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Care Coordination and Community Partnerships for Cancer Care in Critical Access Hospitals

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KEY FINDINGS

- In a survey of 135 Critical Access Hospitals (CAHs), over 90% (122 CAHs) reported that they provide some sort of care coordination services for cancer care in their hospital.
- The most common type of care coordination was related to the exchange of patient information (74.8%), followed by physical therapy and rehab (71.9%), with care coordination services most often provided by nurses (74.1%).
- Over half of the CAHs surveyed (71 CAHs) noted they engaged with outside organizations for cancer-related initiatives, with the majority of those CAHs (61.5%) describing initiatives that involved cancer-related awareness and/or education.

PURPOSE

Critical Access Hospitals (CAHs) can play an essential role in providing services to rural residents with cancer in many ways, such as aiding in the navigation of and referral to appointments for necessary cancer screening and treatment, and addressing social-related barriers (e.g., transportation, housing, social support). However, many CAHs face significant barriers to providing these types of care coordination services. This policy brief describes survey findings from CAHs that utilize a variety of care coordination practices to provide care for rural patients with cancer.

BACKGROUND

Care coordination is a model of health care delivery created due to the complexity of navigating health care systems, and assists in information sharing among stakeholders to provide safer and more effective care for patients, including through strong communication and the provision of coordinated services.[1] Rural communities have distinct challenges that make the need for integrated care coordination critical.[2,3] Common barriers in rural communities are transportation issues, lack of health literacy, and workforce shortages.[4] As a whole, rural residents are older, have lower socioeconomic status,[5] and have poorer health compared with urban residents, which may contribute to added complications in accessing and delivering guideline-recommended care.[4]

These system- and health-related barriers, combined with social and economic challenges, often result in higher avoidable health care utilization in rural areas including emergency department visits, hospitalizations, and readmissions, leading to poor outcomes among rural individuals with cancer relative to their urban dwelling counterparts.[6–8] Effective care coordination can enhance care experiences for patients, improve individual health outcomes, and reduce costs.[6,9]

Rural communities also have higher rates of late-stage diagnosis of cancer and higher rates of cancer mortality.[10] The treatment for individuals with cancer often involves multimodal cancer therapies, co-management of other health conditions in addition to the cancer, and multiple providers and/or sites of care.[2] To address these issues, some rural hospitals, including CAHs, have implemented patient navigator roles to assist cancer patients in managing their care and navigating the health care system as well as serving as a liaison between the patient and medical professionals.[11,12] Assistance by patient navigators has been shown to reduce barriers to treatment for low-income communities and underserved cancer patients.[12–14]

Cancer care coordination has resulted in greater cancer detection as well as diagnosis, treatment, and end-of-life care.[2] Care coordination has also been shown to decrease costs among cancer survivors.[2,15] However, effective care coordination faces numerous barriers, particularly reimbursement and staffing for these critical roles. Care coordination is currently based on a fee-for-service payment model for Medicare. In 2019, the Centers for Medicare & Medicaid Services (CMS) added new Medicare billing codes to cover a range of care coordination services, but this only allows for certain health care professionals (Physicians, Certified Nurse-Midwives, Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants) to provide care coordination.[6,16] Medicare does not reimburse RNs or social workers for care coordination activities,[6] though nurse-led care coordination has demonstrated reductions in emergency department visits, reduction in overall charges, and improvement in quality of care.[17]

APPROACH

The data for this policy brief come from a survey of CAHs across the U.S. fielded between March 1, 2022, and April 30, 2022. To select CAHs for this study, stratified random sampling was used to create a sample of 50 CAHs in each of the four U.S. Census Regions[18] to generate a total of 200 CAHs. The survey achieved a response rate of 67.5%, with 135 respondents.

The survey was intended for Chief Nursing Officers (CNOs) or hospital staff in similar positions. Participants were contacted via phone to complete the survey but were also given the option to respond to the survey online. Over half of the respondents completed the survey over the phone (n=79), while the others completed the survey through the online form (n=56). Participants answered questions about cancer care services and staffing at their hospital.

Data for this analysis included three questions: 1) Which cancer care coordination services does your hospital provide for cancer patients?, 2) Which staff are responsible for care coordination for cancer patients?, and 3) Does your hospital have relationships with community and/or outside groups for education, screening recruitment, or other cancer-related initiatives? If so, describe all programs and initiatives. For the care coordination questions, respondents were provided a list of answers to select and could also indicate "other" and provide additional detail. Responses for question three were coded by two members of the research team using conventional inductive content analysis to identify key themes.

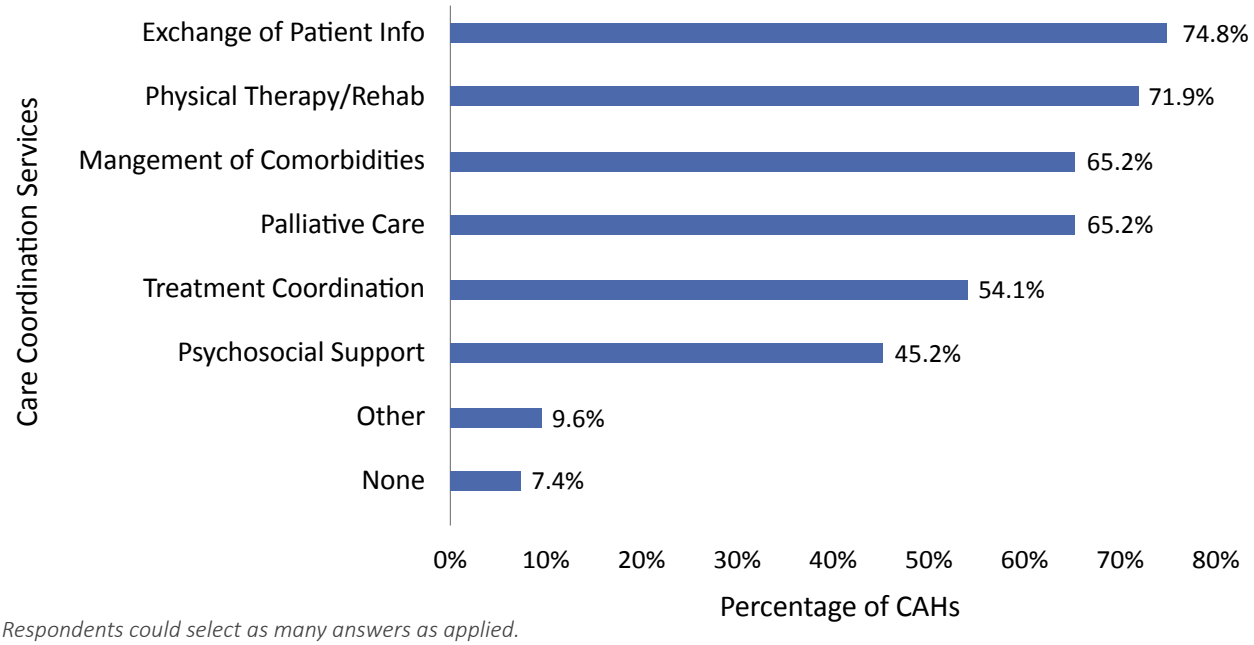
RESULTS

Care Coordination for Cancer Care

Over 90% of the CAH respondents (122 CAHs) reported that they provide some sort of care coordination services for cancer care in their hospital, with a range in types of services provided (see Figure 1). The most common category was exchange of patient information (e.g., transferring records, discussion of patients, etc., 74.8%), followed by physical therapy

and rehab (71.9%). Approximately 65% of CAHs reported management of comorbidities and palliative care as services their hospital provided. Just over half (54.1%) of the CAHs noted they provide treatment coordination, while slightly less than half (45.2%) of CAHs said they provide psychosocial support. The "other" category included responses such as spiritual care, home care, and nutrition services.

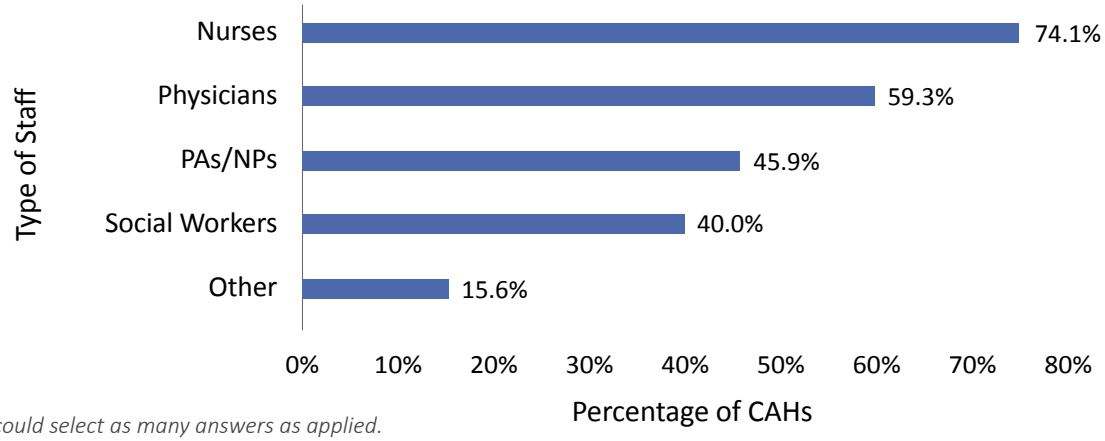
FIGURE 1: Care Coordination Services Provided by CAHs (n=135)



Note: Respondents could select as many answers as applied.

CAHs that provided care coordination services for cancer patients were also asked what type of staff provided these services. The majority of the respondents selected nurses (74.1%), followed by physicians (59.3%) and Physician Assistants/Nurse Practitioners (45.9%) (see Figure 2). Social workers were selected by 40% of CAH respondents, while 15.6% mentioned "other" staff members, which mainly included responses of case managers and care coordinators.

FIGURE 2: Staff Providing Care Coordination at CAHs (n=125)



Note: Respondents could select as many answers as applied.

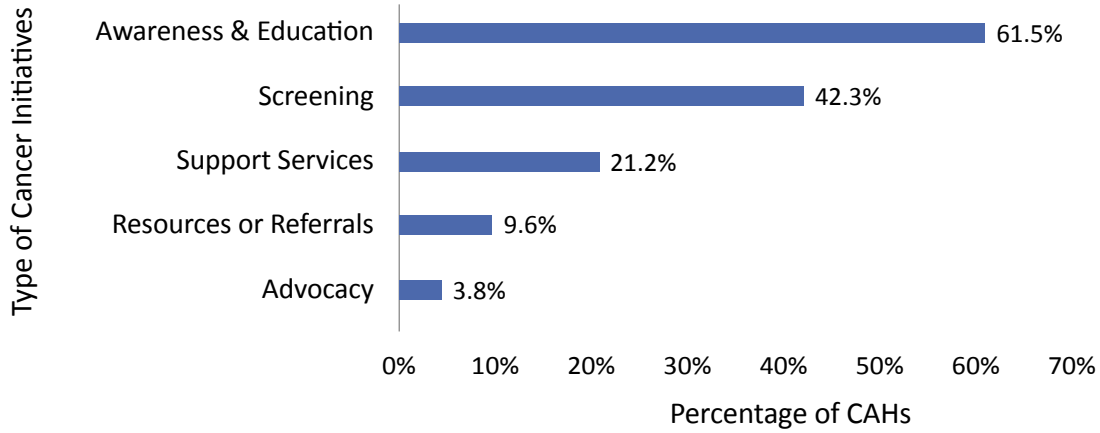
CAH Partnerships for Cancer Initiatives

Nearly 53% of the CAHs surveyed said they had relationships with other community organizations for cancer-related initiatives. Of the 52 CAHs that described initiatives with outside organizations, the majority (61.5%) involved cancer awareness and/or education (see Figure 3). One CAH described their collaborative work:

"We work hand-in-hand with our health department. Related to cancer, we usually have a free prostate screening clinic that our urologist comes down for and we'll do PSA testing. We also do health fairs out in the community to let people know about these services and sometimes we've even brought in a mobile unit. And something else we promote is testing of HPV for our youth. The HPV vaccine. We'll go to the schools and promote that."

Over 40% of CAHs reported that their initiatives focused on screening and over 20% were related to support services, including support groups and counseling. One CAH noted that "A breast cancer screening truck comes," while another mentioned that they were "mainly collaborative with hospice and social work programs that help patients deal with cancer diagnoses." While many services related to cancer care are provided at the hospital, it is clear that collaboration with other organizations and partners plays a role for CAHs, particularly in awareness, education, and screening initiatives.

FIGURE 3: Description of Cancer Initiatives with External Groups (n=52)



Note: Some responses included mention of more than one theme.

DISCUSSION

In this survey of CAHs, the majority provide some type of care coordination services for cancer, primarily focused on the exchange of patient information, followed by physical therapy and rehabilitation services. These services are critical to ensure patients have access to needed services and support recommended as part of multidisciplinary cancer care that optimizes patient outcomes.[3] We also found that just over half of the CAHs in our sample report actively contributing to cancer treatment coordination. Considering the increasingly multidisciplinary nature of cancer care delivery, requiring the coordination of multiple specialties (e.g., surgical, medical and radiation oncology; physical therapy, dieticians) often across multiple health systems, finding opportunities to enhance the capacity and role that CAHs play in providing

treatment coordination may promote long-term improvements in cancer outcomes in their populations. It is also critical to acknowledge the importance of coordinating these services with other providers, including between CAHs, primary care providers (including Rural Health Clinics), long-term care facilities, and many other providers. Each of these different providers may play different roles in ensuring all treatment is coordinated and this coordination has been shown to improve patient outcomes, particularly in cancer care.[2,3,19] However, we recognize the challenges that CAHs face, particularly reimbursement related challenges that may not fully recognize the time and resource intensive nature of coordinating this care, particularly within social work and care coordination teams.[6,17]

Prior research has shown that coordinating team-based cancer care and supportive services play a critical role to ensure timely and appropriate cancer care, which has been shown to improve treatment completion, reduce adverse events, and promote improved survival. 19,20 Since rural communities have limited access to cancer specialists and overall workforce shortages, our research brief has shown that CAHs play an integral role in these care coordination services to ensure their rural residents have access to needed cancer delivery services. However, research has demonstrated that this care coordination is often under-recognized, representing a significant amount of "invisible work" on the part of clinicians and other care team members (e.g., social workers, care coordinators), which increasingly includes working around system barriers that may be amplified in the rural setting (non-interoperable medical systems, suboptimal communication systems).[20–22]

In addition to the complexity of coordinating cancer treatment, rural residents face a number of barriers to receiving coordinated guideline-recommended care.[23,24] Many patients with cancer experience financial, emotional and logistical barriers to care that significantly affect their adherence to recommended care. These challenges are exacerbated among rural residents who face longer travel distances to care,[25] transportation and childcare barriers, among other concerns. One approach to enhance the capacity of providers to coordinate resources addressing these underlying social determinants of health is partnering with local community organizations. Our survey identified that over half of the participating CAHs are partnering with these organizations to support their patients' needs before and during a cancer diagnosis, including providing cancer awareness and education, cancer screening, and support services for individuals with cancer. This approach mirrors one of the best practices identified in 2019 at the American Society of Clinical Oncology forum Closing the Rural Cancer Care Gap: creating new partnerships between providers and community leaders to address local gaps in cancer care and strive for solutions that are local and based on community needs, available resources, and trusting and collaborative partnerships.[26]

CONCLUSIONS

The vast majority of CAHs surveyed provide some sort of care coordination for cancer care services, but there is room for improvement in the types of care provided to address the needs of CAH patients dealing with cancer. External and community organizations provide the opportunity for CAHs to collaborate on issues related to cancer care, particularly in the areas of awareness, screening, and providing support to community members. While none of the CAHs in this survey noted assistance from their State Flex Programs (SFPs) related to the cancer care provided in their hospitals, SFPs can help their CAHs by encouraging partnerships within and across rural communities, as well as providing additional information and resources for supporting CAHs interested in providing cancer care and/or care coordination for cancer care in their hospitals.

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