ACCC
Association of Community Cancer Centers

# Appalachian Community Cancer Alliance

## *Updates on Rural Cancer Care*

Friday April 29, 2024

VIRGINIA ASSOCIATION OF HEMATOLOGISTS AND ONCOLOGISTS

SOUTH CAROLINA ONCOLOGY SOCIETY

American Cancer Society®

West Virginia Oncology Society

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TOPS Tennessee Oncology Practice Society

NORTH CAROLINA Oncology Association

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## Mission and Goals

Support community oncology practitioners to improve access to the entire cancer care continuum and reduce cancer health disparities in the rural Appalachian population by:

- Identifying and addressing challenges in providing care
- Evaluating provider perceptions regarding equity in access to care
- Implementing patient-centric approaches to increase guideline-concordant cancer screening
- Developing interventions for promoting guideline-concordant treatment
- Implementing patient-centered communication strategies to overcome informational barriers
- Discussing relevant cancer clinical trial opportunities within the treatment plan
- Increasing the quality of life and survivorship of cancer patients

**Priority focus areas:** Improving screening for colorectal, cervical, and lung cancers

# Appalachian Community Cancer Alliance

*Who?*

Network of individuals and organizations committed to the vision and mission of the Alliance. Multidisciplinary cancer program staff, cancer survivors, patient advocacy groups, primary care, other specialties, government stakeholders, research or professional organizations are welcome to participate

*What?*

Ongoing network/platform for learning, discussion, sharing of promising practices and tools/resources, performing targeted projects related to Alliance goals, partnership building

*How?*

Staying informed and engaged through the Alliance listserv, website, educational offerings, and regular meetings

# Appalachian Community Cancer Alliance

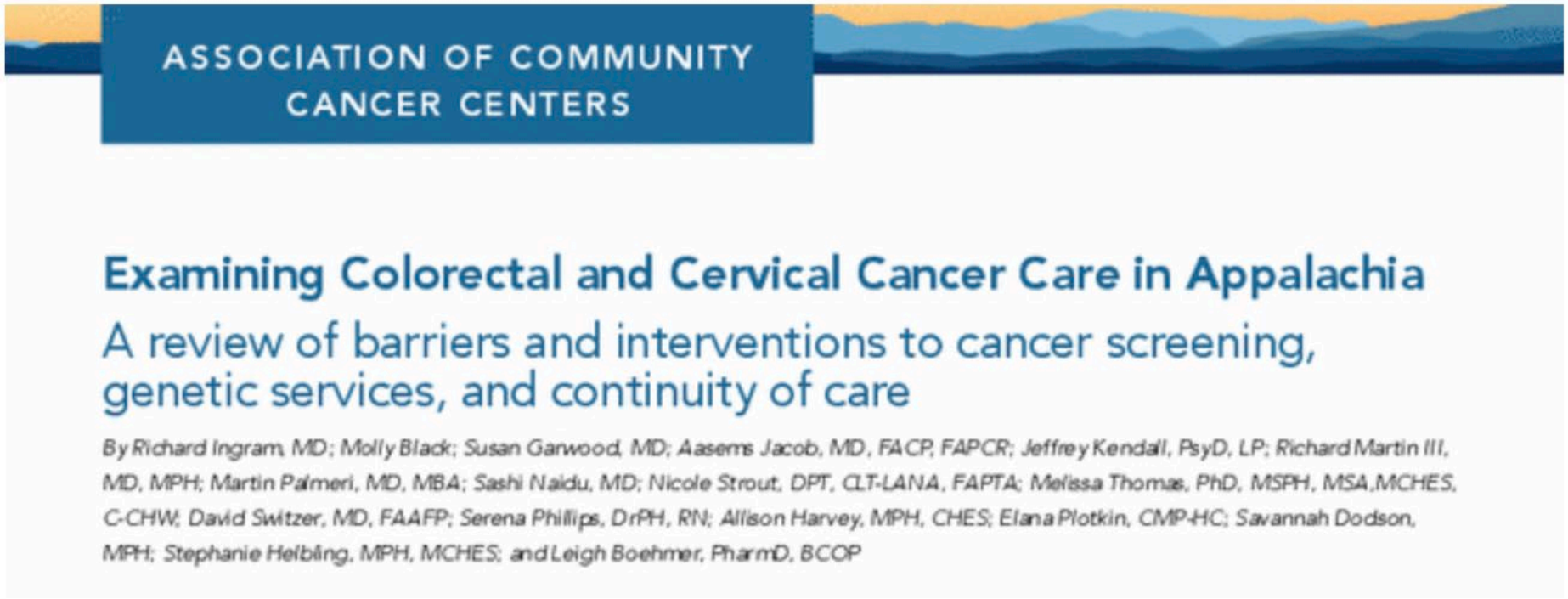
## *Current Activities*

- Rural Appalachian Lung Cancer Screening Initiative – *White House Announcement*
- Landscape analysis
  - Priority Areas: Colorectal and cervical cancer screening
- Barriers and Facilitators to cancer screening

# State of Cancer Care in Appalachia

- Literature review and focus groups to establish current state of cancer care delivery in Appalachia and identify effective practices
  - Preliminary overview to serve as a starting point for activities moving forward
- Findings would contribute to an assessment of Barriers and Facilitators

# LANDSCAPE ANALYSIS HIGHLIGHTS




Ingram, R., Black, M., Garwood, S., Jacob, A., Kendall, J., Martin III, R., Palmeri, M., Naidu, S., Stout, N., & Thomas, M. (2023). Examining Colorectal and Cervical Cancer Care in Appalachia: A Review of Barriers and Interventions to Cancer Screening, Genetic Services, and Continuity of Care. *Oncology Issues*, *38*(3), 50-55. https://journals.healio.com/doi/abs/10.3928/25731777-20230515-09

# Snapshot: Current State of Screening Barriers

| Common | Lung | Colorectal | Cervical |
|---|---|---|---|
| • **Psychological barriers**<br>  • Attitudes, fear, fatalism, lack of perceived risk<br>  • Lack of knowledge<br>• **Language and literacy**<br>• **Costs** (lack of insurance, direct & indirect)<br>• **Logistical barriers** (transportation/ distance, time, childcare)<br>• **Lack of provider recommendation**<br>• **Lack of patient-centered communication**<br>• **Lack of clinic EHR and staff capacity** (accurate history, tracking & reminder capabilities, workflows)<br>• **Lack of geographic access**<br>• **Ensuring follow-up after abnormal result, and ongoing adherence/ management**<br>• **Continuity of care**<br>  • PCP vs. specialist role expectations, communication<br>  • External referrals, challenging closed-loop communication | • **Challenges identifying eligible patients** (incidental suspicious nodules, poor documentation of smoking history)<br>• **Cumbersome CMS shared decision-making documentation requirements**<br>• **Concerns about false-positives**<br>• **Inconsistent eligibility requirements/ guidelines**<br>• **Complexity of management** | **Lack of knowledge about stool-based testing options** (e.g., FIT, FOBT)<br>• PCP recommendation of colonoscopy over stool-based test<br>• Doubt about quality<br>• Incorrect completion<br><br>**Colonoscopy-specific:**<br>• Perceived discomfort of prep/procedure<br>• Embarrassment, sense of violation<br>• Privacy/confidentiality concerns in rural areas | • **Preference for female provider**<br>• **Competing priorities**, caregiving, lack of childcare<br>• **Lack of patient-centered communication**: demeaning or discriminatory attitudes towards women (language, culture, low SES)<br>• **Lack of accommodation for women's logistical needs**, around clinic hours and location<br>• **HPV self-sampling-specific**: forgetting, fear, lack of time, worry about using test incorrectly |

# Snapshot: Current State of Screening Barriers

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# Snapshot: Cross-cutting Interventions

## Community outreach and patient education

- Raise awareness, decrease stigma, educate about ongoing adherence
- Health fairs
- Print and media campaigns
- Web presence, self-referral forms
- Cultural tailoring to high-risk populations

## Remote test options

- HPV self-sampling
- Stool-based tests

## Patient navigation

- Identification of eligible individuals
- Addressing barriers such as screening costs
- Scheduling, reminding, tracking, follow up
- Facilitating communication across patient, providers, multiple organizations
- Educating patients and managing anxiety to encourage follow-up after abnormal screen

## Material supports

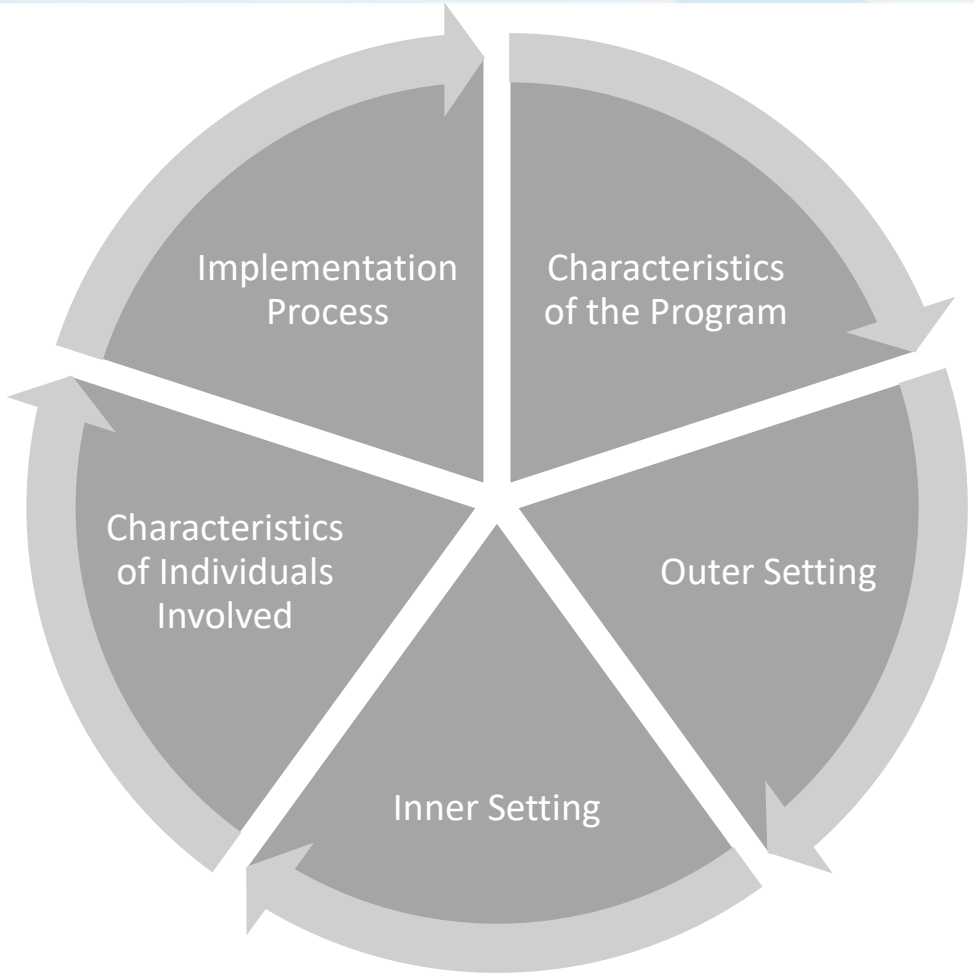
- Transportation
- Charity assistance
- Financial incentives (e.g. gift cards)

## Health care system partnerships

- Technical assistance
- Systems/ infrastructure improvements
- Cross-referrals, expanded outreach
- Information sharing, coordination of activities
- Formalization of workflows and shared care processes

## Policy interventions

- Medicaid expansion
- Expand coverage of lung screening; align screening and coverage eligibility
- Remove some CMS prerequisites for lung screening
- Advocacy for state budget allocation for services (screening, diagnostic, treatment costs)




Consolidated Framework for Implementation Research (CFIR)

- Use evaluative and iterative strategies
- Provide interactive assistance
- Adapt and tailor to context
- Develop stakeholder interrelationships
- Train and educate stakeholders
- Support clinicians
- Engage consumers
- Utilize financial strategies
- Change infrastructure

Expert Recommendations for Implementing Change (ERIC)

# CFIR -> ERIC Methods and Analysis

- CFIR domains informed an inductive thematic coding of landscape analysis data conducted by a team of qualitative experts.
- 29 barriers and 31 facilitators were defined and characterized across the 5 domains of the CFIR.
- Determinants were analyzed using the on-line RIZOME matching tool
- The highest ranked strategies to support implementation were in the ERIC domains of
  - *Train and Educate Stakeholders,*
  - *Change Infrastructure,*
  - *Use Financial Strategies*
- Implementation mapping identified strategies at the individual provider, clinical, health system, and community levels.

# Findings: CRC Intervention

| Colorectal cancer screening | | |
|---|---|---|
| **Barriers** | Cost | Associated costs of screening interventions may not be covered by insurers, or there are significant out-of-pocket costs. |
| | Design | FOBT restricts food, medications, vitamins before taking a sample.<br>FOBT requires multiple samples be taken.<br>Colonoscopy preparation is uncomfortable and there is a negative stigma about the test. |
| | Complexity | Colonoscopy has multiple steps for scheduling/care coordination.<br>At-home tests require attention to multiple steps in process to obtain, package, and mail sample. |
| **Facilitators** | Relative Advantage | Perception of ease of use of FIT or FOBT testing compared to colonoscopy. |

# Findings: CRC Inner Setting

| Within the medical clinic | | |
|---|---|---|
| **Barriers** | Relational connections: communication | Contradictory messages from providers.<br>Lack of physician recommendation for any cancer screening test.<br>Physician diminishes evidence for tests other than colonoscopy. |
| | Relational connections: culture | Not offering shared decision making when reviewing test options.<br>Only offering a single mode for testing. |
| | Structural characteristics: Information technology infrastructure | EHR systems are not able to share information.<br>No ability to make EHR changes on site to adapt system for new processes, requesting changes is a burden especially when there is repeated need for adaptation.<br>Internet connectivity is poor, computer systems are sometimes unavailable challenging staff to use scheduled time for calls or chart reviews. |
| | Structural characteristics: work infrastructure | No dedicated staff to support a navigation role.<br>Workflows are not set up for staff to conduct EHR reviews and make calls to patients, calls for patient reminders are time intensive. |

# Findings: CRC Inner Setting

| Within the medical clinic | | |
|---|---|---|
| **Facilitators** | Access to knowledge and information | Clinical academic detailing, clinician reminders. |
| | Structural characteristics: Information technology | Decision support alerts.<br>Automated reminders.<br>Develop tracking systems for referrals.<br>Customize templates and other documentation processes. |
| | Structural characteristics: Work Infrastructure | Having staff, such as navigators, make reminder up calls and follow up with test results.<br>Have staff that conduct targeted outreach to individuals who are due for screening.<br>Employ team-based care models. |
| | Relational connections: communication | Posters in clinic to prompt conversations<br>Reminder cards given at clinic visits.<br>Create incentive programs for patients completing screening. |
| | Incentive systems | Create provider report cards on screening performance. |

# Findings: CRC Outer Setting

| Environment outside of the medical clinic | | |
|---|---|---|
| **Barriers** | Economic conditions | Out of pocket costs and insurance status<br>Competing financial priorities. |
| | Local conditions | Transportation is not available.<br>Distance to care and follow up is significant.<br>Travel time and costs are high.<br>Lack of infrastructure for internet connectivity.<br>Limited access to screening services. |
| | Societal pressure | Misinformation from social networks.<br>Social norms are resistant to or stigmatize screening. |

# Findings: CRC Outer Setting

| Environment outside of the medical clinic | | |
|---|---|---|
| **Facilitators** | Partnerships and connections | Collaborators in communities to promote screening; community centers, employer-sponsored health events.<br>Developing shared resources for partner organizations; technical assistance, expert consultations. |
| | Societal pressure | Social media outreach.<br>Culturally sensitive outreach strategies and materials. |
| | Local conditions | Incentivizing community resources by paying for transportation.<br>Incentivizing completion of screening. |
| | Financing | Accessing charity or foundation funds to pay for screening. |
| | Policy and law | Medicaid expansion.<br>Preventive care models from payers.<br>Employer policies; paid time off.<br>Reporting requirements to external funders/ regulatory bodies. |

# Findings: CRC Individual Characteristics

| Roles and characteristics of the individuals involved in implementation | | |
|---|---|---|
| **Barriers** | Other implementation support | Navigators or community health workers who support the screening process often work across various parts of the care continuum and in different settings leading to fragmented follow up. |
| | Capability | Knowledge and awareness of current evidence may be low among providers who make recommendations and staff who support the screening process.<br>Effective provider-patient communication dynamics may be challenged (e.g., not listening to patient preferences, insensitive communication, complex language in communication, directive language, not considering patient-level preparedness for change). |
| | Motivation | Team members with low awareness or lack of acceptance of current options for CRC screening may not be motivated to implement processes.<br>Physicians with preference for one type of test may be disinclined to offer other options for screening. |
| | Innovation deliverers | Staff and provider turnover has been high, post-pandemic, leading to burdensome and repeated training and sometimes a lack of champions for screening. |

# Findings: CRC Individual Characteristics

| Roles and characteristics of the individuals involved in implementation | | |
|---|---|---|
| **Facilitators** | Implementation team members | Team-based approach with clinic champions creates positive environment and serves a role in improving provider engagement as well as patient engagement<br>.<br>Diversity in team members is important to bring a variety of perspectives to support the process for screening, but they also serve as champions to message back to various clinical teams and staff the importance of the process. |
| | Implementation facilitators | Having external support to review processes and troubleshoot without bias to the clinic culture. |
| | Opportunity | Giving clinic staff the responsibility for screening outreach and follow up tasks, enabling them with the time and resources to fulfill tasks.<br><br>Giving providers simplified tools to reduce the burden of time/clicks through the EHR to complete tasks. |
| | Opinion leaders | When leaders (providers/administrators) are bought in and on board it helps to facilitate buy in among other providers and staff. |

# Findings: CRC Implementation Process

| | | |
|---|---|---|
| **Barriers** | Engaging: Innovation deliverers | Lack of clinician time per patient, competing priorities.<br>Processes rolled out in EHR, but providers are not trained/aware of what to do. |
| | Tailoring strategies | Lack of EHR capabilities and lack of resources to build new capabilities. |
| | Reflecting and evaluating: Implementation | Lack of process improvement review and action. |
| **Facilitators** | Assessing needs | Determining baseline screening rates and patients due for screening, understand how to track, how to alert to needs, and project volume. |
| | Assessing context | Assess clinic-level and provider-level readiness to change, motivation, culture. |
| | Tailoring strategies | Tailoring EHR systems to support process.<br>Shift tasks across staff. |
| | Planning | Develop screening processes/protocols with team input.<br>Planned review of programs and metrics |
| | Teaming | Include individuals with various staff roles in the planning process including schedulers, office staff, nurses etc. |
| | Reflecting and evaluating: implementation | Tracking time and resources for EHR adaptations, staff burden, documentation |
| | Engaging: innovation recipients | Understand patient perspective on benefit or burden of calls/reminders, receptivity to incentives offered, and other processes put in place. |

# Findings: Cervical Cancer Intervention

| Cervical cancer screening | | |
|---|---|---|
| **Barriers** | Design | The nature of an internal examination may be stigmatizing to some women |
| | Cost | Indirect costs to obtain screening including time off work, childcare, and transportation. |
| **Facilitators** | Relative Advantage | Methods for home self-sampling for HPV have been well received |
| | Adaptability | Enabling self-HPV home testing for those who cannot access clinical services can enable identification of high-risk individuals to prompt discussions and interventions for screening. |

# Findings: Cervical Cancer Inner Setting

| Medical clinic | | |
|---|---|---|
| **Barriers** | Structural characteristics: Work infrastructure | Clinic hours are inflexible/inconvenient, providers have limited availability.<br>No processes are in place to identify women who are due for screening.<br>Lack of OB/GYN specialists able to provide follow-up care.<br>Clinics lack the ability to provide services for abnormal screening findings |
| | Relational connections: Communication | Providers may not discuss risk and benefit of screening in language that patients understand. |
| **Facilitators** | Structural characteristics: Work infrastructure | Staffing with nurse navigators to counsel on screening and risks, and to coordinate care.<br>Using reminder cards, phone calls. |
| | Funding | Paying for indirect costs such as transportation, providing incentive payments |
| | Structural characteristics: Information technology infrastructure | Developing tools for clinic-based tracking, generating lists for care coordinators, setting reminder alerts.<br>Creating standing order sets for testing.<br>Developing decision support tools for providers. |

# Findings: Cervical Cancer Outer Setting

| Environment outside of the medical clinic | | |
|---|---|---|
| **Barriers** | Local conditions | High provider turnover rate, long wait times to see specialist in rural areas.<br>FQHCs in rural areas are disconnected from healthcare systems |
| | Partnerships and connections | Community resources and services may not be available to provide care locally when there are abnormal findings. |
| **Facilitators** | Partnerships and connections | Obtaining relationships with existing community-based clinics to introduce screening on-site (e.g., flu shot clinics, community centers)<br>Outreach to groups that may not have health insurance benefits to promote free screening opportunities.<br>Develop relationships departments of health, academic centers, faith-based organizations, and local community influencers. |
| | External pressure: Societal pressure | Increase awareness of free cervical screening programs.<br>Developing women's health events and providing screening on-site<br>Mailing fliers to alert women to free screening clinics and upcoming events. |
| | Policies and Law | Encourage employer wellness initiatives to address screening.<br>Use patient registries to identify individuals due for screening.<br>Offer paid time off for screening as an employer benefit. |

# Findings: Cervical Cancer Individual Characteristics

| Roles and characteristics of the individuals involved in implementation | | |
|---|---|---|
| **Barriers** | Engaging: Deliverer of the innovation | Providers do not initiate conversations about cervical cancer screening.<br>Lack of patient-centered approach, use of demeaning language, discriminatory attitudes about women, not listening/addressing concerns. |
| | Capability | Providers may not be aware of current guidelines, considering changes in recent years. |
| **Facilitators** | Capability | Assure providers have adequate information about current guidelines, and knowledge of procedures in the clinic to address screening. |
| | Opportunity | Enable providers to have schedule availability to provide screening, follow up, and necessary education for patient encounters. |
| | Engaging: Deliverer of the innovation | Convey importance of the screening and follow up.<br>Communicate so as to mitigate uncertainty, answer questions, offer clear information.<br>Engage patients using patient-centered communication strategies; project caring about wellbeing of the woman and her family, conveying respect by seeking consent to screen rather than assuming implicit consent.<br>Be sensitive to the woman's personal circumstances and practical barriers. |

# Findings: Cervical Cancer Implementation Process

| Process to implement cervical screening | | |
|---|---|---|
| **Barriers** | Teaming | Abnormal findings require management from a specialist and these services are frequently not available locally, primary care clinic may not have relationships established to streamline follow up care, adding burden to providers, staff, and patients. |
| **Facilitators** | Tailoring strategies | Bundling services to provide multiple screenings in one single visit.<br>Automating referral processes for navigation services for all patients in a health clinic allowing for outreach from the navigator rather than waiting for a provider visit. |
| | Assessing context | Understand the clinic-level resources and relationships, identify gaps in resources and staffing. |
| | Planning | Actively plan and iterate on improving screening procedures and follow up processes.<br>Seek to engage community partners and health system partners when resource gaps exist. |

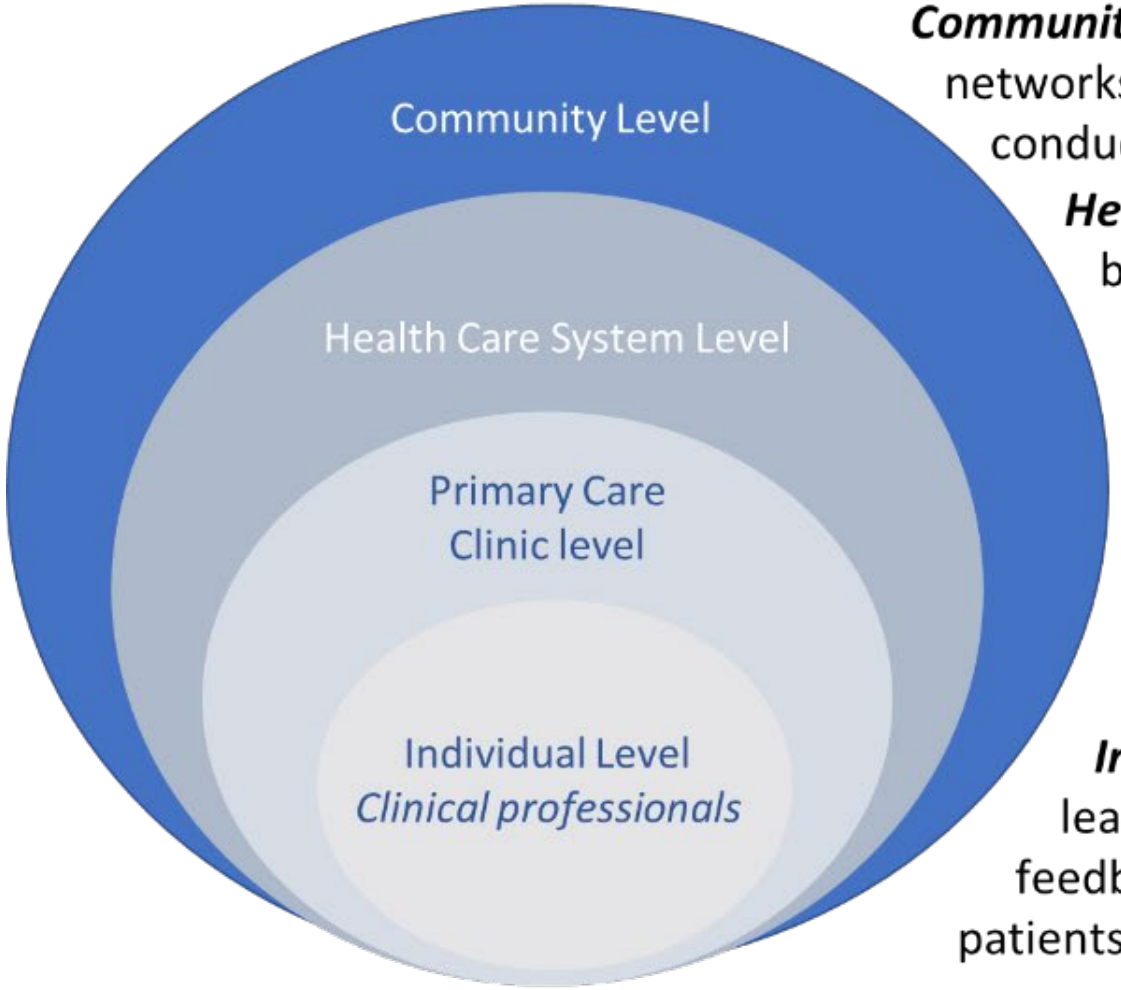
# Findings: ERIC Strategies Prioritized

| Strategy by ERIC Cluster | Priority Ranking |
|---|---|
| **Train and Educate Stakeholders** | |
| Conduct educational meetings for all stakeholders | 79% |
| Distribute educational materials to providers and staff | 59% |
| Improve access to knowledge and information | 55% |
| Develop tools to enhance provider uptake and adherence to the program | 50% |
| **Change infrastructure** | |
| Create infrastructure, including developing IT resources, and improving staff workflows | 78% |
| Consider new staffing models, including shifting roles and tasks across existing staff for efficiencies | 69% |
| **Use financial strategies** | |
| Identify additional funding to support infrastructure changes | 78% |
| **Use evaluative and iterative strategies** | |
| Develop a formal implementation blueprint to facilitate in-clinic processes | 73% |
| Conduct local needs assessment to understand community readiness, available resources, and resource gaps in implementing screening procedures | 50% |

# Findings: ERIC Strategies Prioritized

| Strategy by ERIC Cluster | Priority Ranking |
|---|---|
| **Provide interactive assistance** | |
| Review fidelity of processes and hold staff accountable when deviations from the pathway occur | 73% |
| Use facilitation teams to review measures of performance and provide feedback to improve processes | 52% |
| **Develop stakeholder interrelationships** | |
| Build coalitions across the outer setting (e.g. communities and health systems) to problem solve and champion screening | 62% |
| Create network weaving across health systems and community partners to improve follow up after screening procedures | 57% |
| Create a culture of clinic champions that support and drive the approach to screening and follow up | 52% |
| Develop academic partnerships as part of a coalition | 50% |
| **Engage consumers** | |
| Include patients/consumers and family members in assessing preferences for screening procedures | 59% |
| Actively engage patients/consumers to be active participants in the screening process | 58% |
| Improve public awareness of the screening pathways | 50% |

# Findings: Multilevel Implementation Mapping




***Community level*** Improve public awareness, build coalitions and networks with community partners, include academic partners, conduct needs assessment.

***Health system level*** Identify administrative champions, build networks with specialty providers, report on performance improvements, create IT infrastructure, find funding support.

***Clinic level*** Train and educate staff and providers, adapt clinic workflow and shift staff roles, establish IT infrastructure, promote fidelity through continuous evaluation, find funding support, conduct context assessment, use facilitation teams.

***Individual level*** Educate providers, develop champions to lead the program, create a supportive environment for feedback and change, adhere to the program, actively engage patients as participants in the screening process.

# Key Takeaways

- Providers want an improved system
- Desire for dissemination of evidence-based practices and practical tips on "how to" implement/weigh evidence
- Multilevel approaches are needed to improve system change

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# Questions?

Appalachian
Community Cancer Alliance:
*Improving Cancer Care in Rural Appalachia*

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Association of Community Cancer Centers

accc-cancer.org/ACCA