

**Implementing the Commission on Cancer Standard 8.1 Addressing Barriers to Care**

#### A Road Map for Comprehensive Cancer Control Professionals and Cancer Program Administrators

**January 2021**

The GW Cancer Center Implementing CoC Standard 8.1: Addressing Barriers to Care | i

This Road Map has been adapted from its original version to specifically highlight Step 2.

It is strongly recommended you review the Road Map in its entirety by visiting the [GW Cancer Control TAP website for the Implementing the Commission on Cancer Standard 8.1 Addressing Barriers to Care](https://cancercontroltap.smhs.gwu.edu/news/implementing-commission-cancer-standard-81-addressing-barriers-care)

Special thanks to Dr. Mandi Chapman Pratt, Sarah Kerch, and Shayla Scarlett for allowing the American College of Surgeons Cancer Programs to adapt this step of the road map for the National Breaking Barriers QI project.

For more information on the Breaking Barriers project, please visit this [website](https://www.facs.org/quality-programs/cancer-programs/breaking-barriers-quality-improvement-collaborative/).

STEP 2a: Understand the communities in which your patients live and work by considering the following. It is recommended you discuss as a group and record this information. Note, see page 9 for helpful resources in completing this information.

1. Program Name:
2. In which zip codes do a majority of your cancer patients live?
3. Describe any known trends in patient characteristics. Consider:

Education level:

Average age range:

Employment rates:

Poverty level:

1. Consider and record what percent of your patients identify in following racial categories:

Asian:

Black/African American:

American Indian/Alaskan Native:

Native Hawaiian and Other Pacific Islander”

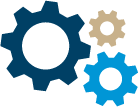
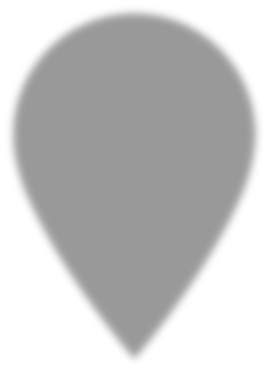
White/Caucasian:

1. Consider and record your patient population identified ethnic origins:
2. What languages do your patients speak?
3. What is the insurance breakdown of cancer patients you see in your facility?

% Private Insurance: %Public Insurance: %Self Pay/Other

1. Any other notes about the medical social related health needs your clinic sees (eg. Rates of asthma, exposure to lead, etc)

STEP 2b: IDENTIFY BARRIERS TO CANCER CARE



Identify barriers to care from various sources and choose one to focus on. Barriers may be patient-centered, provider- centered or health system-centered (CoC, 2019). Determine potential solutions to reduce cancer disparities.

The table below provides some examples of identified barriers, as well as actions and solutions that could be used to address them. Please note that this is not an exhaustive list and could look different from the barriers faced by your organization and patient population.

In the “Identified Resource or Action Taken” column, please respond with what resources may be available for patients. Consider their location, hours of operation, languages spoken, or insurance/payment required. It is reasonable that some barriers may not have a solution at this time, but asses what is available and share this information with other healthcare providers once completed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IDENTIFIED**  **BARRIERS** | **EXAMPLES** | **POTENTIAL ACTIONS** | **POTENTIAL SOLUTIONS** | **IDENTIFIED RESOURCE or ACTION TAKEN (may include name and contact information of resource or website)** |
| **Logistical** | * Transportation issues * Housing insecurity/transient population * Lack of childcare | * Identify patients who require transportation to medical care or support services within or outside their community * Identify patients who require childcare * Identify patients who may be housing insecure or transient and may be difficult to get ahold of | *Transportation (within community):*   * Work with local Medicaid managed care organizations on improvements to transportation vendor availability * Work with ride sharing companies (e.g., Lyft) to pay for rides for patients * Engage local churches or non-profit organizations * Identify local or national resources that provide financial assistance for transportation and create an instructional document for patients on how to access these resources (e.g., [American Cancer Society](https://www.cancer.org/treatment/support-programs-and-services/road-to-recovery.html) [(ACS’s) Road to Recovery](https://www.cancer.org/treatment/support-programs-and-services/road-to-recovery.html))[\*](#_bookmark10)   *Transportation (outside of community):*   * Utilize [ACS’s Hope Lodges](https://www.cancer.org/treatment/support-programs-and-services/patient-lodging/hope-lodge.html)\* or [Ronald](https://www.rmhc.org/our-core-programs/ronald-mcdonald-house-programs) [McDonald Houses](https://www.rmhc.org/our-core-programs/ronald-mcdonald-house-programs)\* for children * Develop a hotel partner program * Work with administrators of telemedicine services to provide care * Implement a screening process to [identify patients experiencing food insecurity](https://hungerandhealth.feedingamerica.org/resource/childrens-healthwatch-hunger-vital-sign/); develop relationships with community food banks |  |
| **Psychosocial** | * Mental health concerns (anxiety, depression) * Substance use disorders (SUD) * Social isolation | * Evaluate CoC Standard 5.2 and assess your programs psychosocial distress tool against population needs * Together with social workers or other behavioral health clinicians, select and implement an assessment tool to identify mental health concerns * Identify patients that may have previous or current substance use disorders * Identify and flag patients at high risk for social isolation (elderly, patients in assisted care facilities, transient populations, etc) | * If available, refer to “in-house” mental health providers * Develop relationships with community mental health and/or SUD providers and learn how to make referrals to their services * Educate staff on the co-occurrence of SUD, mental health conditions, and impact on cancer treatment and outcomes * Create a support group for cancer patients to facilitate connection |  |
| **Economic** | * Lack of insurance or under-insurance * High co-pays or deductibles * Prescription medication costs * Financial and legal issues * Employment * Food insecurity | * [Assess financial](https://www.cancer.gov/about-cancer/managing-care/track-care-costs/financial-toxicity-hp-pdq) and legal issues faced by patients during and after treatment * Have navigators document barriers * Identify patients for whom employment is unstable or inflexible * Identify patients that struggle with food security | * Provide financial counseling and navigation services to all patients diagnosed with cancer * Work with local insurance exchange navigators or safety net insurers to enroll eligible patients * Screen patients for financial assistance eligibility and navigate them to co-pay and other [patient assistance programs](https://www.patientadvocate.org/) * Develop support initiatives such as [medical-](http://medical-legalpartnership.org/) [legal partnerships](http://medical-legalpartnership.org/) * Provide [ACS’s National Cancer Information](https://www.cancer.org/treatment/support-programs-and-services.html) [Center (NCIC)](https://www.cancer.org/treatment/support-programs-and-services.html) with information about resources in your community and refer patients to NCIC * BMC [Patient Medical-Legal Need Survey](https://static-content.springer.com/esm/art%3A10.1186%2Fs12913-016-1443-1/MediaObjects/12913_2016_1443_MOESM1_ESM.pdf) * Implement a screening process to [identify patients experiencing food insecurity](https://hungerandhealth.feedingamerica.org/resource/childrens-healthwatch-hunger-vital-sign/); develop relationships with community food banks |  |
| **Cultural and Linguistic** | * Lack of culturally or linguistically competent services * Patient mistrust or negative perception of health care providers * Systems that perpetuate structural racism | * Assess cultural and linguistic competency of services and providers * Understand cultural background(s) of patient population * Review policies and procedures to determine if they result in an unanticipated burden on   some populations | * Adopt the [Office of Minority Health’s National](https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53) [Standards for Culturally and Linguistically](https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53) [Appropriate Services in Health and Health](https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53) [Care](https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53) * Ensure access to in-person or telephone medical interpreter services on demand * Conduct culturally humble community outreach * Change policies and processes that disproportionately burden people historically discriminated against |  |
| **Communication** | * Low health literacy * Lack of knowledge about wellness behaviors * Lack of knowledge about resources or events * Unclear provider explanations to patients | * Track and document communication issues * Assess patient understanding of treatment plan and available resources | * Collaborate with on-site or community wellness group to offer support groups * Ensure access to patient navigators * Ensure educational materials meet health literacy standards for readability (e.g., reading grade level should be 5th grade or below) * Provide materials in the languages of patients seen in the clinic * Provide patients with worksheets to prioritize questions for their health care team; consider referring patients to the [Cancer Survival Toolbox.](https://canceradvocacy.org/resources/cancer-survival-toolbox/?gclid=EAIaIQobChMI-tWvzOvq_QIV3XNvBB0MZgoBEAAYASAAEgLWt_D_BwE) * Improve provider communication skills   through training and practice-based learning |  |
| **Provider Centered** | * Perceptions or attitudes, including implicit bias * Time constraints and demand for health care services * Administrative barriers * Provider burnout | * Assess providers’ perceptions, time constraints and other administrative barriers, like excessive paperwork | * Measure patient satisfaction and identify   opportunities to improve patient-  provider interactions   * Use resources from the American   Medical Association or other  organizations to reduce administrative  burden associated with prior  authorization programs from insurers   * Work directly with managed care   organizations to reduce referral burden   * Prioritize diversity of background and   perspective in the workforce to optimize  peer-to-peer learning   * Complete the [Implicit Association Test (IAT)](https://implicit.harvard.edu/implicit/takeatest.html) |  |

**Next Steps:**

We highly recommend you share this document with other team members, post it in a public space, or discuss during huddles or team meetings.

For locally identified resources, it is recommended you update their contact information every 6 months to ensure the service is still operational.

We recommend you review step 3 of the GW Cancer Control Toolkit to better understand how to address these barriers.

Future Breaking Barriers survey will contain questions related to your experience with this worksheet.

The below table includes some helpful resources and links to help you better understand your patient population. This list is not exhaustive and your are encouraged to continue to add links, webpages, or resources that relate to

your own local community. For example, your state DHS website often has helpful population health data by region or zip code.

|  |  |
| --- | --- |
| Resource Type | Resource link |
| Training | * [GW Oncology Patient Navigation Training](https://cme.smhs.gwu.edu/gw-cancer-center-/content/oncology-patient-navigator-training-fundamentals) * [Implicit Bias: A Practical Guide for Healthcare Settings](https://cme.smhs.gwu.edu/www.dcrxce.com/content/implicit-bias-practical-guide-healthcare-settings#group-tabs-node-course-default1) |
| Data | * [Barriers to Care ArcGIS](https://storymaps.arcgis.com/stories/aae195ca5edd48739ce78eda985b52bd) * [NIH Map Stories](https://nexus.od.nih.gov/all/2021/01/06/explore-reporters-state-map-visualizations/) * [Community Health Rankings & Roadmaps](https://www.countyhealthrankings.org/) * CDC [Behavioral Risk Factor Surveillance System](https://www.cdc.gov/brfss/index.html) * [The Surveillance, Epidemiology, and End Results](https://seer.cancer.gov/) * [Census](https://www.census.gov/data) * Use your own National Cancer Database (NCDB) Tools and the Continuous Quality Improvement Program (CQIP) Resource sent to your program each year (access through QPort) |
| Community Resources | * [Findhelp.org](https://www.findhelp.org/) * State sponsored referral programs (e.g. [Community Resource Inventory](https://dc.openreferral.org/)) |
| Other Local Resources |  |

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