Commission on Cancer
American College of Surgeons

Breaking Barriers: Final Wrap up

December 6, 2024

Logistics- We're on Zoom!

- Please mute yourself!
- Don't put us on hold!
- This meeting is being recorded and slides will be available on the project website ~5 days after this call
- Reach out to cancerqi@facs.org with questions, comments, suggestions, or feedback

Agenda for today

- Welcome
- A Lookback at the Breaking Barriers Journey
- Data Review
- Lessons Learned and Accomplishments
  - Patient, Provider, and System
  - From the Program Perspective
- Wrap up
  - Next Steps
  - Claiming Credit Logistics

Introducing our Speakers

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

Kelley Chan, MD, MS
General Surgery Resident, Loyola
Clinical Scholar, ACS Cancer Programs

Shayla Scarlett, MBA, MPA
GW Cancer Center
Assistant Director, Community Outreach, Engagement, and Equity

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

Sharon Gentry, MSN, RN, HON-ONN-CG, AOCN, CBCN
Editor in Chief Journal of Oncology Navigation & Survivorship®
Editor in Chief CONQUER: the journey informed™

Kaitlin Byrd
Augusta Health Systems
Cancer Program Quality and Accreditation Coordinator

Breaking Barriers Team

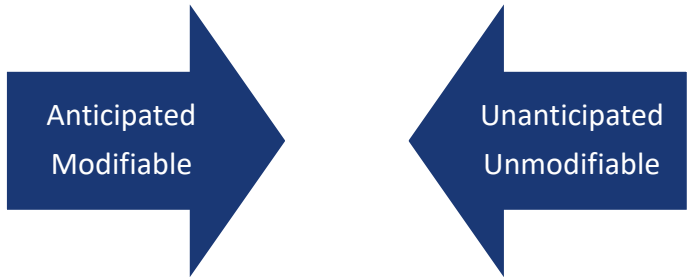
- Kelley Chan, MD, MS (ACS)
- Shea Coates (QI)
- Sharon Gentry, MSN (Navigation)
- Bruce Haffty, MD (Rad Onc)
- Susan Hedlund, LCSW (CoC)
- Lauren Janczewski, MD, MS (ACS)
- Laurie Kirstein, MD (Cancer Programs)
- Shelly Nasso (Survivorship)
- Eileen Reilly, MSW (QI)
- Shayla Scarlett, MBA, MPA (Community)
- Trey Shelton, MD (Rad Onc)
- Rebecca Snyder, MD (DEI)
- Liza Wick, MD (QI/CoC)
- Anthony Yang, MD, MS (QI)
- Kathy Yao, MD (QI/NAPBC)

The Breaking Barriers Journey

Breaking Barriers Goals

Barriers to care exist in cancer treatments for various reasons

- Physical
- Emotional
- Psychological
- Social
- Financial
- Ethnic
- Geographic
- Spiritual
- Cultural



Breaks in (Radiation) Therapy may be detrimental to outcomes

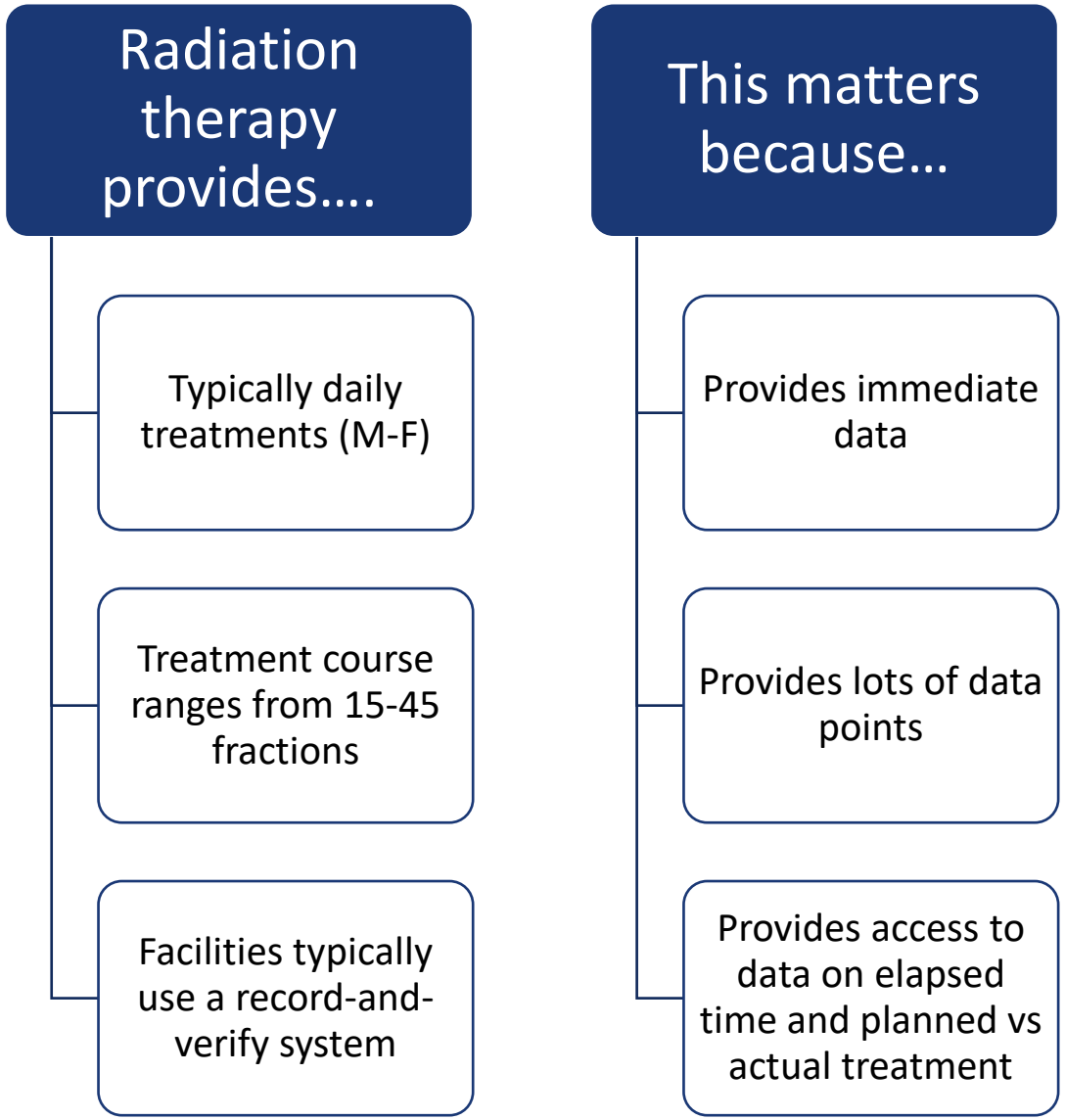
- Systemic, and indicate a need for larger reform
- Unique to a program

Breaks can be measured

Unplanned breaks can become data for programs to help improve outcomes through shared quality initiatives

Radiation Therapy compliance is one surrogate marker for overall barriers to treatment

Breaking Barriers: Why start with Radiation visits?

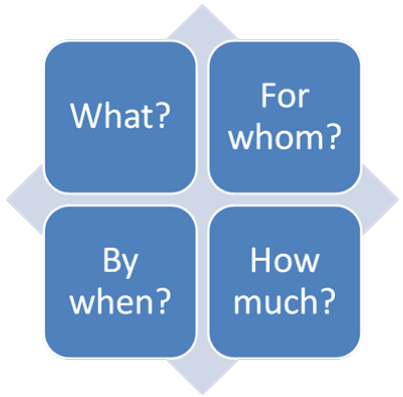


What are we trying to accomplish?

SPECIFIC	Who and what?
MEASURABLE	By how much?
ACHIEVABLE	How?
RELEVANT	Why?
TIME-BOUND	When?

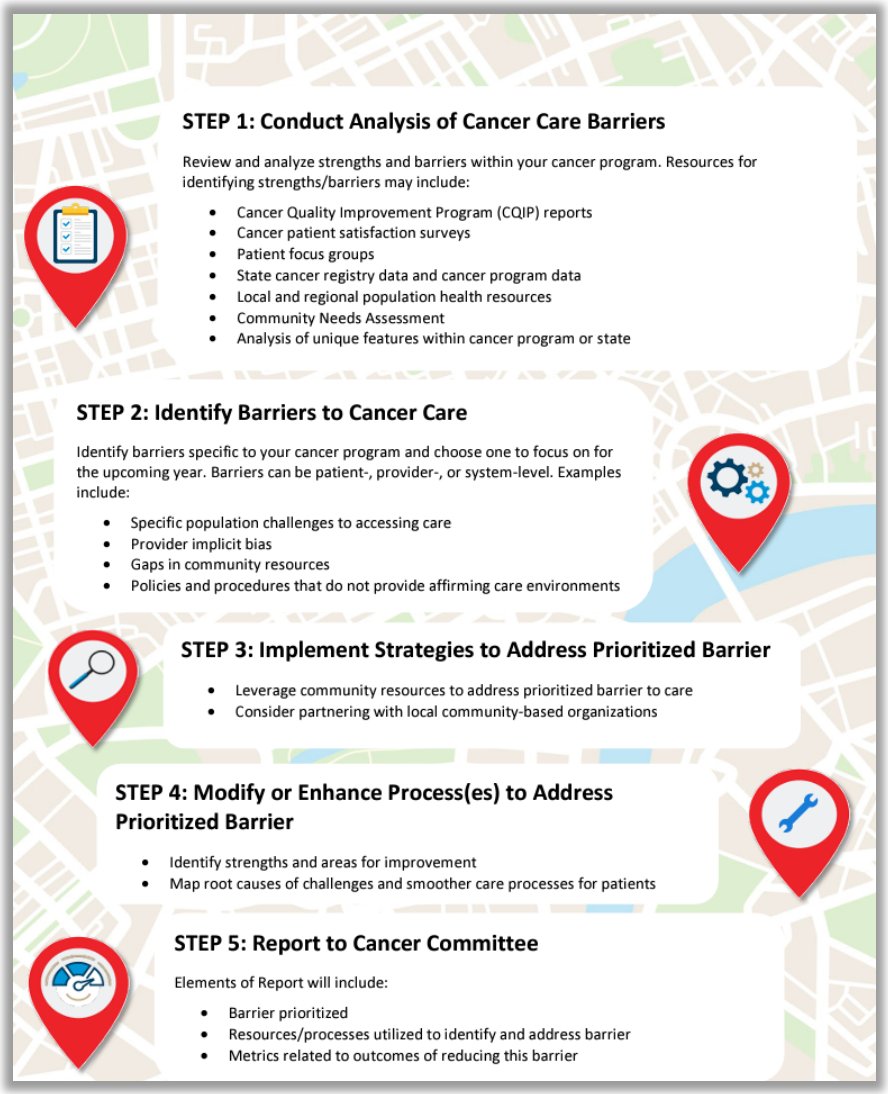
- By the end of the improvement period, reduce the rate of “no-shows” to radiation therapy appointments by at least 20% relative to each participating program’s individual baseline

- Example: No show rate is 10%- by the end of participation, no show rate is reduced to 7.5%



CoC Standard 8.1 Road Map

- Developed to support CCC professionals working with cancer programs to:
  - Meet CoC standards
  - Advance cancer plan objectives



Addressing Barriers at the Community Level

Financial resources to address food insecurity and transportation	Staffing	Affordable housing	Challenge
Institutional/ individual fundraising	Building relationships with Community Social Workers/ Case Managers Align staffing structure to meet clinical workflow needs	Advocacy	Opportunity

Toolkit

Breaking Barriers Quality Improvement Collaborative

7 Min | Print | Share | Bookmark

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 20% from each participating program's individual baseline.
- 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.

Please submit questions to cancerqi@facs.org.

Year 1

Year 2

Breaking Barriers 2024 New and Returning Participants–Application

Participant Info

Full Survey (new participants only)

Data Metrics

Breaking Barriers Year 2 At-a-Glance

Breaking Barriers Toolkit

The American College of Surgeons Cancer Pr... offers this "Breaking Barriers" Toolkit to help you and your colleag... that will increase patient compliance with ca...

The Toolkit is organized by the most prevalen... through baseline data collection results. They... issues, (2) illness unrelated to treatment toxi... treatment, and (3) conflicting appointments. ... potential strategies for success are provided ... tools and materials also are included for direc... modified use in your practice. Before you beg... view the *Breaking Barriers: Breaking Down the ...*

Table of Contents

*Not all interventions may need to be implem... Consult with your local quality improvement ... specific barriers to care experienced in your ...

If you have questions, please email CancerQI...

ACS Cancer Prog...

Barrier #1 Transportation Issues

Intervention:	**Identify Transportation Issues**
Strategies:	**Just Ask:** If a patient unexpectedly or regularly misses radiotherapy (RT) treatments, it is important to follow up with a phone call and ask if transportation to appointments is a barrier to their care. Implement this strategy by clearly designating the responsibility of patient follow-up to a member/group of members of the cancer treatment team (e.g., physician, advanced practice provider, clinic nursing staff, nurse navigator, social worker, medical assistant) and document the reason for missed treatment in the patient's chart. **Patient Education:** For any patient documented as missing treatment, administer a "Modified Distress Tool" to recognize the patient's needs and identify appropriate resources and referrals. A sample "Modified Distress Tool" can be found in Appendix 1 and Appendix 2.
Intervention:	**Leverage Rideshare/Hospital-Based Transportation**
Strategies:	**Local Resources:** Local transportation resources identified on your initial community scan should be leveraged to assist patients in your program struggling with this barrier to care. Examples include applying for gas cards and highlighting transportation via the local public transportation system or available resources already at your hospital or in your community. Implement this strategy by clearly designating the responsibility of identifying transportation resources to a member/group of members of the cancer treatment team (e.g., advanced practice provider, clinic nursing staff, nurse navigator, social worker), applying for local transportation resources, and ensuring patients identified as having transportation issues are referred to these programs. **National Resources:** Several national resources and programs are available to assist patients with transportation: Medical Transportation through Medicaid • *https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-factsheet.pdf* Uber/Lyft Health Programs • *https://www.uberhealth.com/* • *https://www.lyft.com/healthcare* Additional Transportation Resources: • *Cancer and Transportation Resources | CancerCare* • *Transportation and Other Cancer Support Services | Livestrong* • *Help with Transportation for Cancer Patients | OneVillage* • *Implementing A Transportation Hub*

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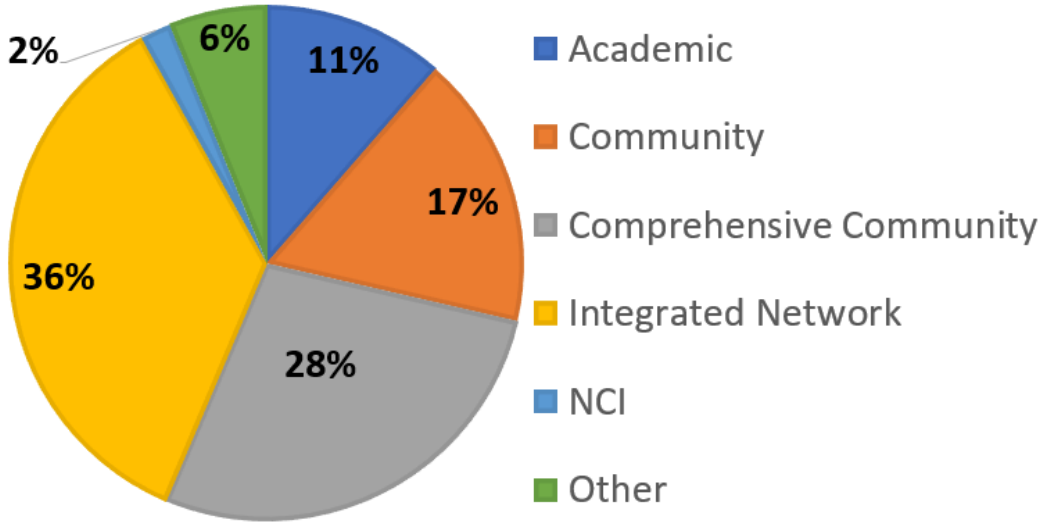
Data: Two Years of Quality Improvement

Year 1

- **360 programs** scheduled **61,419 patients** across eight disease sites
- 3,115 patients (**5.1%**) were non-adherent
- Baseline program-level non-adherence was **11.8%**



Baseline Reasons for Missed Treatments

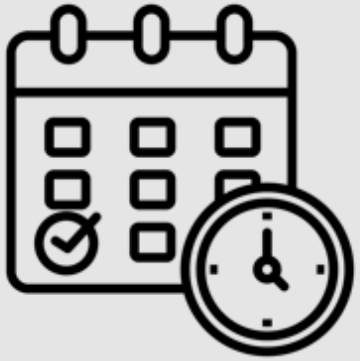
Illness

56.6%

Transportation

31.8%

Conflicting Appointments

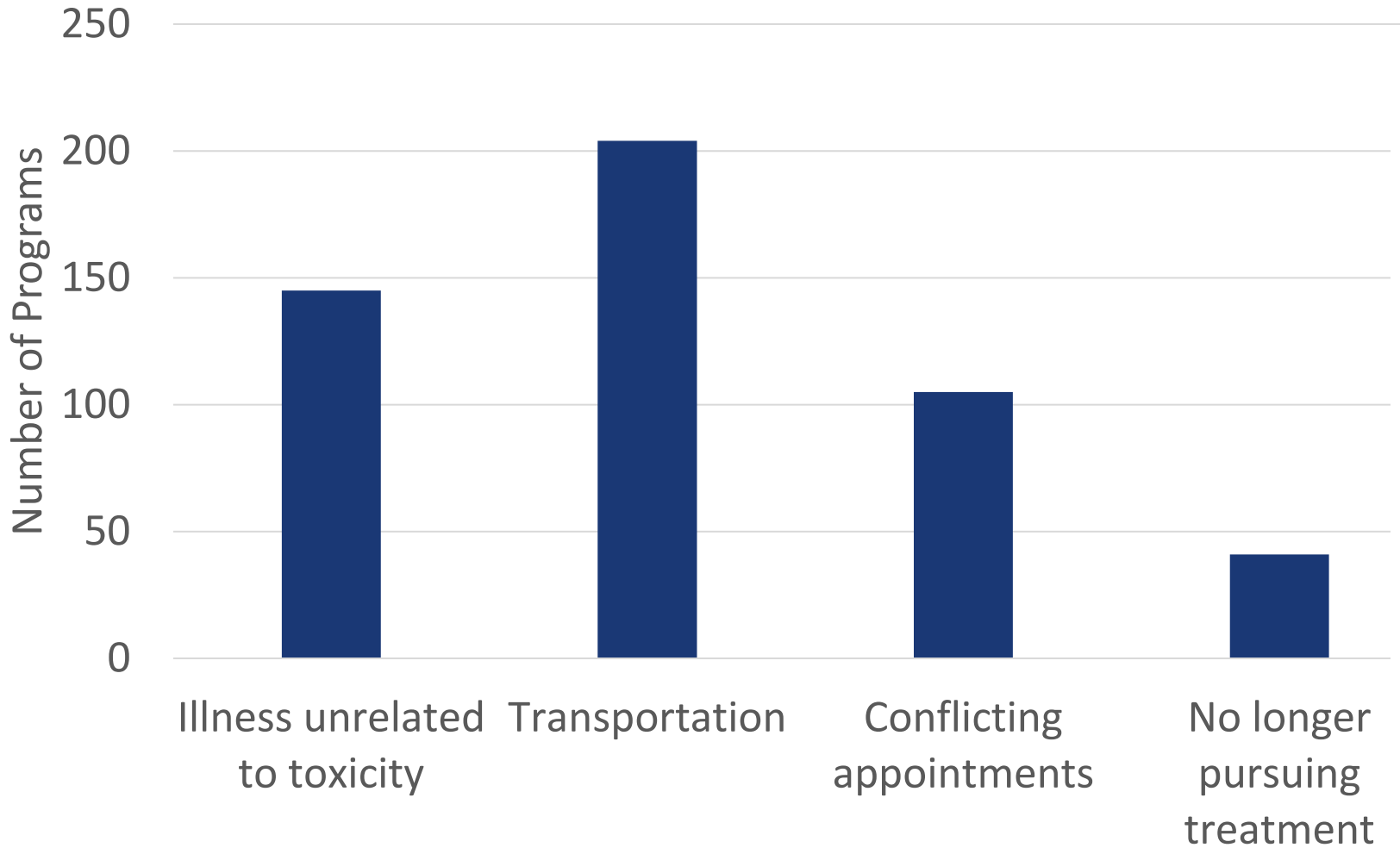


15.2%

No Longer Pursuing Treatment

14.0%

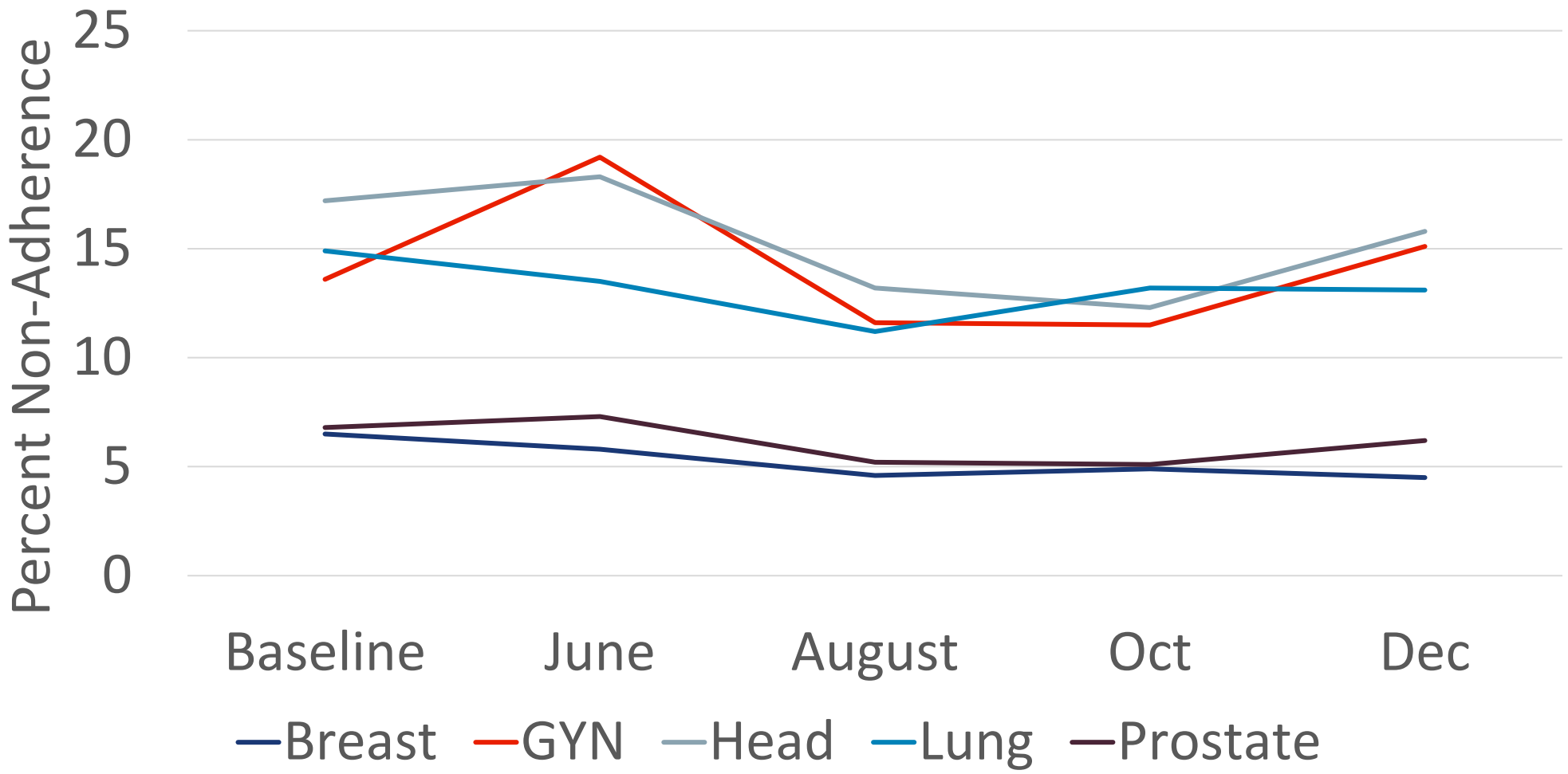
Barriers Programs Chose to Address at End of Year 1



70.6% of programs already have a plan to address these barriers!

61.1% of programs have already identified programmatic and/or community referrals

Non-adherence by Primary Site



Year 2

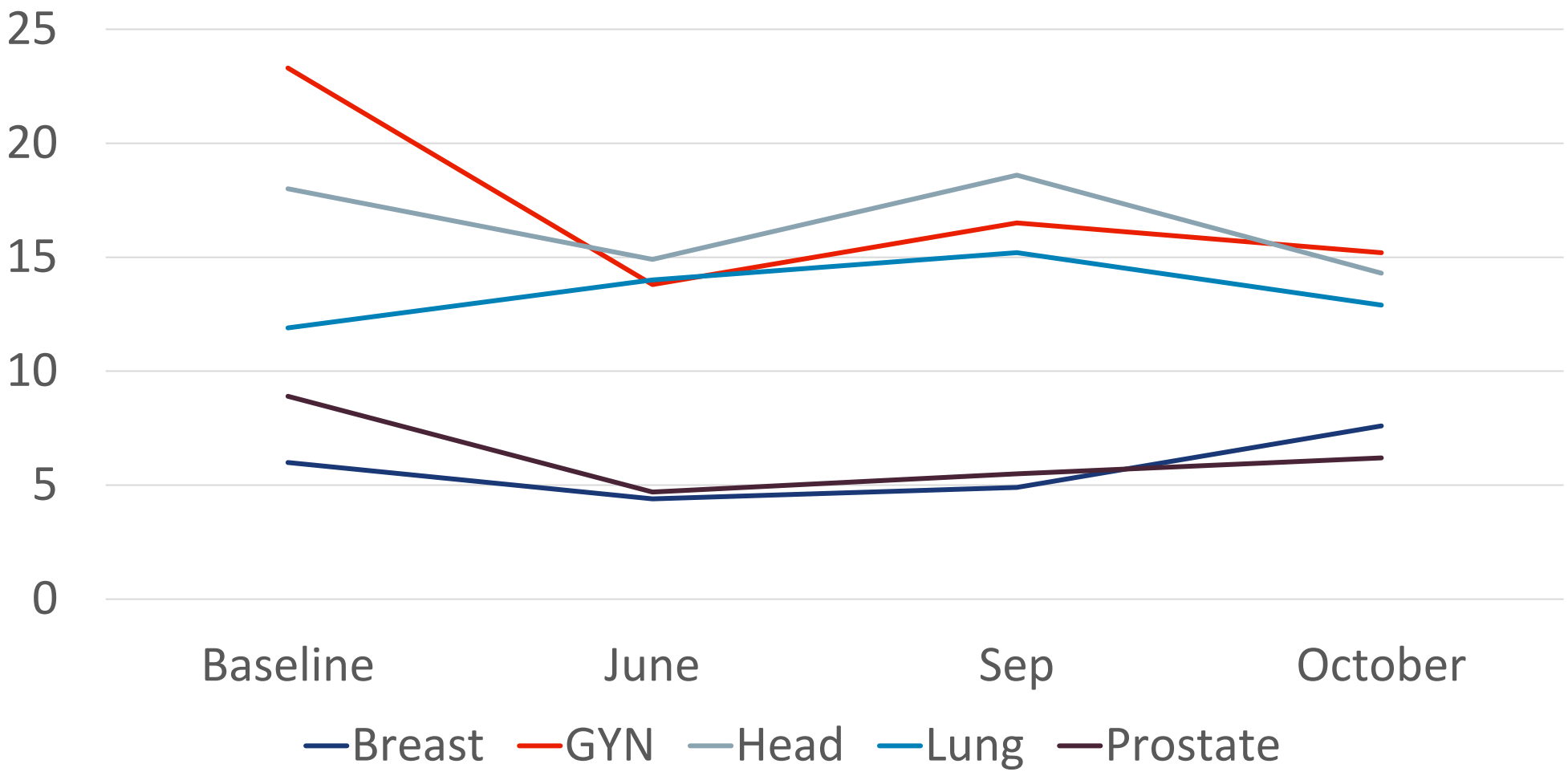
- **218 programs** scheduled **50,188 patients** across eight disease sites
  - **188** programs from Year 1
  - **38** new programs
- 3,307 patients (**6.6%**) were non-adherent
- Baseline program-level non-adherence was **12.5%**
- Final data collection non-adherence **10.9%**

Total Disease Site Submissions

- 622 total submissions across all disease sites
  - 295 had patients with 3 or more missed appointments (47.4%)

Disease Site	Programs reporting on this site, n	Programs with patients missing ≥ 3 appointments (n, %)	
		Baseline 2024	Current Data
Breast	133	96 (55.8)	**70 (52.6)**
Upper GI	37	15 (28.8)	**17 (46.0)**
GYN	45	29 (50.9)	**17 (37.8)**
H&N	98	85 (60.7)	**53 (54.1)**
Prostate	93	65 (54.6)	**44 (47.3)**
Lung	94	71 (57.7)	**47 (50.0)**
Rectum	54	28 (44.4)	**17 (31.5)**
Other	68	44 (60.3)	**30 (44.1)**

Non-adherence by Primary Site



Total Patient Submissions

- 10,950 total patients scheduled
  - 608 patients with 3 or more missed appointments (5.5%)

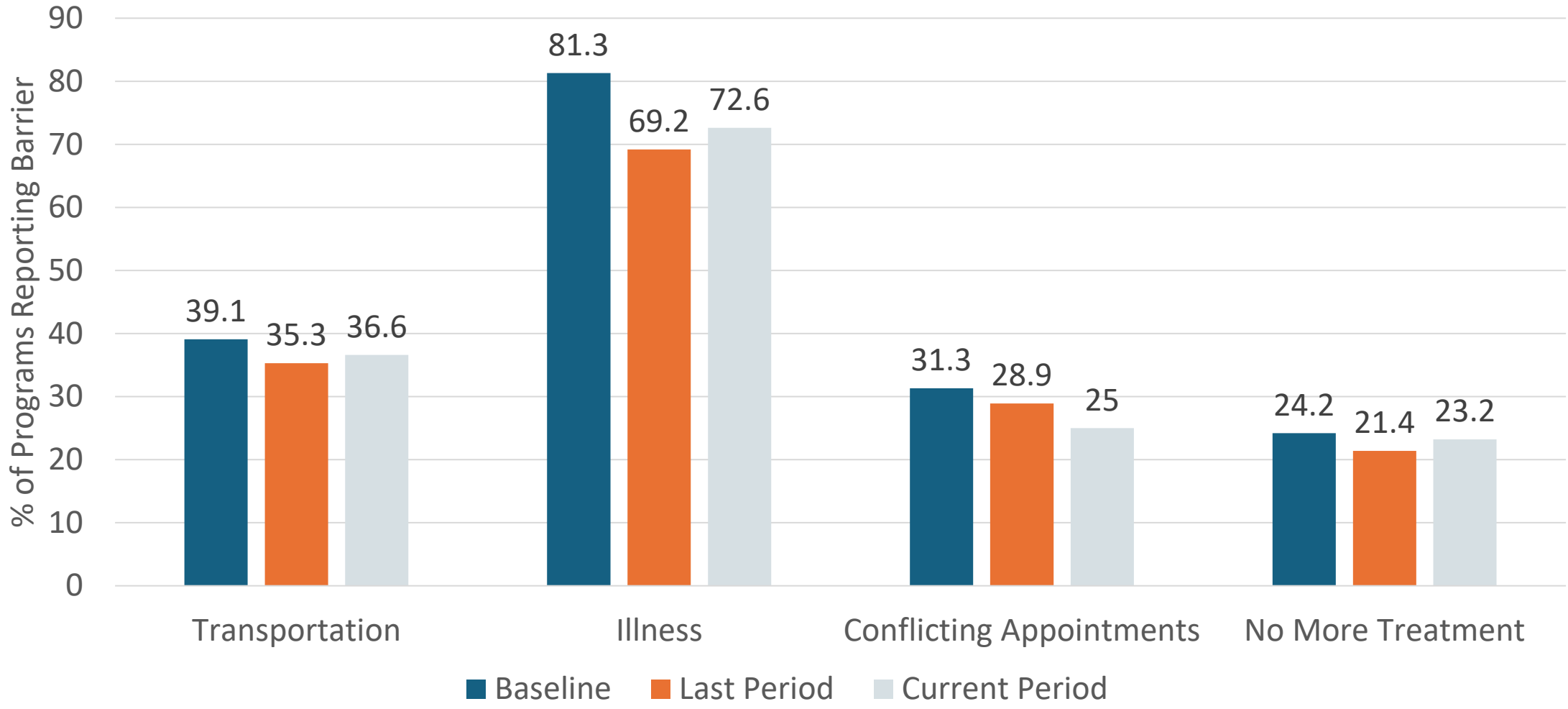
Disease Site	Total patients scheduled, n	Patients missing ≥ 3 appointments (n, %)	
		Baseline 2024	Current Data
Breast	3299	265 (4.8)	↑ 184 (5.6)
Upper GI	445	38 (13.1)	↓ 27 (6.1)
GYN	276	94 (23.4)	↓ 22 (8.0)
H&N	846	266 (14.6)	↓ 94 (11.1)
Prostate	1739	166 (7.5)	↓ 94 (5.4)
Lung	858	135 (9.4)	↓ 80 (9.3)
Rectum	211	52 (17.3)	↓ 25 (11.9)
Other	3296	116 (3.2)	↓ 82 (2.5)

Hospital Level Analysis

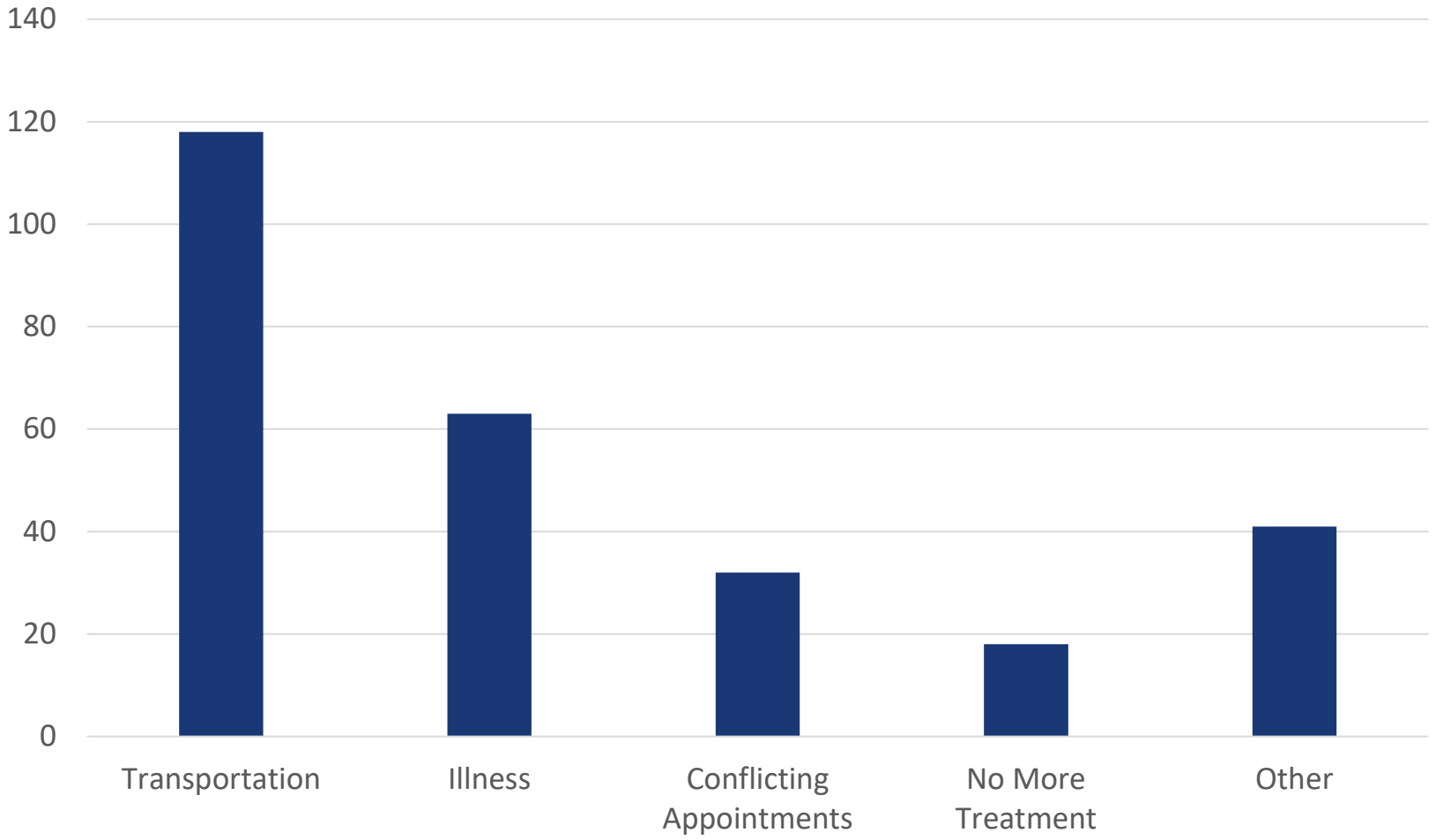
- Median per program 6.1% (IQR 0-15.5%)
  - 144 hospitals with patients with 3 or more missed appointments (70.9%)

Program Type	Number of programs, N=203	Median % per type (IQR)	Mean %	
			Baseline 2024	Current Data
Academic	25	4.8% (0-12.5%)	**15.2%**	**↓ 8.8%**
Community	57	4% (0-25.0%)	**18.3%**	**↓ 14.7%**
Comprehensive Community	38	0% (0-11.8%)	**11.1%**	**↓ 10.5%**
Integrated Network	69	0% (0-12.5%)	**10.0%**	**10.0%**
NCI	4	2.7% (0.1-7.2%)	**4.3%**	**4.4%**
Other	10	16.7% (9.7-28.6%)	**13.4%**	**↑22.5%**

Patient Reasons for Missed Radiotherapy



Which Barriers Have Programs Addressed?



Other:

Financial toxicity

RT side effects

Food insecurity

Prep or PEG related

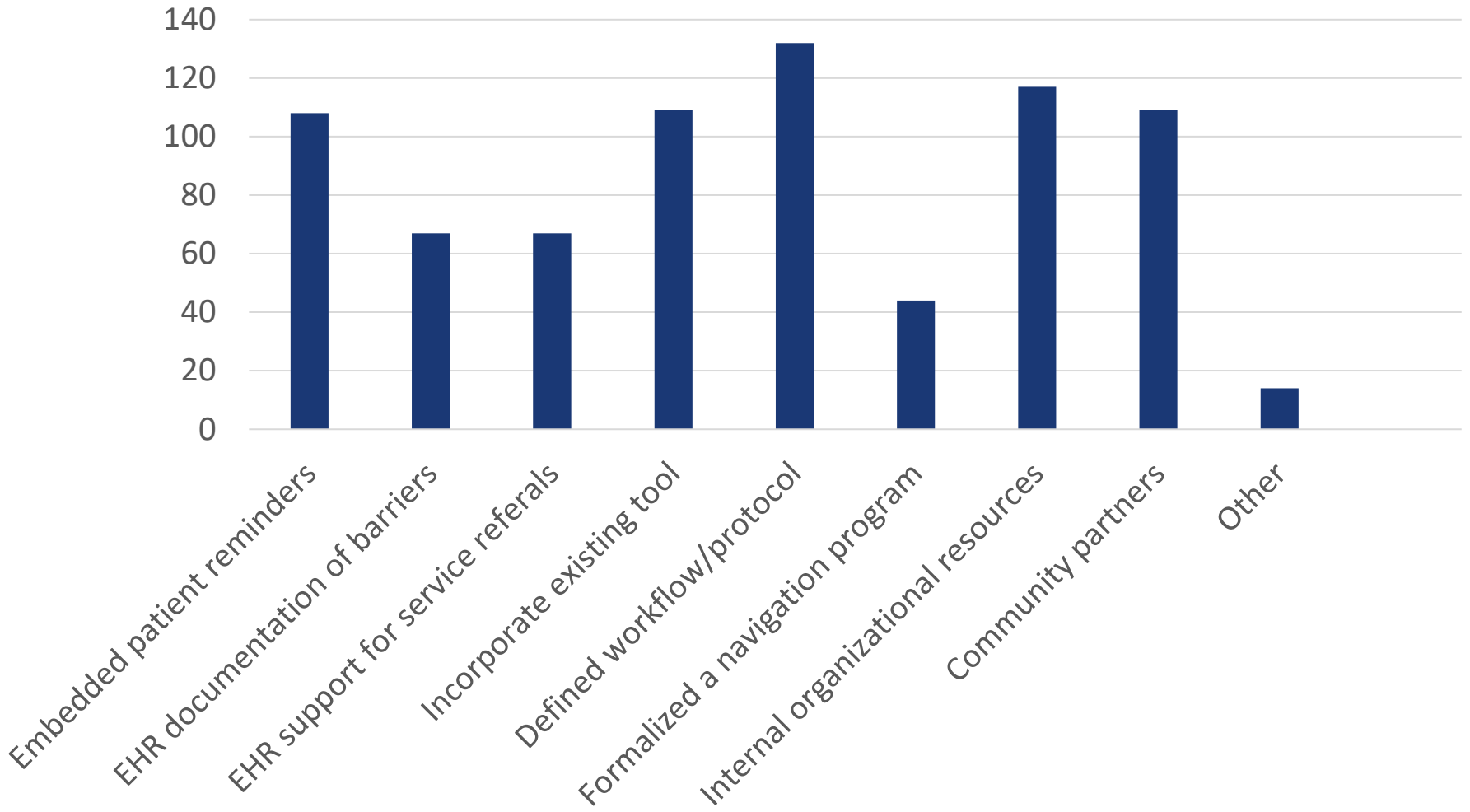
Timely QA

Second contact info

Which strategies has your team been working to implement during this time?

Median strategies per program :

4 (IQR 2-5)



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Lessons Learned: Patient, Provider, and System Barriers

Examples of Patient-Centered Barriers

Logistical

- Transportation issues
- Housing insecurity/transient population

Psychosocial

- Mental health concerns (anxiety, depression)
- Substance use disorders (SUD)
- Social isolation

Economic

- Food insecurity
- Employment
- Lack of insurance or under-insurance
- High co-pays or deductibles
- Prescription medication costs
- Financial and legal issues

Examples of Patient-Centered Barriers

Cultural and Linguistic

- Patient mistrust or negative perception of health care providers

Communication

- Low health literacy
- Lack of knowledge about wellness behaviors
- Lack of knowledge about resources or events
- Unclear provider explanations to patients

Examples of Provider-Centered Barriers

- Perceptions or attitudes, including implicit bias

- Time constraints and demand for health care services

- Administrative barriers

- Provider burnout/ other personal factors

Examples of Health-System Barriers

Cultural and Linguistic

- Lack of culturally or linguistically competent services
- Systems that perpetuate structural racism

Institutional

- Critical care staff shortages (physicians, nurses, technicians)
- Limited appointment availability, office hours

Steps to Address Barriers to Care

Know the community you serve **and** key characteristics about the people you serve

Urban vs rural environment	Food access	Internet access	Literacy/ health literacy rates
Race and ethnic identity	Sexual orientation and gender identity	Age demographic breakdown	Languages spoken by patients
Zip codes where your patients reside	% +/- Federal poverty level	Education level	Employment rates
	Insurance breakdown	Substance abuse use	

Steps to Address Barriers to Care

2

Identify the barriers that could most impact the patients in your cancer center

- Review the examples provided under patient, provider, or health-systems barriers
- Consider gathering patient accounts of why appointments were missed in the past in order to prioritize your focus
- Identify potential solutions to address barriers and assess feasibility to implement

Steps to Address Barriers to Care

3

Develop a resource list to address barriers that is regularly reviewed and updated at least every 6 months

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One Program's Journey

Kaitlin Byrd

Lessons Learned and Key Takeaways

There was a strong perception that transportation is a top barrier. We found that what was really going on was that although most transportation challenges were ultimately resolved, these issues took up the majority of our social workers' time.

Because of this project, our speech pathologist now come onsite for one day a week to see our patients

This project ensured that we were actually using data to address patients that missed 3 or more appointments

When we first started this study, the navigators were sure transportation needed to be #1 barrier, but after the first round of data we found it was patient hospitalizations. This data gave us what we needed to create a solid plan to make some changes.

I think we have found that what we thought wasn't the reason patients cancelled. It seems to be more about balancing all their conflicting appts

Looking at data by disease site helps us focus on specific disease sites and create proactive processes to help these patients in the future

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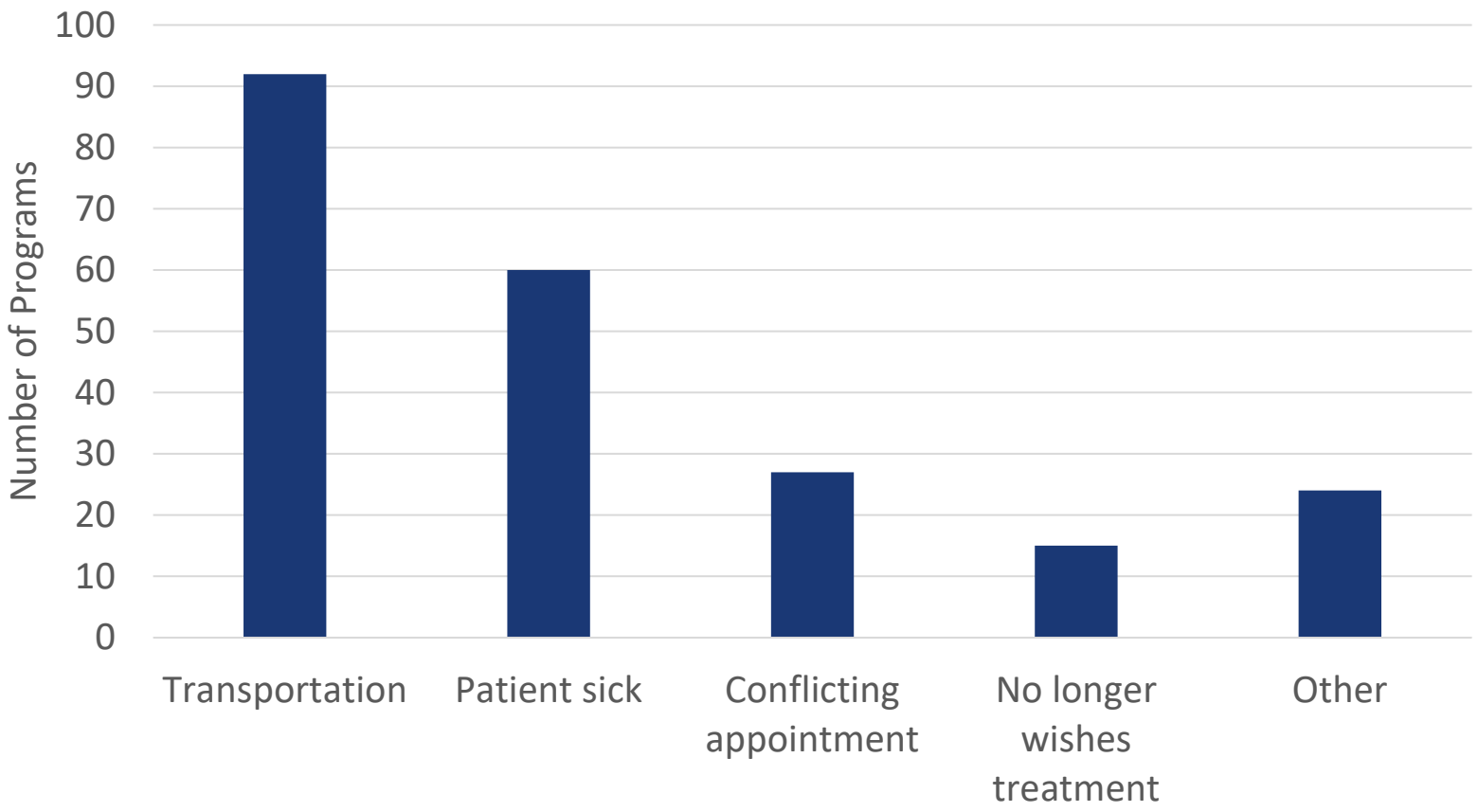
Post Survey Data

Barriers Addressed



Other:

Financial toxicity

Treatment toxicity

Food insecurity

Prep or PEG related

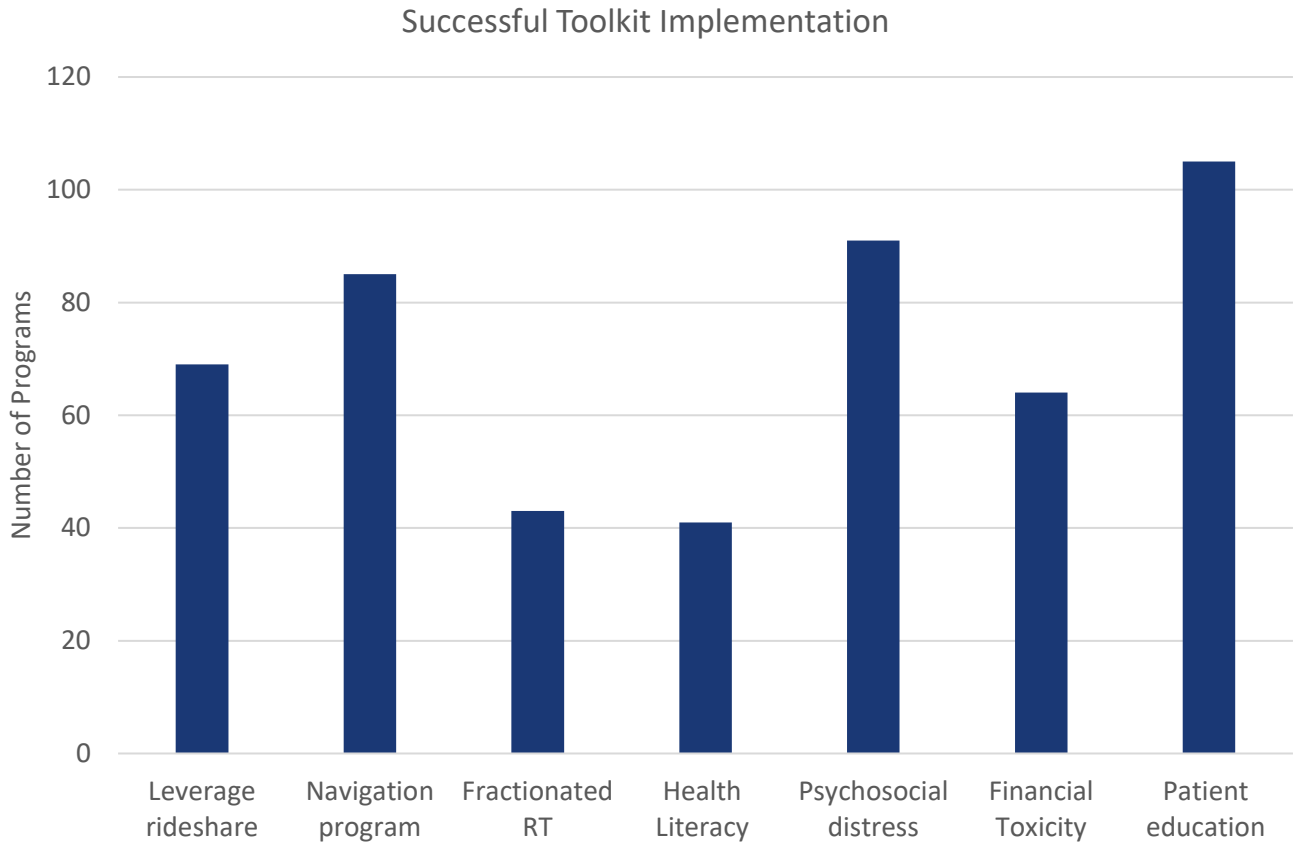
Patient education

Timely QA

Alternate contact info

BB Toolkit Implementation

- 111 (73.0%) implemented an implementation from the BB toolkit



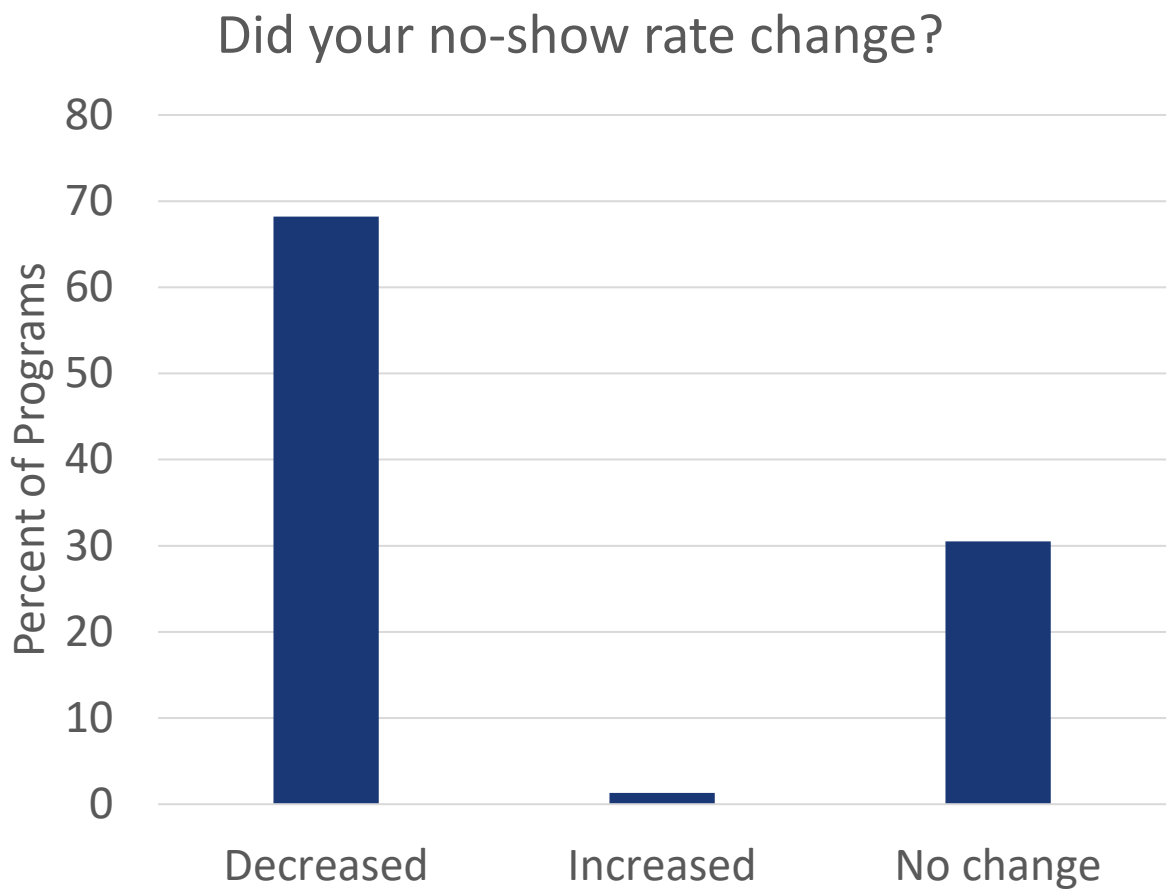
Other Developed Tools:

- Data collection tools
- System protocols (QA)
- Software changes (secondary contact information)
- Collaboration with walk in clinic for PCP establishment
- Extended hours and weekend appointments

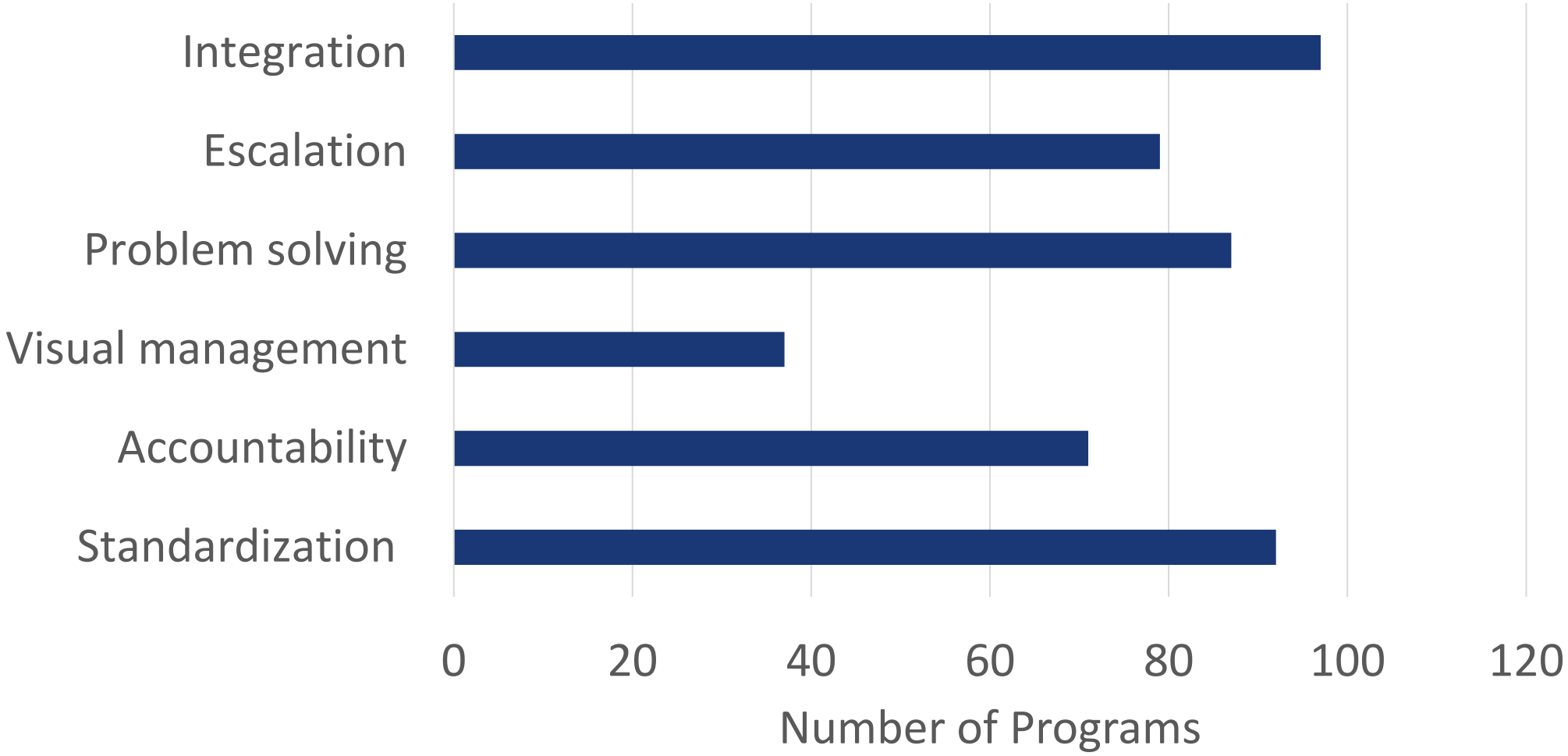
Was your participation in BB successful?

- 97.4% reported success
  - Identification of patient education needs
  - Implementation of transportation systems
  - Proactive discussions with patients to anticipate needs
  - Development of navigation system

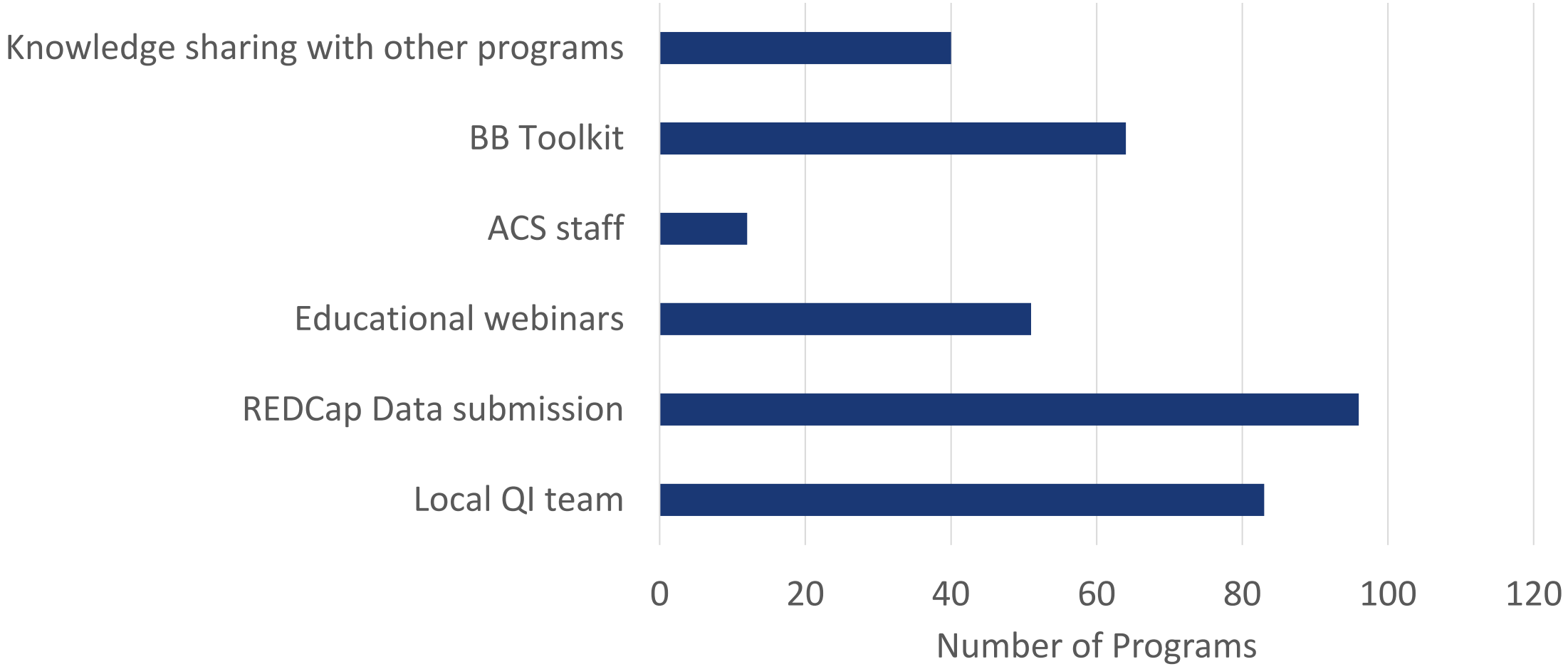
- 2.6% were not successful
  - Started with low rates so no improvements seen
  - No improvement despite tracking and action steps



How will you sustain changes?



What components contributed most to your success?



Future Plans

The Hope is to Spread and Scale

- At the Program level:
  - Share your work at ACS Quality and Safety Conference or Future ACS Cancer Conference
- Nationally, applying for grants
- Publish results
- Expand and enhance the Breaking Barriers toolkit

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Admin Wrap up

Wrap Up

- Attestation surveys will be sent mid January to the primary contact
- Complete the attestation and **save a copy**
  - Upload it to PRQ

Wrap up

- NEW 2025 QI Projects
  - Year 2 Lung NODES for Standard 5.8
  - Genetic Access Pilot (GAP) Project (applications due 12/20/2024)
  - Learn more by subscribing to Cancer Program Newsletters

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