5%)
Prostate	316 (5.2%)	11.1% (7.1%-20.0%)
Lung	331 (8.5%)	18.5% (11.1%-33.3%)
Rectum	94 (14.0%)	40.0% (25.0%-50.0%)
Other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

p=0.001

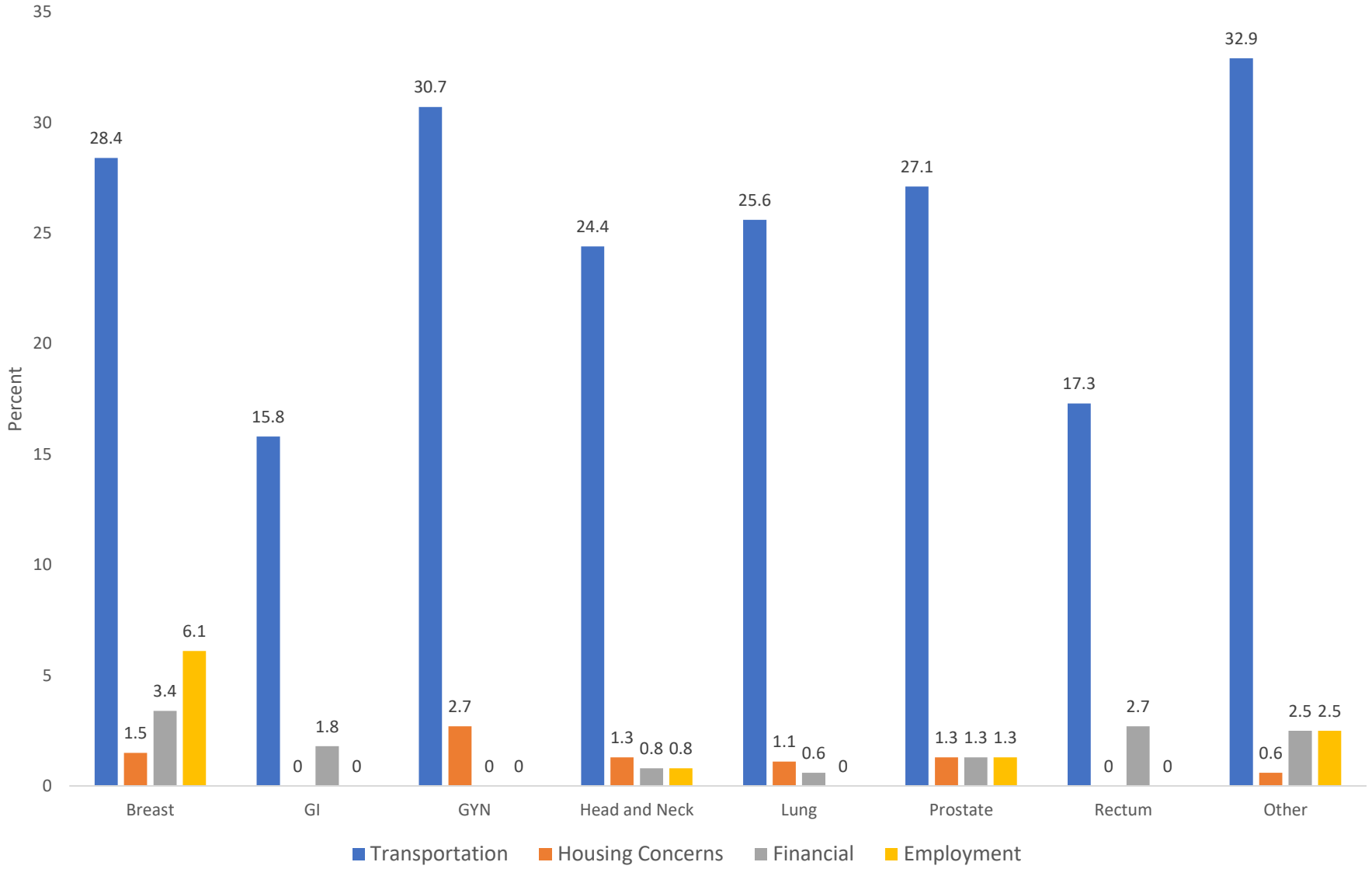
Reasons for Missed Radiotherapy Treatments



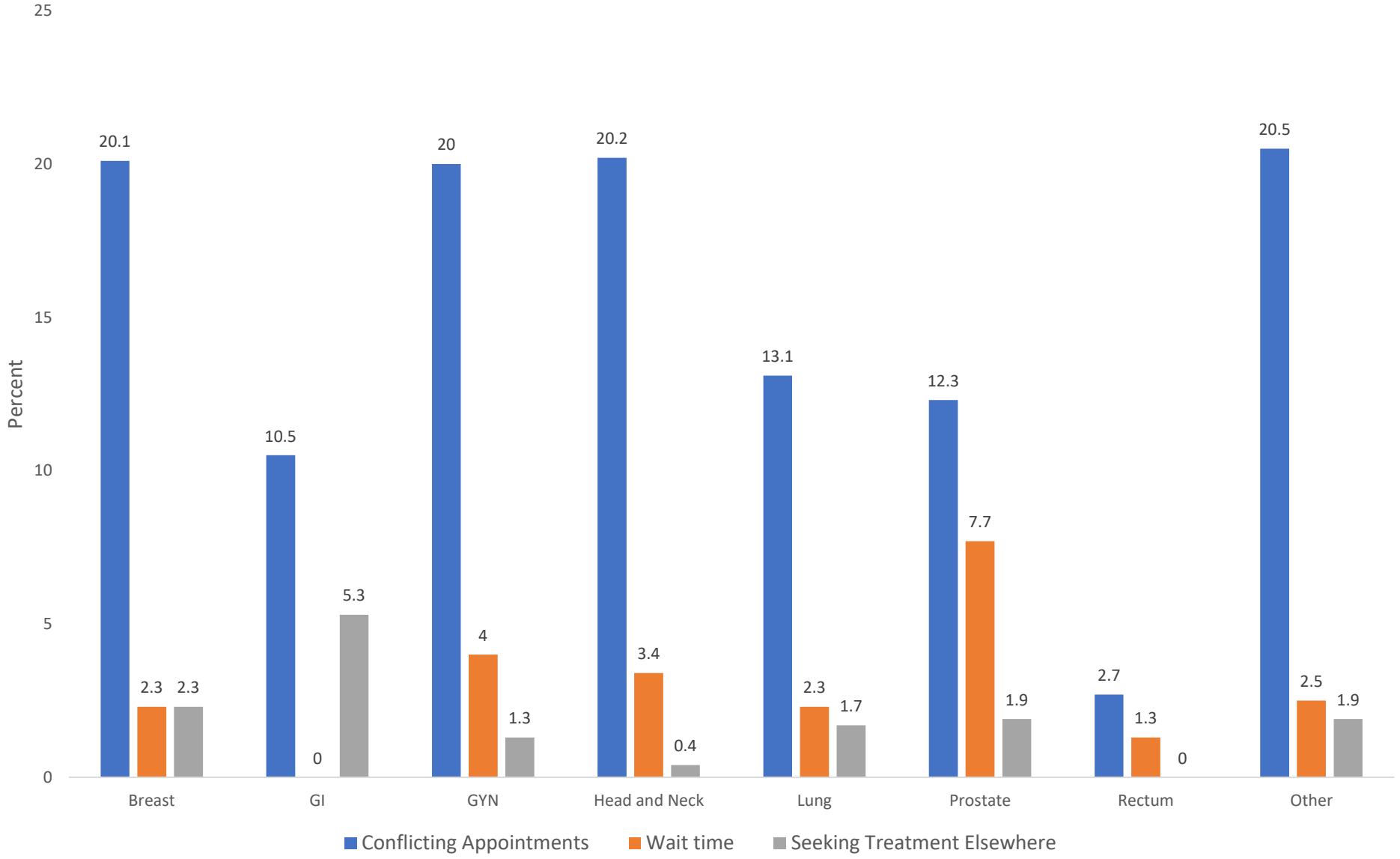
Illness and Psychosocial Factors



Socioeconomic Factors



Healthcare Systems



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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

Poll Question

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

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Breaking Barriers: A Deep Dive

Charles Shelton, MD

Radiation Oncology, The Outer Banks Hospital

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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)

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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

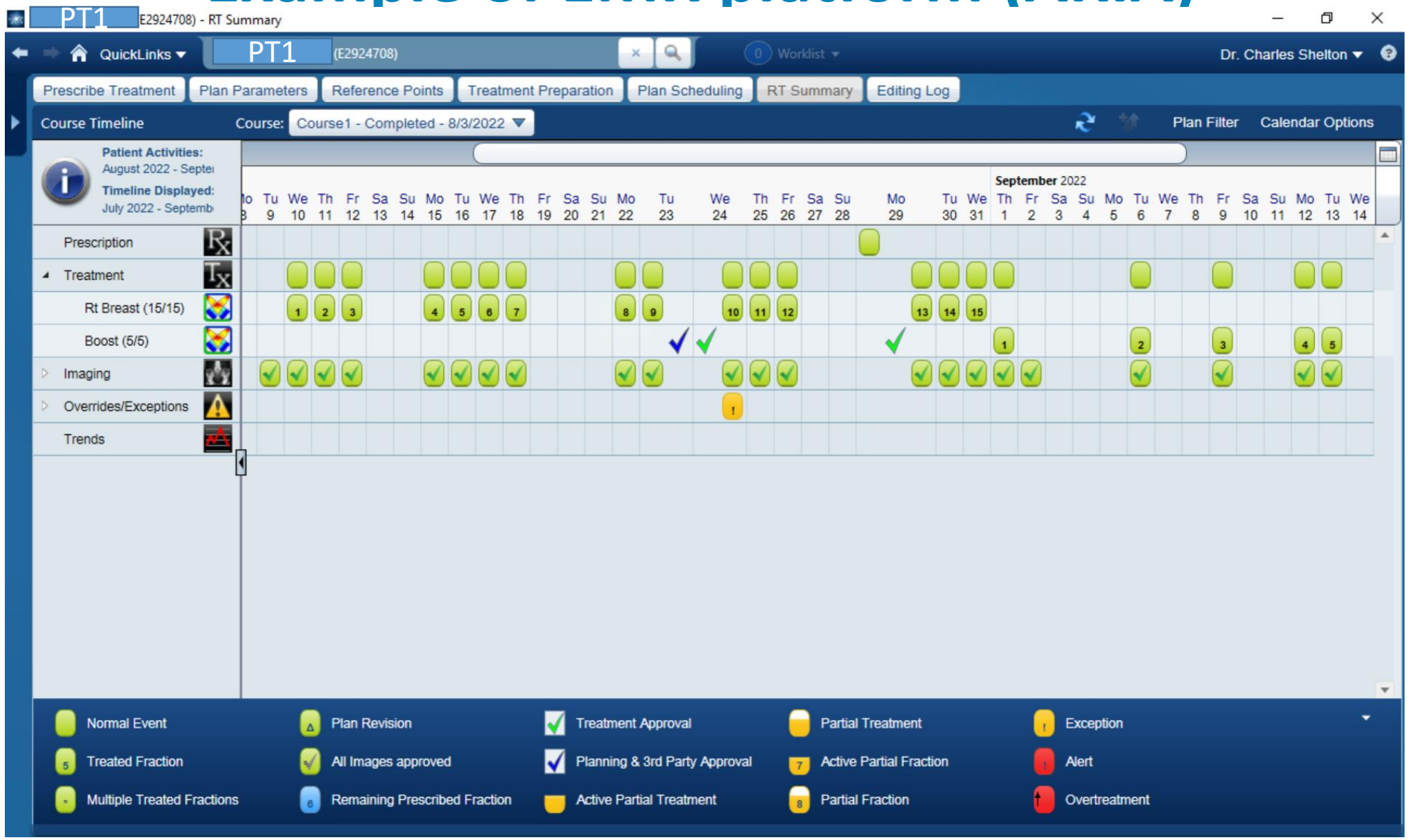
- Remember curative intent is usually 15-45 treatments, includes all sites, and usually not stage IV (not bone or brain metastases)
- We excluded ultra-fast short course of RT for this study (e.g. SBRT)

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 ≥ 3 No-shows is significant

Results:

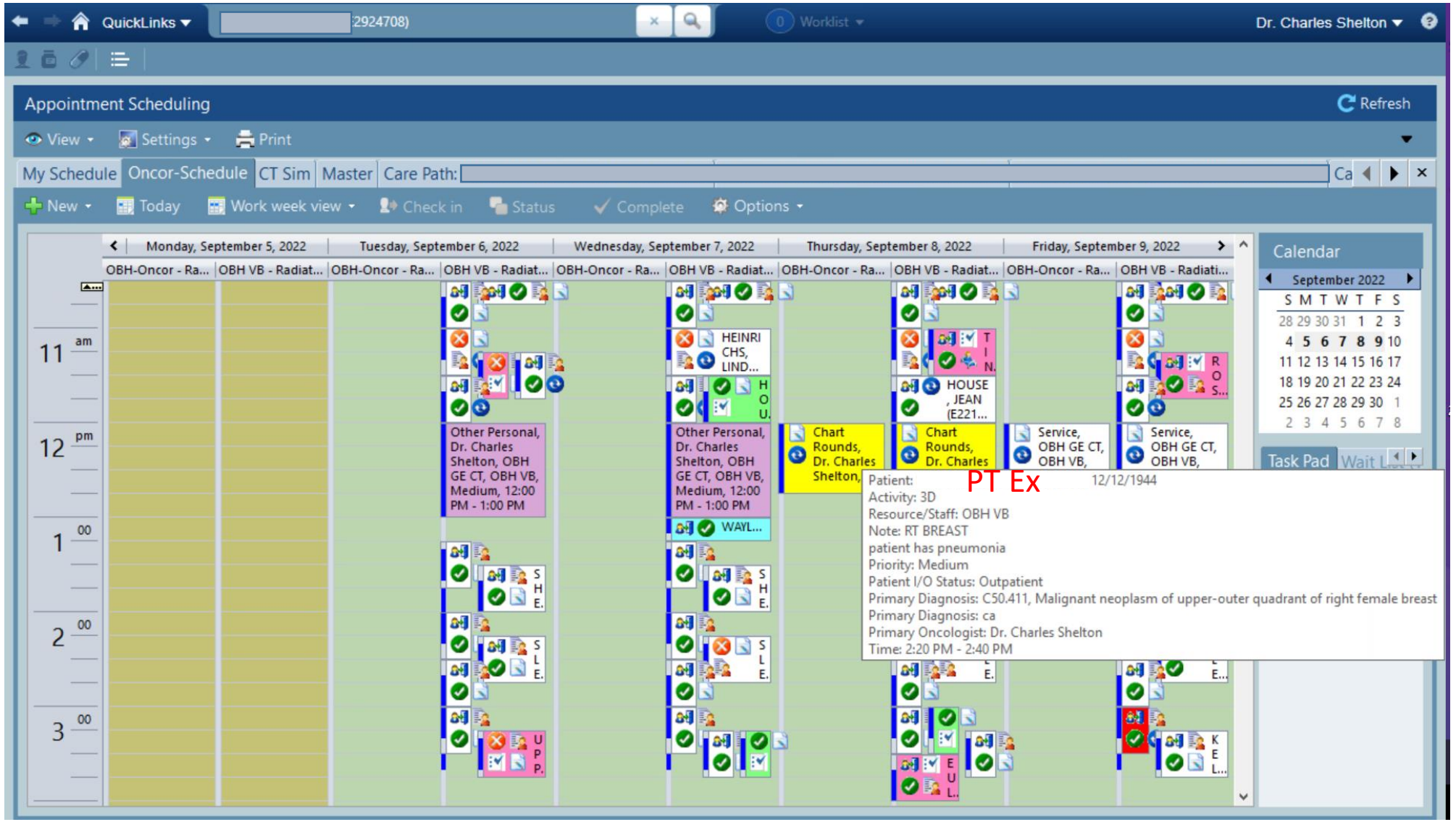
- *We had 24 patients (16%) who experienced 3 or more "no-shows" for various reasons that form the body of this analysis for us at our hospital RT clinic. The majority of these patients completed therapy, but it was delayed due to the "no-show" rates (3 days generally translates into half a week)*

- *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



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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?

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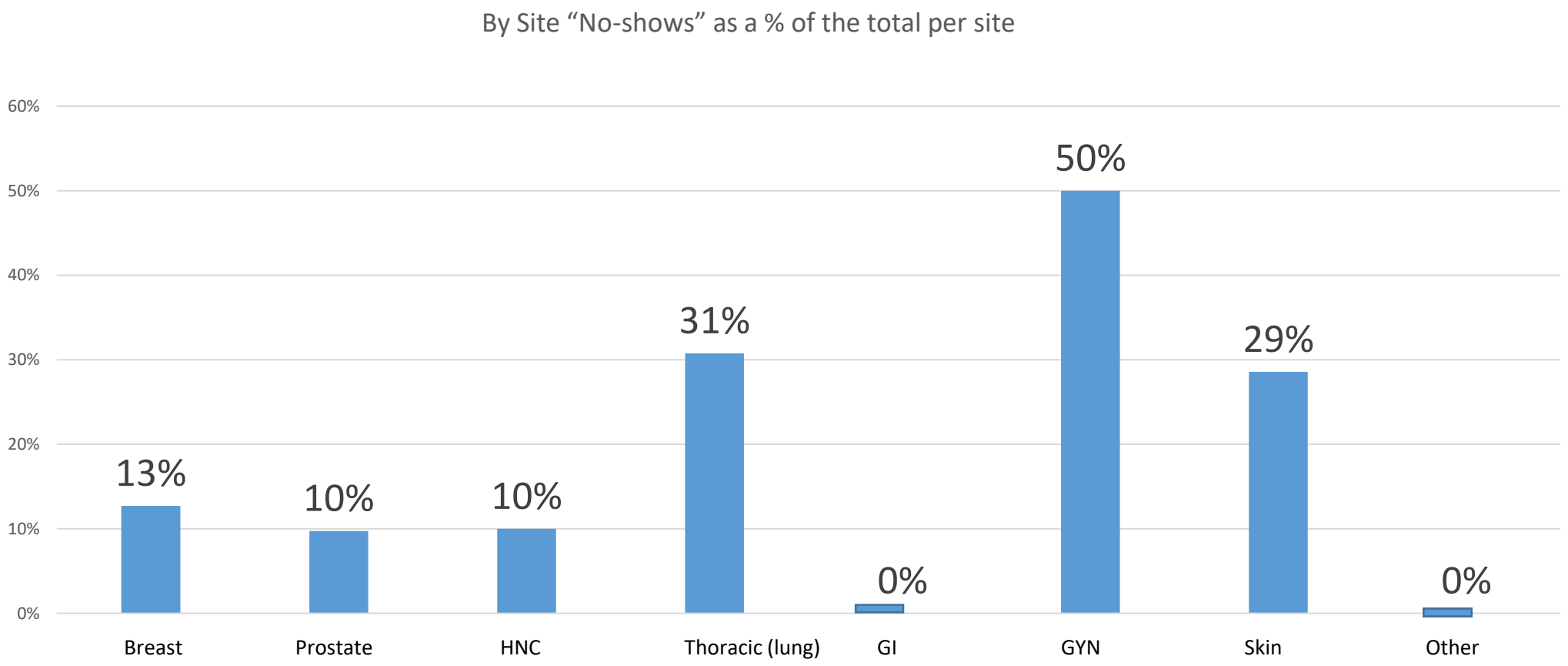
3. Analytics-Trends in Barriers

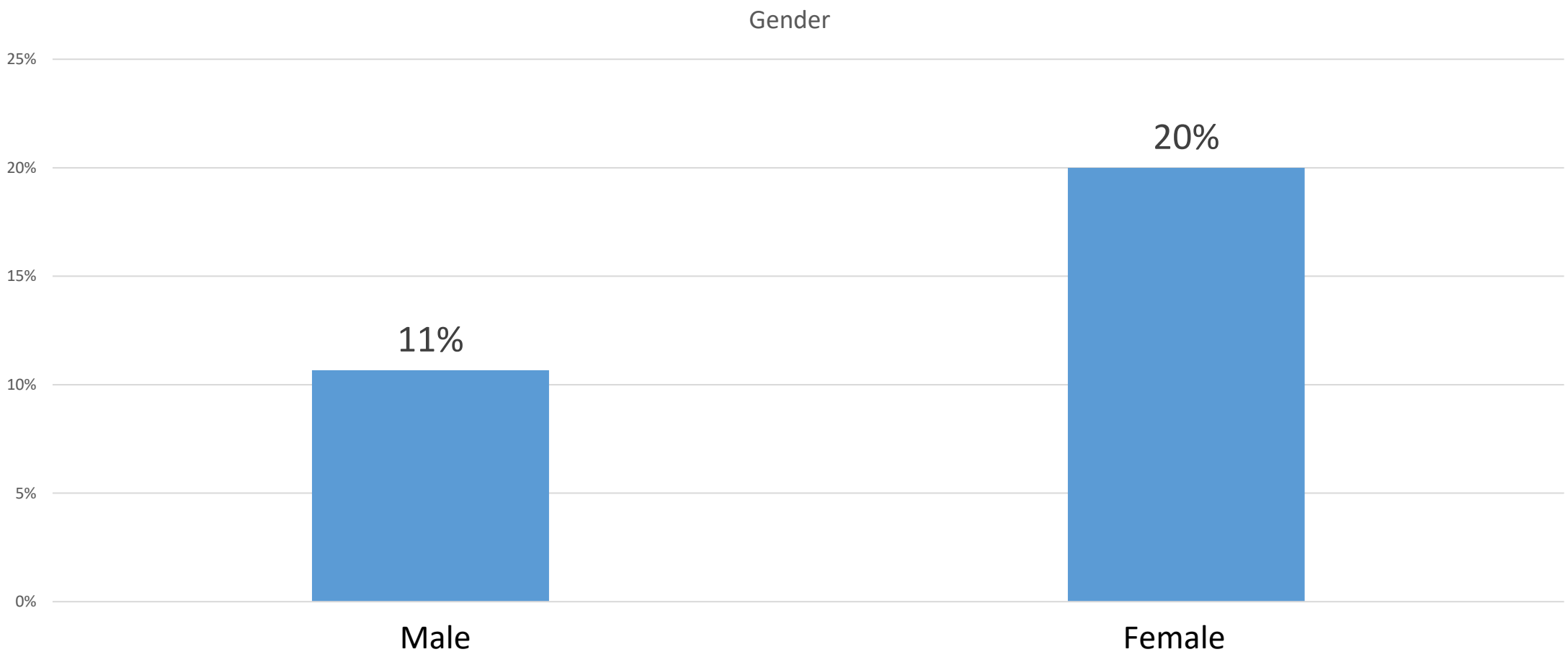
We analyzed our data for these correlates:

- 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)

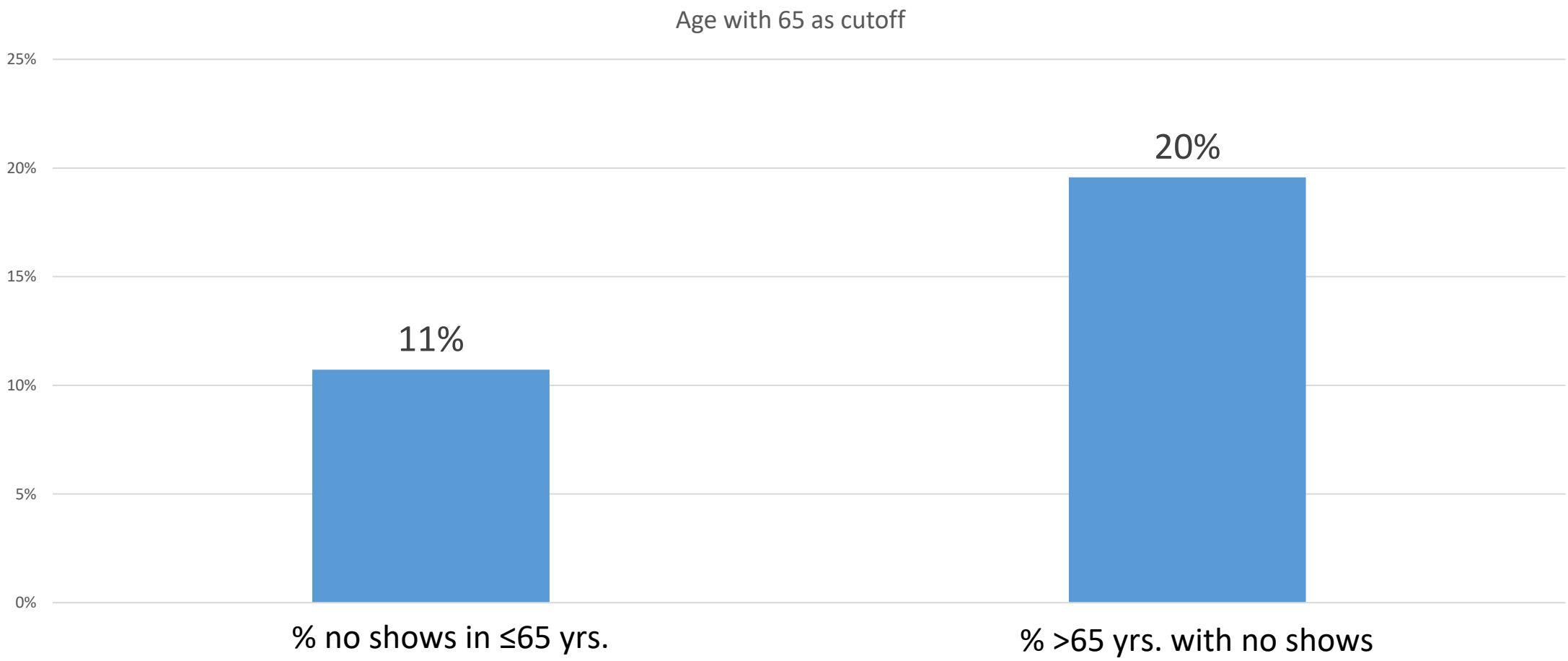
Site of RT treatment correlation



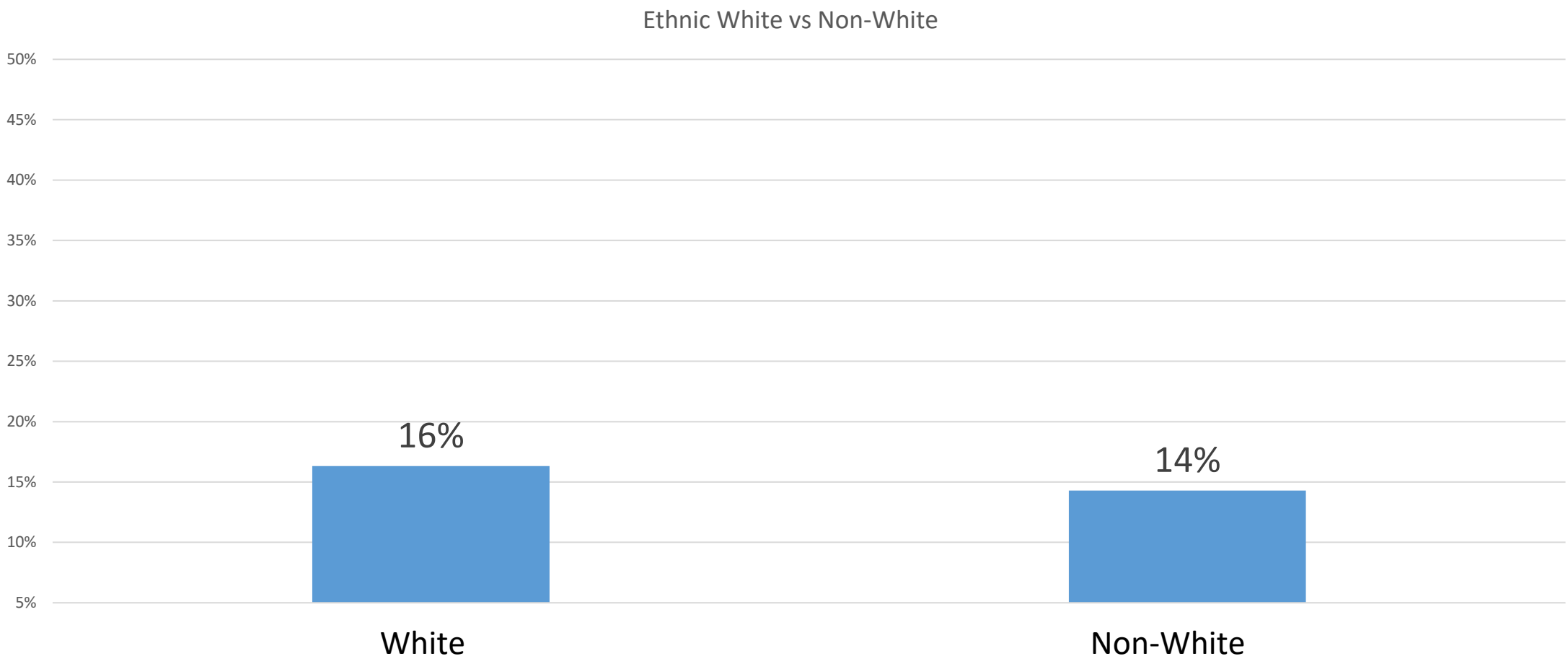
Gender correlation



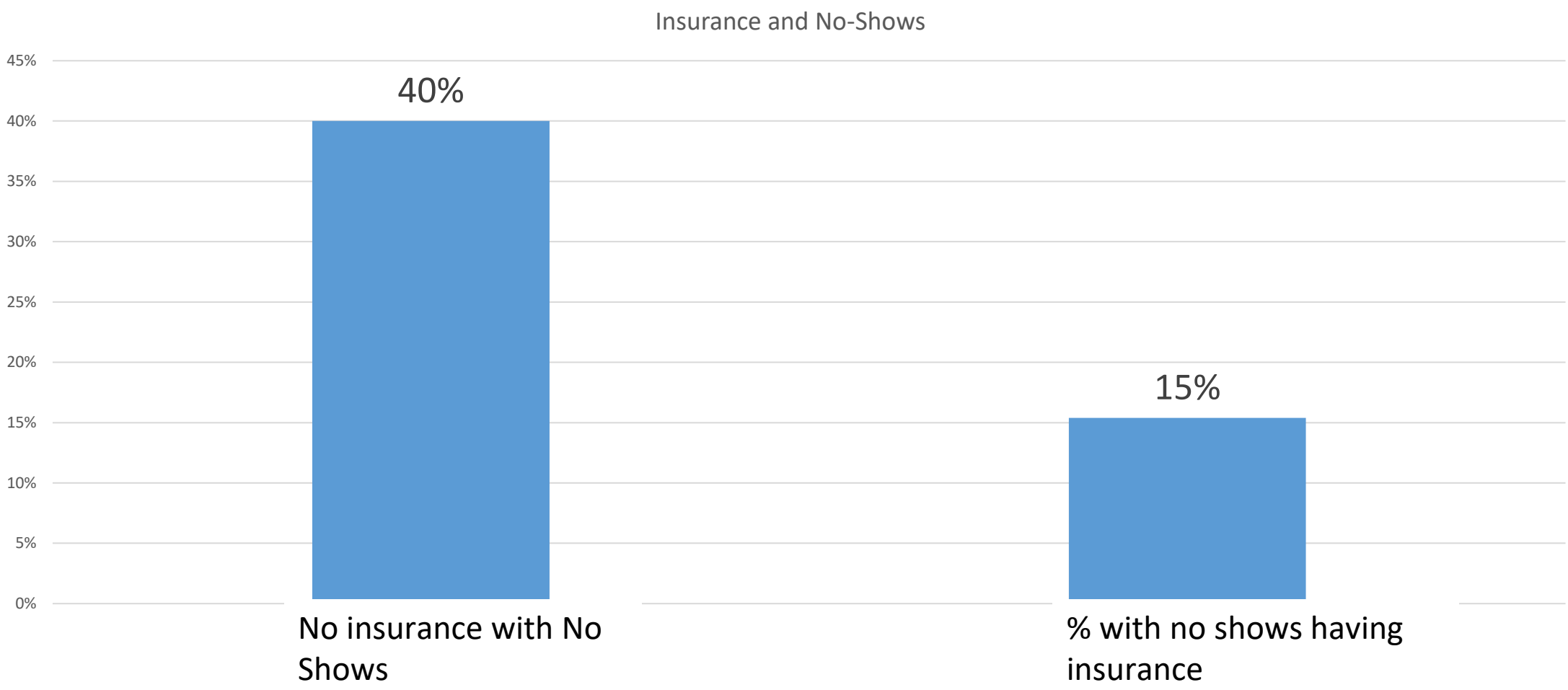
Age correlates



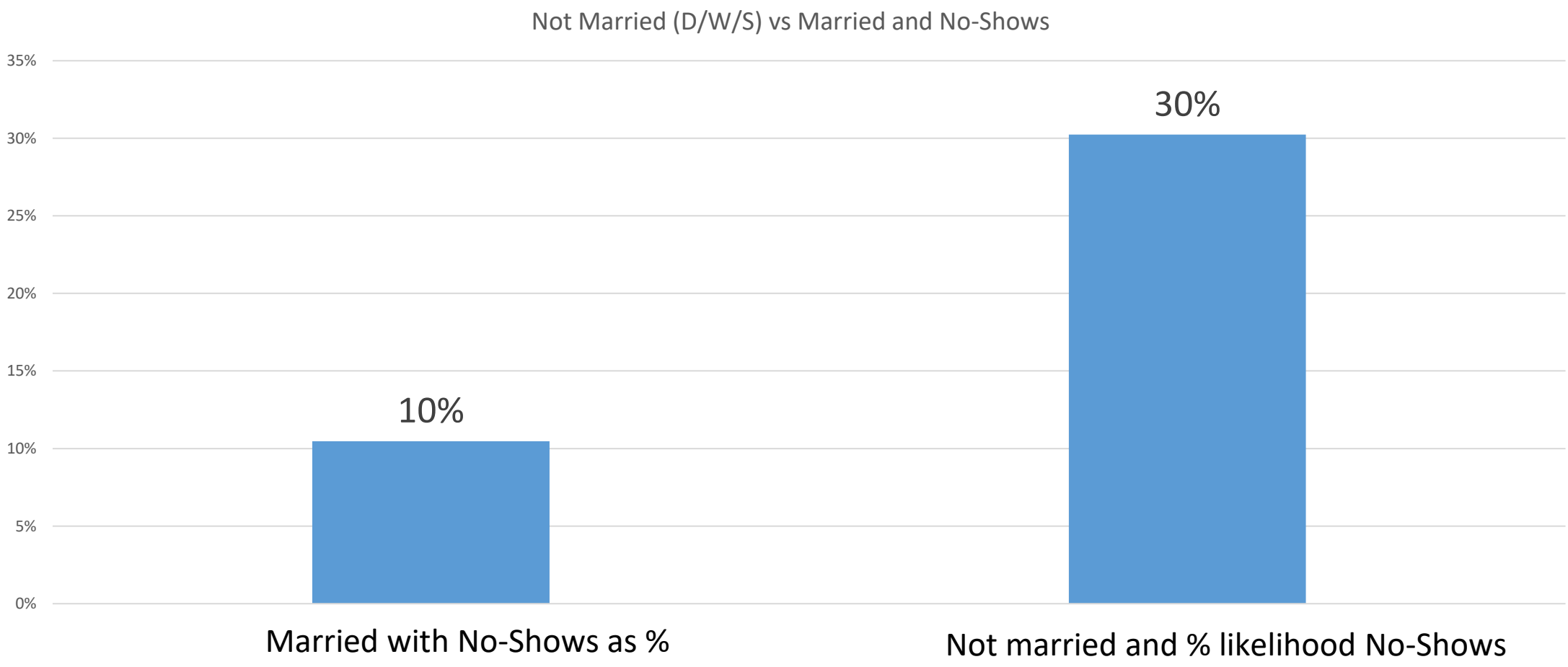
Ethnicity, not so much for us



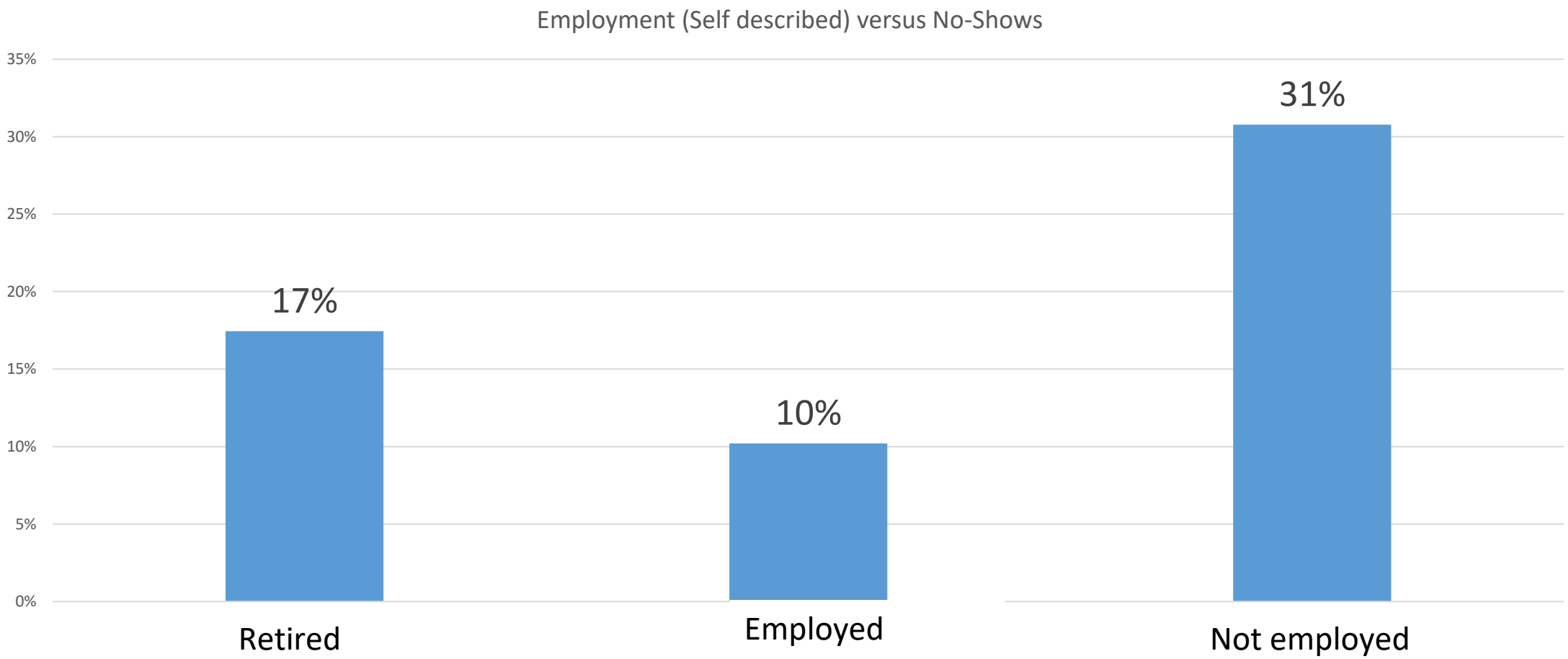
Insurance status correlates



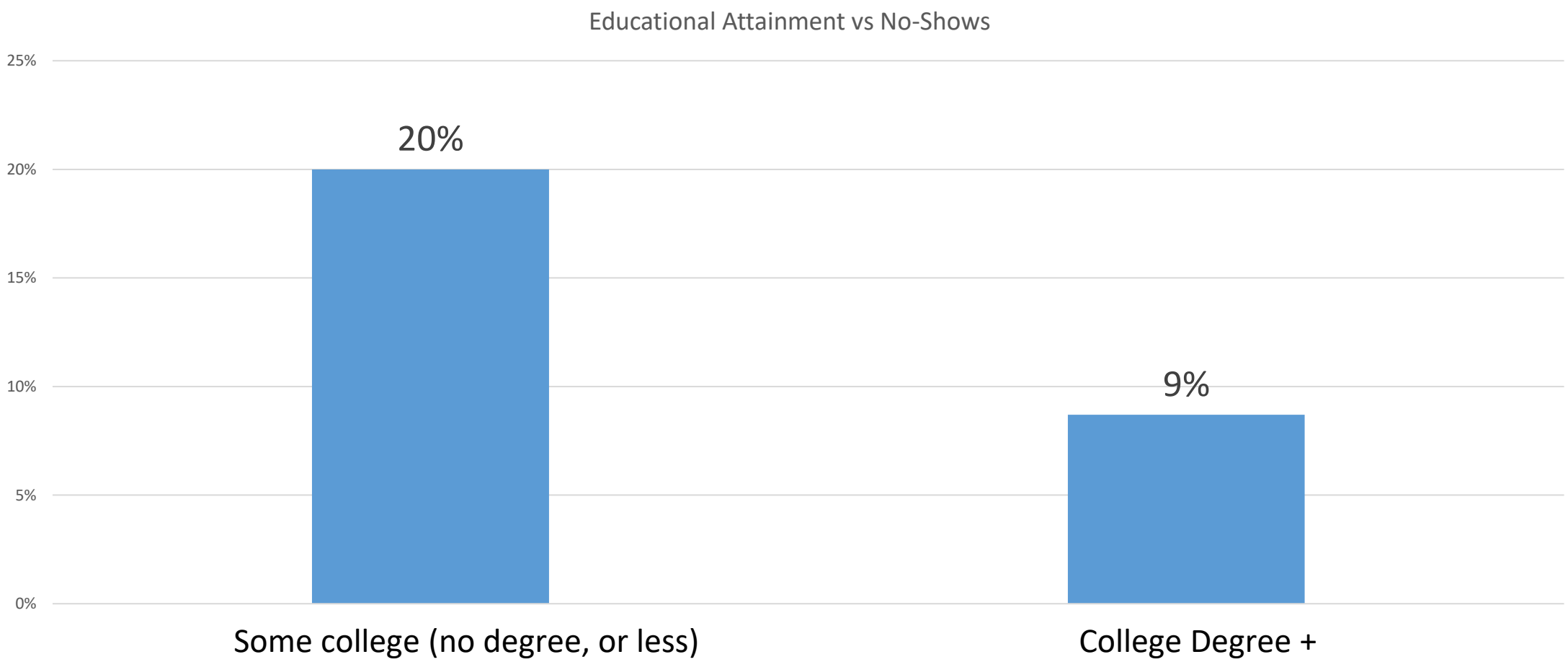
Marital Status correlates



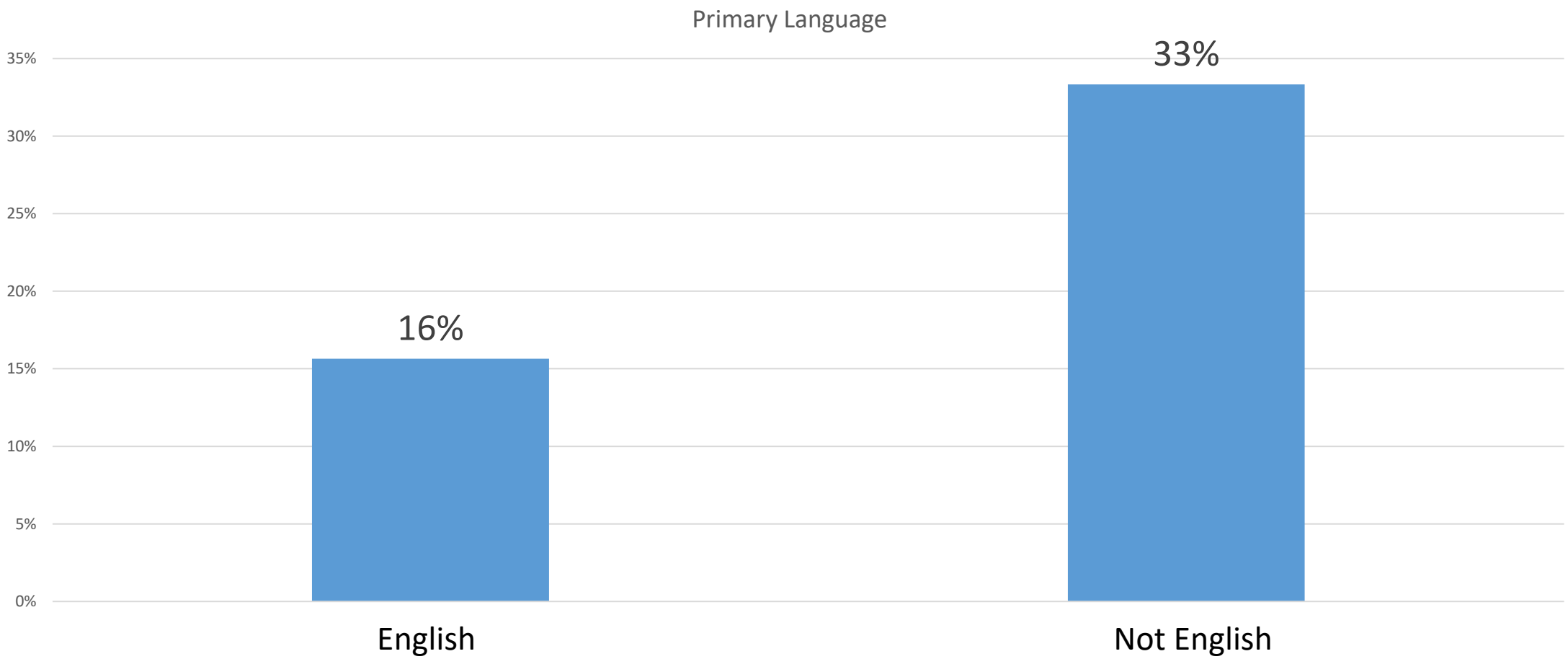
Employment status correlates



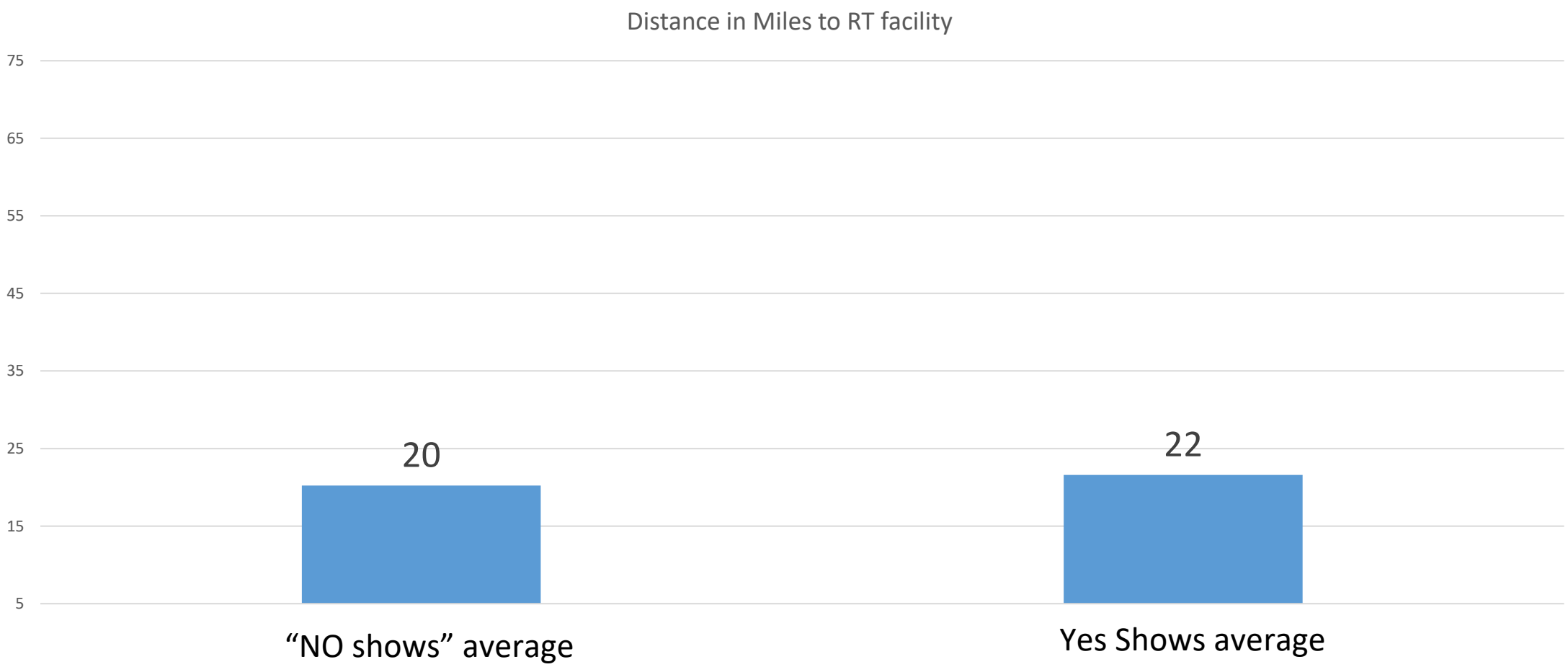
Education correlates



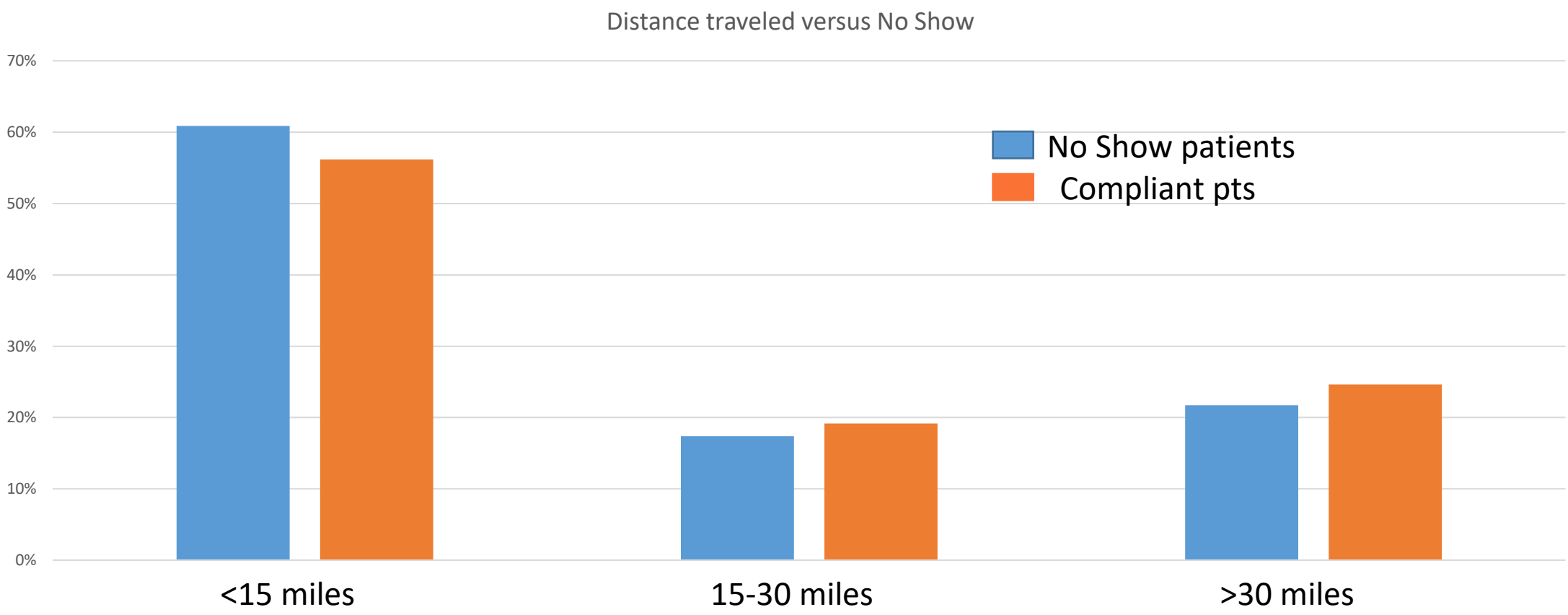
Language was a barrier



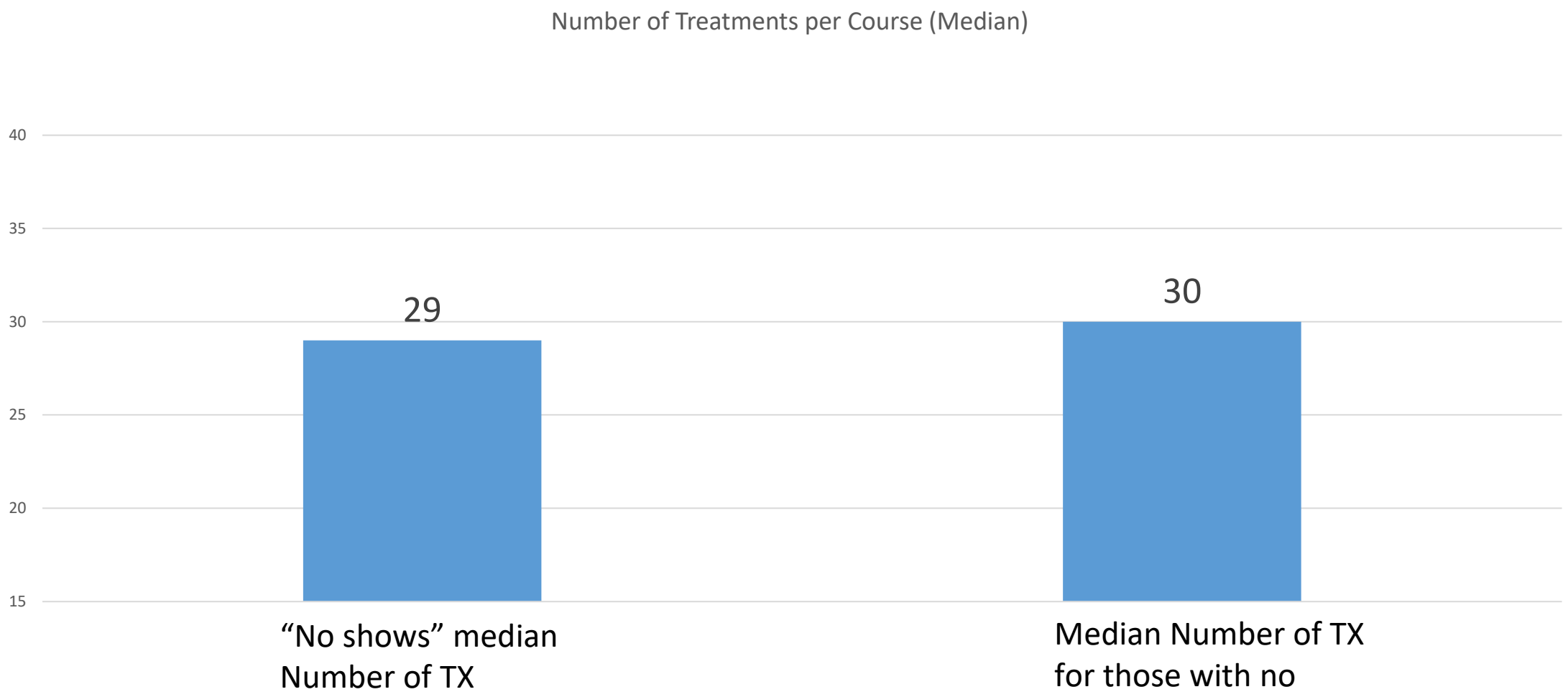
Distance to RT facility not correlating for us



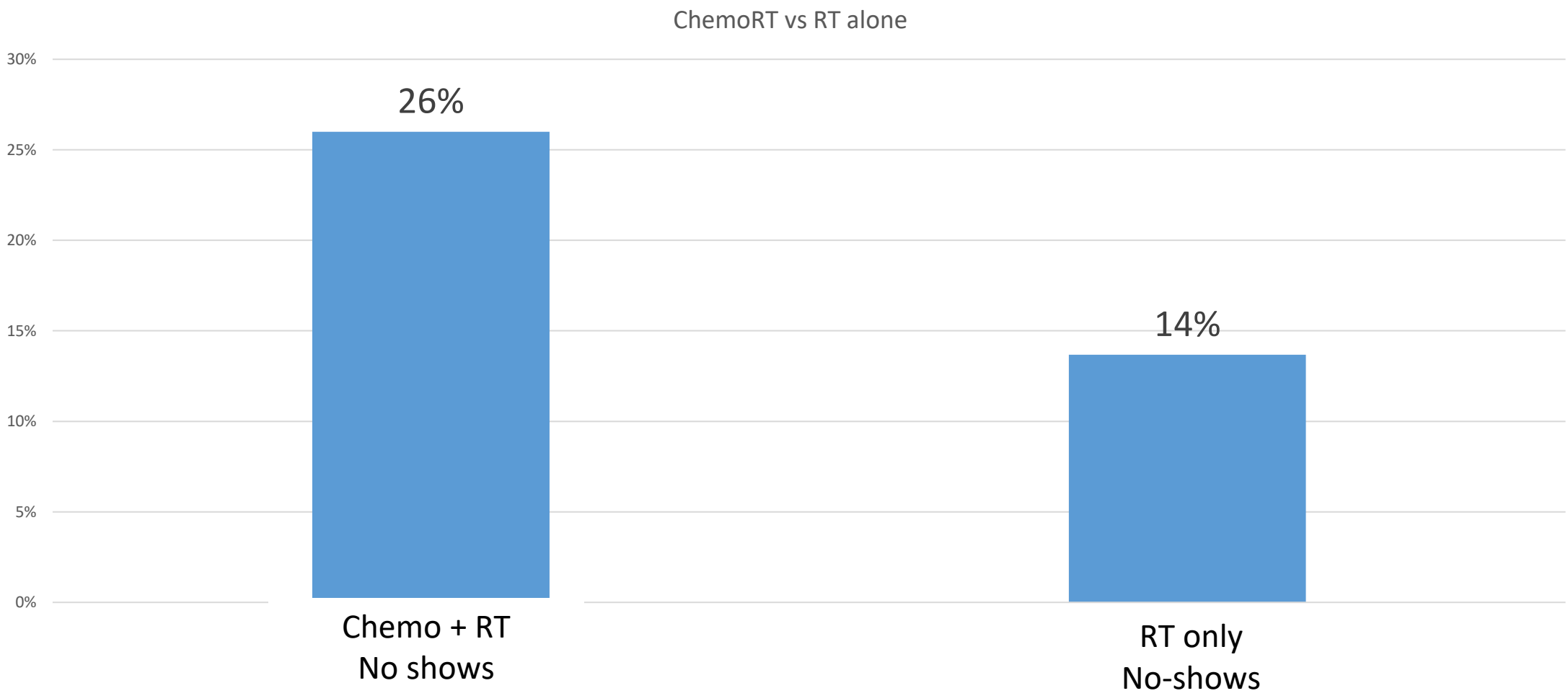
Distance further analyzed



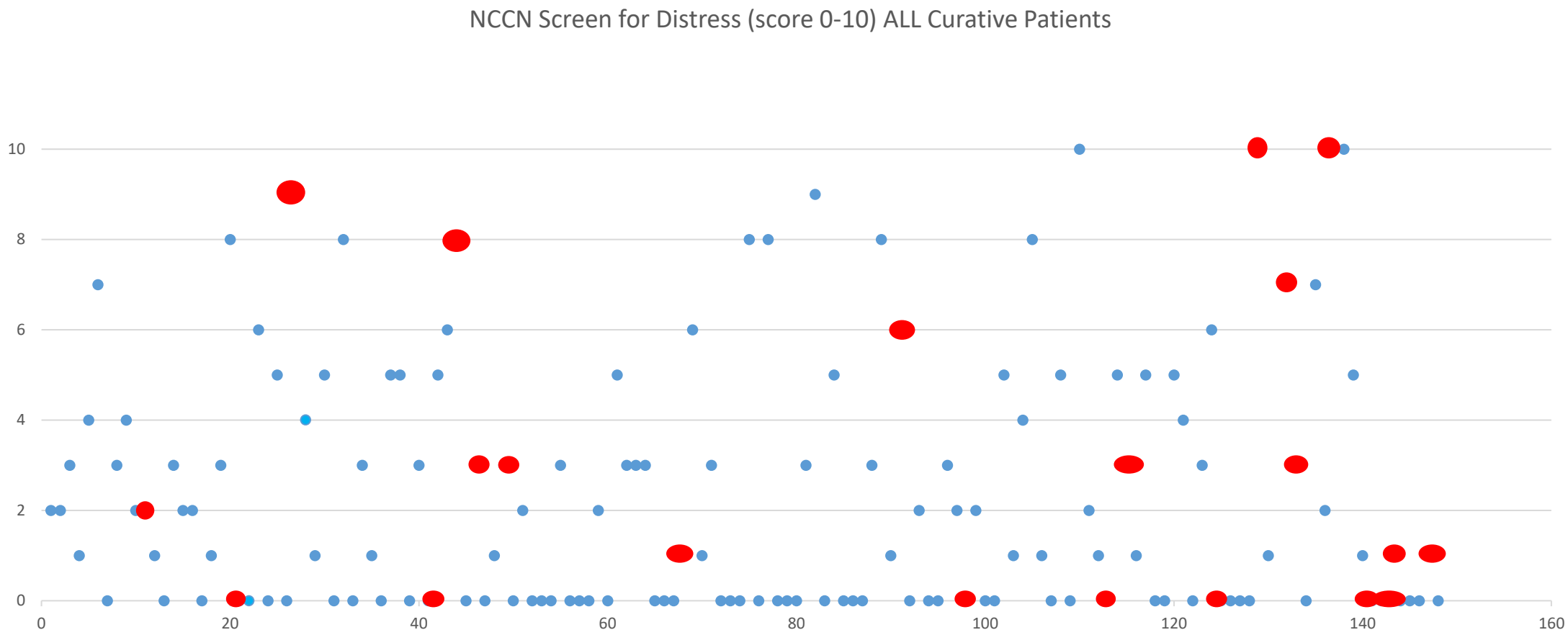
Number of treatments did not correlate for us



Adding chemo to RT did trend towards more barriers



Distress Screen Tool (NCCN)



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.

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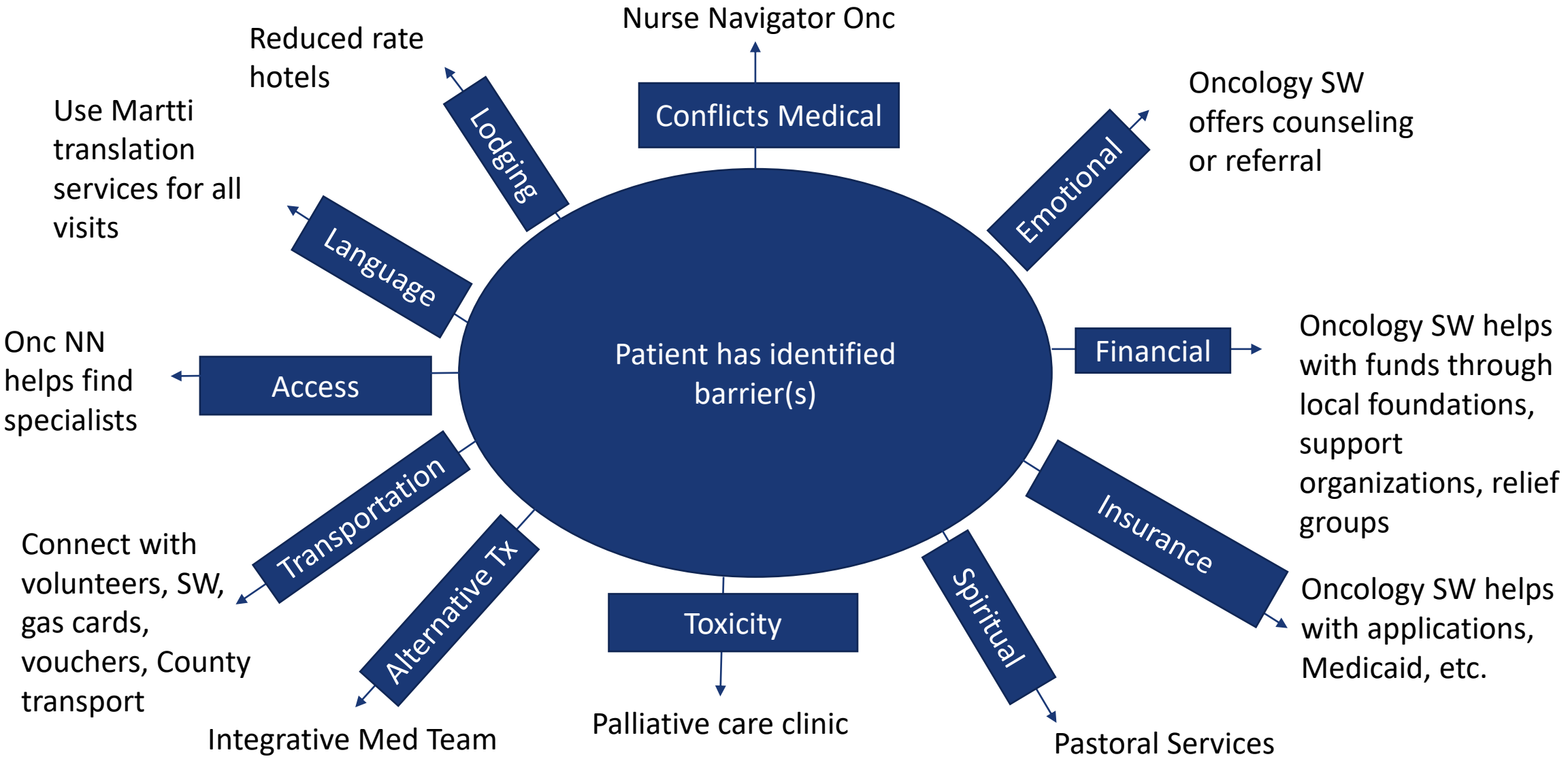
4. Developing Community Map

How we map resources to identified barriers



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)

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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

CAPE COD HEALTHCARE

The Standard

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)

8.1 Addressing Barriers to Care

Definition and Requirements

Each calendar year, the cancer committee identifies at least one patient-, system-, or provider-based barrier to accessing health and/or psychosocial care that its patients with cancer are facing and develops and implements a plan to address the barrier.

Cancer Barriers Analysis

The cancer committee reviews and analyzes the strengths and barriers of the cancer program. Resources for identifying strengths and barriers may include, but are not limited to:

- Cancer Quality Improvement Program (CQIP) reports
- Cancer patient satisfaction surveys
- Patient focus groups
- Use of state cancer registry data compared to cancer program data
  - Is the cancer program treating the main cancers that occur in its area?
  - Are vulnerable populations being reached?
- Population health resources from public health work done locally and regionally
- Community Needs Assessment
- Analysis of unique features of the cancer program and/or state (for example, affordable or adequate lodging for patients receiving care at a rural facility)

Identification of Barriers

Each calendar year, the cancer committee identifies barriers that are specific to the cancer program and chooses one to focus on for the upcoming year. Examples include, but are not limited to:

- Gaps in community resources
- Identified populations in need
- Uninsured or underinsured
- Health care provider shortages

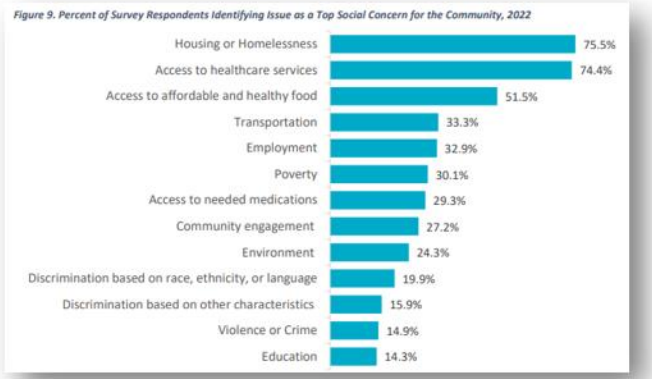
Each calendar year, the cancer committee minutes document a report that includes all required elements:

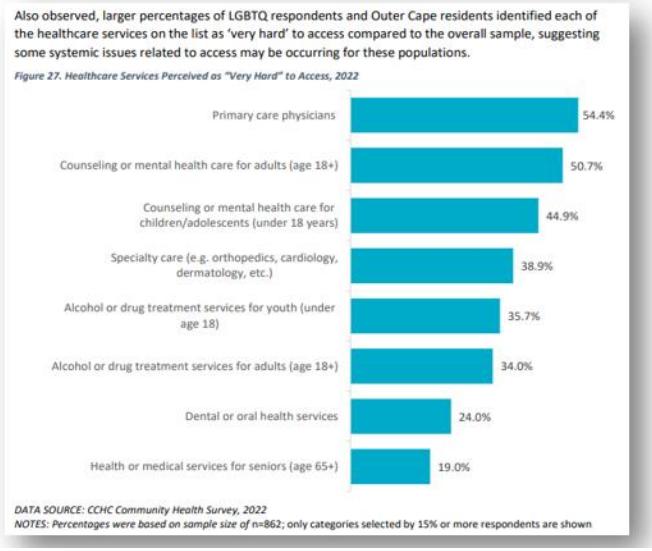
- What barrier was chosen
- What resources/processes were utilized to identify and address this barrier
- Metrics related to outcomes of reducing the chosen barrier

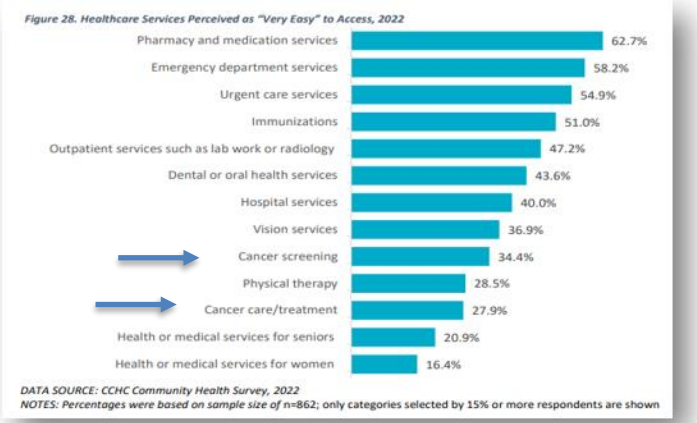
Sources of Information for Consideration

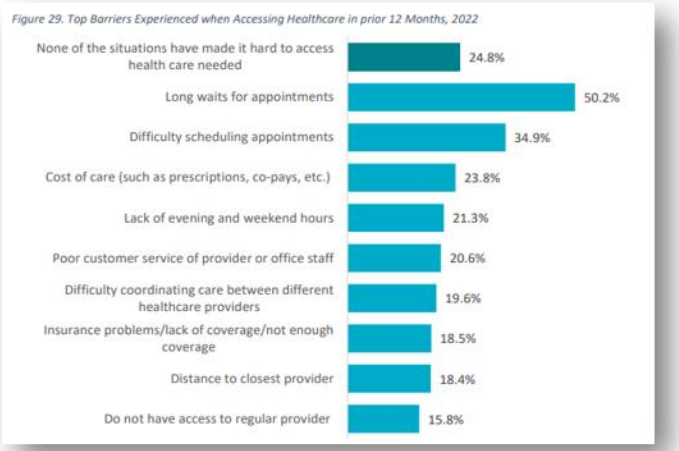
- Community Needs Assessment:
  - Themes and Priority Areas
  - Demographic information
    - ✓ Age
    - ✓ Language
    - ✓ Race
    - ✓ Food Security
    - ✓ Insurance status
  - Social Concerns (food, transportation, access to healthcare services, etc.)
  - LGBTQ barriers to healthcare services by 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









Examples: Community Needs Assessment slides

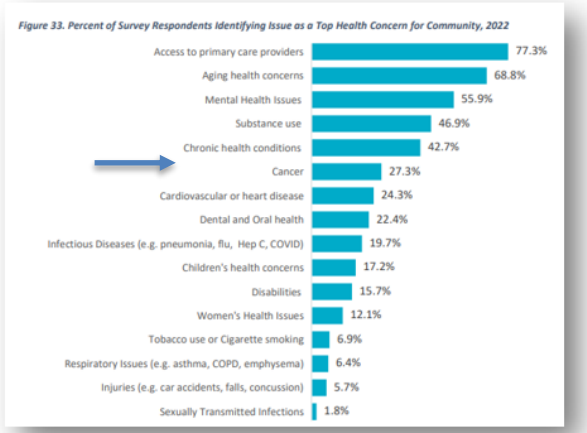
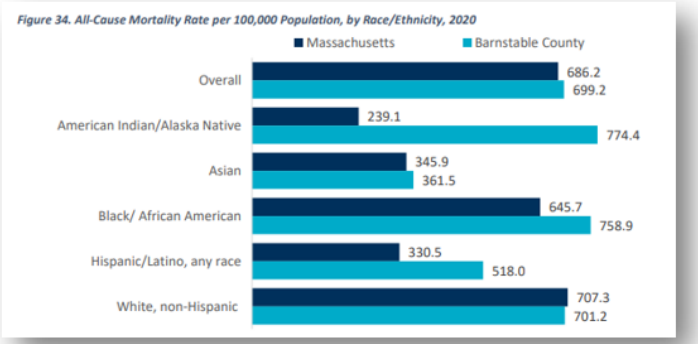
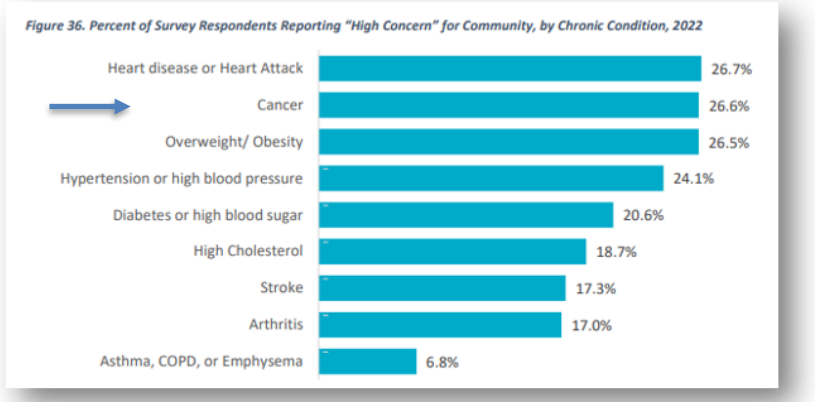


Figure 35. Leading Causes of Mortality, Age-Adjusted Rates per 100,000 Population, 2020

RANK	MASSACHUSETTS 2015	BARNSTABLE COUNTY 2015	MASSACHUSETTS 2020	BARNSTABLE COUNTY 2020
1	Cancer 152.8	Cancer 164.1	Cancer 135.2	Cancer 132.7
2	Heart disease 138.7	Heart disease 149.8	Heart disease 126.9	Heart disease 124.4
3	Accidential Injuries and Poisonings 58	Accidental Injuries and Poisonings 80.1	COVID-19 100.2	Accidental Injuries and Poisonings 72.4
4	Chronic lower respiratory diseases 33	Alzheimer's disease 29.2	Accidental Injuries and Poisonings 54.3	COVID-19 39.2
5	Cerebrovascular disease 28.4	Cerebrovascular disease 28.7	Chronic lower respiratory diseases 27.8	Cerebrovascular disease 31.8
6	Alzheimer's disease 20.2	Chronic lower respiratory diseases 28.5	Cerebrovascular disease 24.4	Chronic lower respiratory diseases 25.2
7	Pneumonia and Influenza 17.1	Pneumonia and Influenza 17.7	Alzheimer's disease 18.6	Alzheimer's disease 22.5
8			Diabetes 17.2	Chronic Liver Disease and Cirrhosis 14.2
9			Pneumonia and Influenza 14.5	Intentional self-harm (suicide) 13.6
10			Kidney Disease 13.2	Diabetes 12.8

DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2015 and Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2020





Example: Cancer Registry Data

Primary Site	Total	%	Male	%	Female	%
ORAL CAVITY & PHARYNX	39	2.6%	31	4.4%	8	1.0%
Tongue	14	0.9%	13	1.9%	1	0.1%
Salivary Glands	6	0.4%	3	0.4%	3	0.4%
Floor of Mouth	1	0.1%	1	0.1%	0	0.0%
Gum & Other Mouth	4	0.3%	4	0.6%	0	0.0%
Tonsil	12	0.8%	9	1.3%	3	0.4%
Oropharynx	2	0.1%	1	0.1%	1	0.1%
DIGESTIVE SYSTEM	237	16.0%	130	18.7%	107	13.6%
Esophagus	22	1.5%	15	2.2%	7	0.9%
Stomach	12	0.8%	8	1.1%	4	0.5%
Small Intestine	3	0.2%	2	0.3%	1	0.1%
Colon Excluding Rectum	85	5.7%	45	6.5%	40	5.1%
Cecum	21		5		16	
Appendix	6		4		2	
Ascending Colon	20		12		8	
Hepatic Flexure	5		3		2	
Transverse Colon	6		4		2	
Splenic Flexure	5		4		1	
Descending Colon	5		2		3	
Sigmoid Colon	16		10		6	
Large Intestine, NOS	1		1		0	
Rectum & Rectosigmoid	38	2.6%	23	3.3%	15	1.9%
Rectosigmoid Junction	4		3		1	
Rectum	34		20		14	
Anus, Anal Canal & Anorectum	17	1.1%	8	1.1%	9	1.1%
Liver & Intrahepatic Bile Duct	19	1.3%	11	1.6%	8	1.0%
Liver	13		10		3	
Intrahepatic Bile Duct	6		1		5	
Gallbladder	1	0.1%	0	0.0%	1	0.1%
Other Biliary	2	0.1%	0	0.0%	2	0.3%
Pancreas	38	2.6%	18	2.6%	20	2.5%
RESPIRATORY SYSTEM	201	13.6%	101	14.5%	100	12.7%
Larynx	7	0.5%	6	0.9%	1	0.1%
Lung & Bronchus	194	13.1%	95	13.6%	99	12.6%
BONES & JOINTS	1	0.1%	1	0.1%	0	0.0%
Bones & Joints	1	0.1%	1	0.1%	0	0.0%
SOFT TISSUE	2	0.1%	1	0.1%	1	0.1%
Soft Tissue (including Heart)	2	0.1%	1	0.1%	1	0.1%
SKIN EXCLUDING BASAL & SQUAM	45	3.0%	23	3.3%	22	2.8%
Melanoma -- Skin	43	2.9%	21	3.0%	22	2.8%
Other Non-Epithelial Skin	2	0.1%	2	0.3%	0	0.0%

Primary Site	Total	%	Male	%	Female	%
BREAST	374	25.2%	4	0.6%	370	47.1%
Breast	374	25.2%	4	0.6%	370	47.1%
FEMALE GENITAL SYSTEM	59	4.0%	0	0.0%	59	7.5%
Cervix Uteri	4	0.3%	0	0.0%	4	0.5%
Corpus & Uterus, NOS	36	2.4%	0	0.0%	36	4.6%
Ovary	11	0.7%	0	0.0%	11	1.4%
Vagina	2	0.1%	0	0.0%	2	0.3%
Vulva	4	0.3%	0	0.0%	4	0.5%
Other Female Genital Organs	2	0.1%	0	0.0%	2	0.3%
MALE GENITAL SYSTEM	198	13.4%	198	28.4%	0	0.0%
Prostate	192	13.0%	192	27.5%	0	0.0%
Testis	6	0.4%	6	0.9%	0	0.0%
URINARY SYSTEM	142	9.6%	102	14.6%	40	5.1%
Urinary Bladder	110	7.4%	84	12.1%	26	3.3%
Kidney & Renal Pelvis	31	2.1%	17	2.4%	14	1.8%
Other Urinary Organs	1	0.1%	1	0.1%	0	0.0%
BRAIN & OTHER NERVOUS SYSTEM	22	1.5%	11	1.6%	11	1.4%
Brain	16	1.1%	10	1.4%	6	0.8%
Cranial Nerves Other Nervous System	6	0.4%	1	0.1%	5	0.6%
ENDOCRINE SYSTEM	8	0.5%	0	0.0%	8	1.0%
Thyroid	6	0.4%	0	0.0%	6	0.8%
Other Endocrine including Thymus	2	0.1%	0	0.0%	2	0.3%
LYMPHOMA	56	3.8%	34	4.9%	22	2.8%
Hodgkin Lymphoma	3	0.2%	1	0.1%	2	0.3%
Non-Hodgkin Lymphoma	53	3.6%	33	4.7%	20	2.5%
NHL - Nodal	33		21		12	
NHL - Extranodal	20		12		8	
MYELOMA	18	1.2%	8	1.1%	10	1.3%
Myeloma	18	1.2%	8	1.1%	10	1.3%
LEUKEMIA	34	2.3%	26	3.7%	8	1.0%
Lymphocytic Leukemia	23	1.6%	18	2.6%	5	0.6%
Myeloid & Monocytic Leukemia	10	0.7%	8	1.1%	2	0.3%
Acute Myeloid Leukemia	4		3		1	
Chronic Myeloid Leukemia	5		4		1	
Other Myeloid/Monocytic Leukemia	1		1		0	
Other Leukemia	1	0.1%	0	0.0%	1	0.1%
MESOTHELIOMA	4	0.3%	3	0.4%	1	0.1%
Mesothelioma	4	0.3%	3	0.4%	1	0.1%
MISCELLANEOUS	42	2.8%	24	3.4%	18	2.3%
Miscellaneous	42	2.8%	24	3.4%	18	2.3%
Total	1,482		697		785	

Example: Issues Identify at Service Line Meetings

Oncology Service Line

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Tumor Site Service Line Follow up updated 1.4.23

Tumor Site	Update	Identified	Initiated	Completed
Gyn	✓ Established e-consult for gyn surgeons to communicate with Dr. Feltmate ✓ CCH/FH Rehab Department is exploring strategies to Expand pelvic floor therapy and post-treatment quality of life interventions such as sexuality availability within the system ✓ Collaborating with Drs. Chute and LaCorte re: Gynecologic Oncology Clinic and CCHC Gyn Surgeon logistics ✓ Initiated inventory of gyn onc patient instructions given in Boston and at CCHC to align	•Improve integration of palliative/EOL care •ID ways to better coordinate with Boston when patients need to go there for IR •Improve PCP lack of knowledge about capabilities on Cape and appropriate referrals for triage through Dr. Chute's office		✓ Hired RN Navigator
Neuro		• Obtain MR perfusion software • Increase frequency of tumor board to twice a month • Explore need for Laser Interstitial Thermal Therapy through tracking potential cases at tumor conference		

Oncology Service Line

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Tumor Site Service Line Follow up updated 1.4.23

Tumor Site	Update	Identified	Initiated	Completed
Thoracic	✓ **All Service Line identified items completed**			✓ Completed a successful PI with rehab services to increase applicable oncology referrals. Increased from baseline of 12 to over 100 per month. ✓ Hired RN Navigator for lung nodule program/thoracic cancer patients ✓ Implemented EBUS for Hyannis
Head and Neck	✓ Head and Neck Patient Navigation initiation TBD		✓ RN Navigator hired – initial focus is on thoracic and gyn	✓ Implemented Speech and Nutrition Clinic 12/20/22
GI	Transesophogeal ultrasound feasibility determination - not feasible or a priority due to low volume at this time.			✓ Workflow for assuring inclusion of IR ablation of kidney & liver tumors in tumor registry data capture. ✓ CCH general tumor board for inclusion of cases such as GI January 2022 (ACoS, CoC accreditation compliance issue) ✓ Dr. Anuj Patel (DFCI) has held two medical oncology 2nd opinion clinic
Breast		✓ Potential for outpatient surgery center approach	✓ Confirmed DFCI is Opening COMPASS HER2 breast trial to CCH ✓ Initated breast patient navigation assessment and PI for CCHC	✓ Days to first treatment analysis completed with process changes implemented ✓ Promotion of High Risk Breast Program ✓ Completed PROMPT Clinical Trial

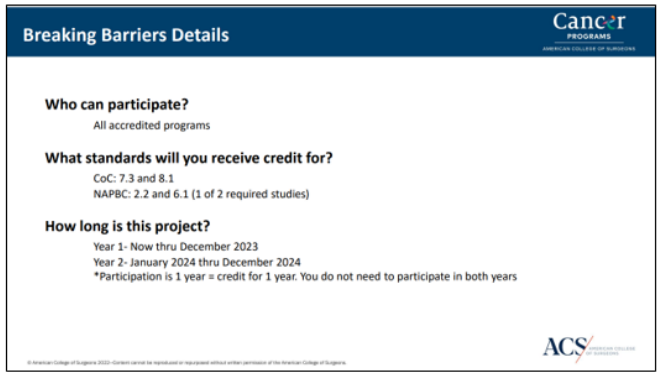
And of course, the Breaking Barriers Opportunity

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

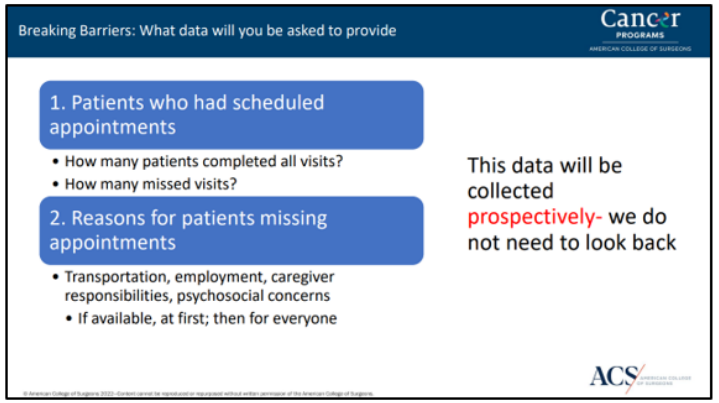
Describe the identified barrier to care
Resources/Processes utilized to identify the barrier to care
Resources/Processes utilized to address the barrier to care
Metrics related to outcomes of reducing the barrier to care
Evaluation of the resources and processes developed to address the barrier to care. Includes strengths and areas for improvement
Date annual report was presented to Cancer Committee (mm/dd/yyyy)

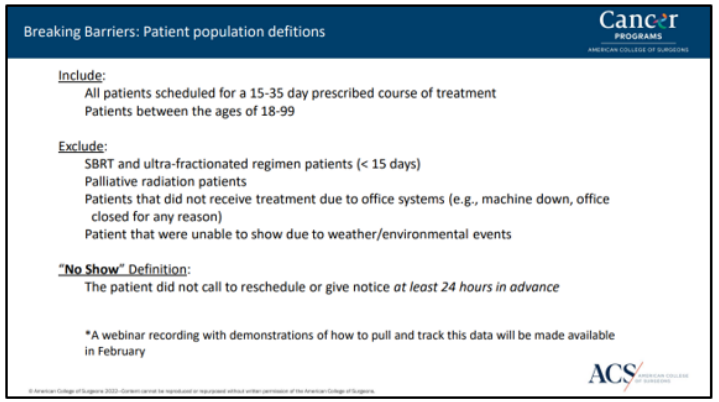
Recommended Options for System-based Barrier

Breaking Barriers: An ACS Cancer Programs National QI Project



*NOTE: Will need to have at least 1 update on roll-over Barrier to Care from 2022: Access to Nutritional Food

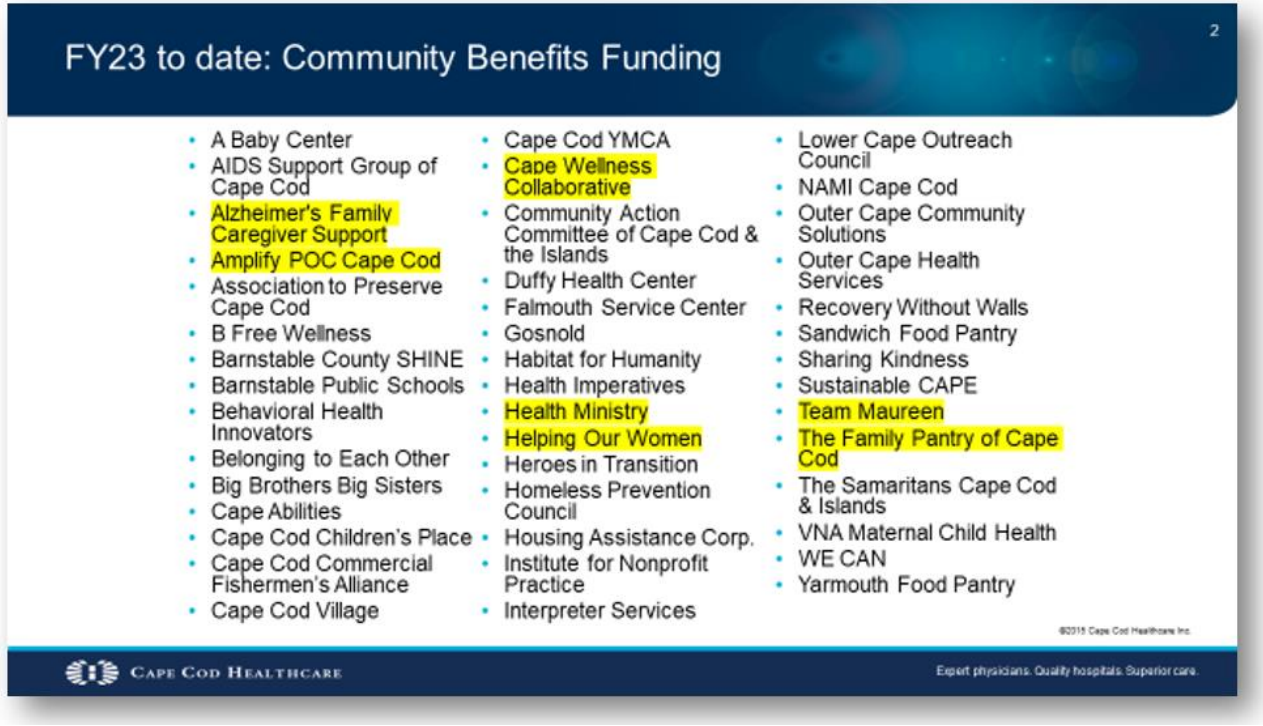




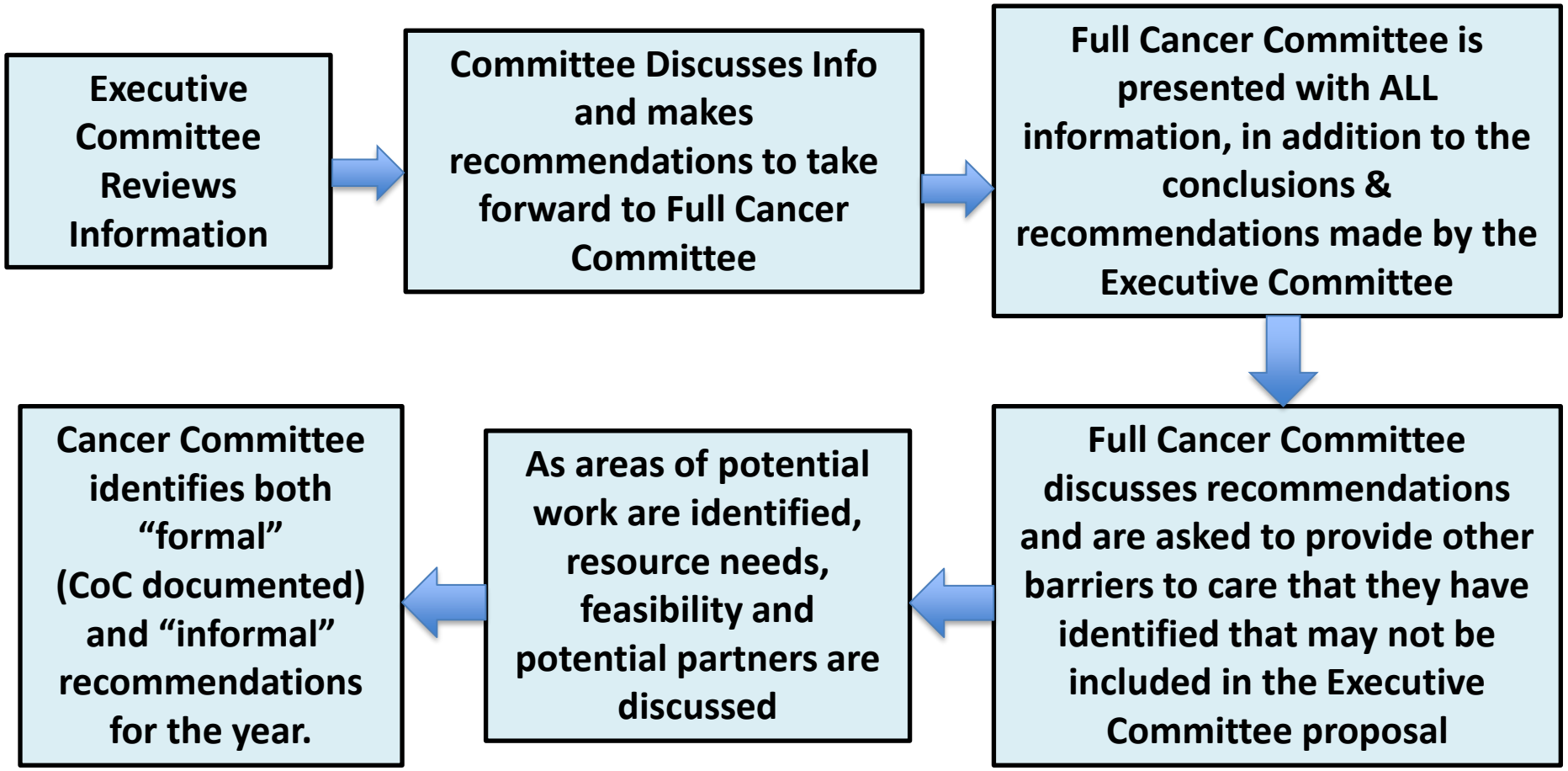
Who might we partner with?

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



This year's results & conclusions

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)*

ACS CoC Commission on Cancer
American College of Surgeons

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

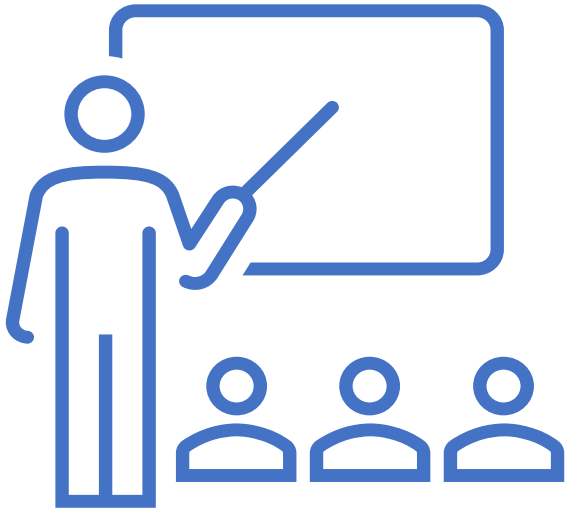
More in depth questions about barriers

- 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



ACS CoC Commission on Cancer
American College of Surgeons

Reminders

ACS Cancer Conference 2024

February 22-24, 2024 | Austin, TX

Save the Date

*facs.org/**cancerconference***

ACS Cancer Programs

American College of Surgeons

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

Commission on Cancer
American College of Surgeons

Q and A

Reach out to cancerqi@facs.org