Building a Rural Cancer Program

Wade T. Swenson, MD, MPH, MBA

1

Presentation Objectives

Participants will be able to answer the following questions:

1. Recognize barriers and challenges that rural communities encounter in obtaining cancer care.

2. Understand the advantages and operational aspects of a decentralized cancer care model.

3. Implement practical strategies, harness beneficial partnerships, and utilize resources necessary to establish and maintain a rural cancer program.

2

Presentation Questions

1. True/False: The concentrated urban oncology workforce contributes to a barrier to cancer care for rural residents.

2. True/False: The financial sustainability of the Rural Cancer Oncology Home Model largely depends on the 340B Drug Pricing Program and specific Medicare and Medicaid reimbursements connected to the CAH status and Rural Health Clinics.

3. True/False: Cancer related mortality is increasing among rural residents.

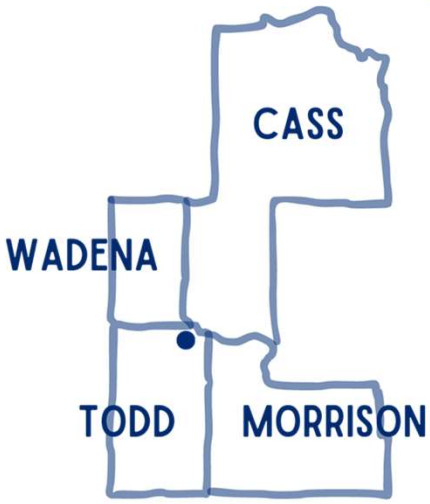
3

Lakewood Health System

4

LHS Service Area

- Elderly Population
- Poverty
- Food Insecurity
- Inadequate Broadband



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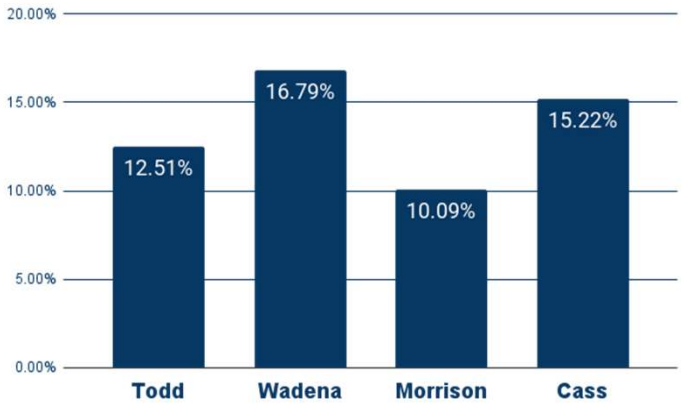
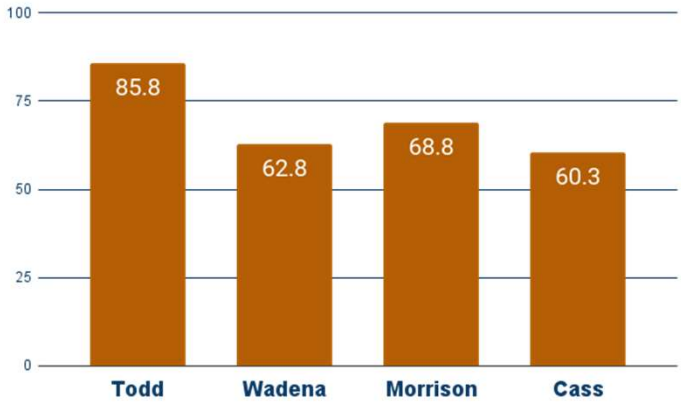
County Poverty Rates



Minnesota state average is 9.6%

6

Digital Distress Index

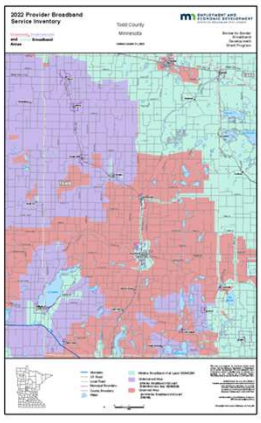


Scores above 50 are considered in distress

7

County Broadband Access

Todd



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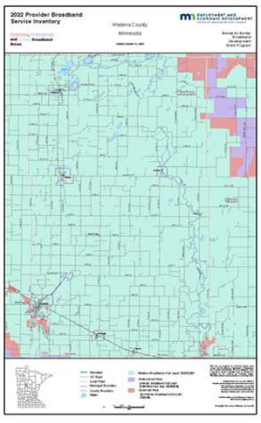
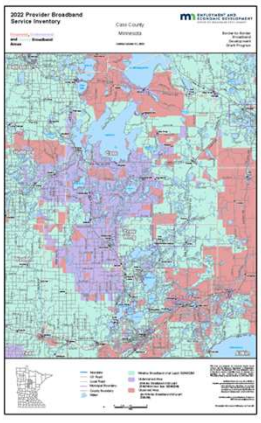
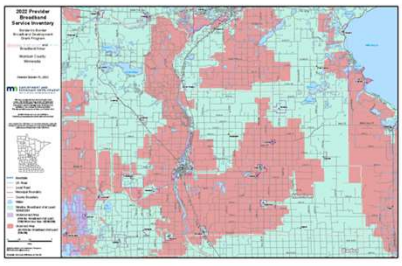


Cass



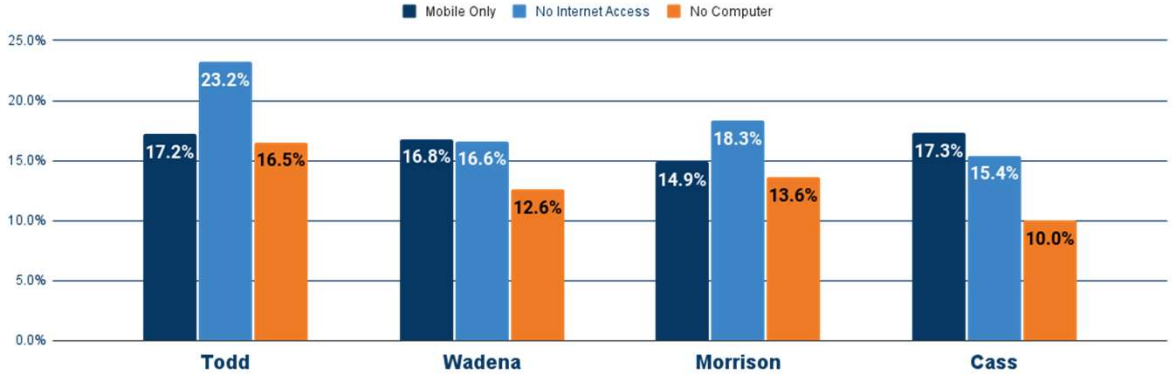
Unserved
Underserved
Served Broadband Area

Morrison



8

Restricted Broadband Access

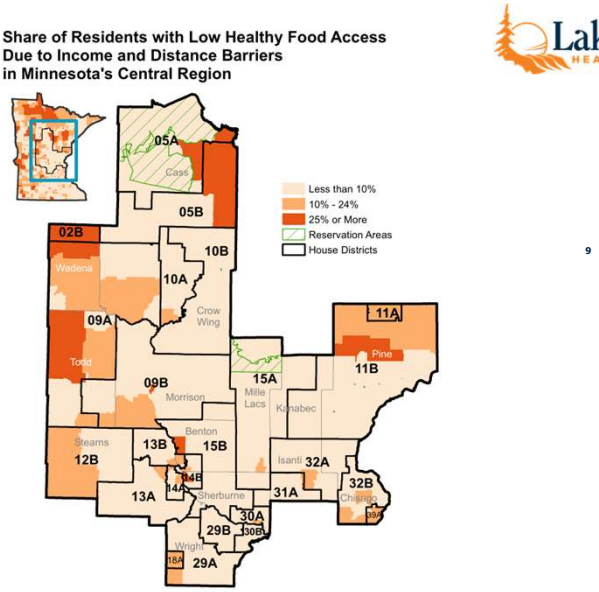


Households relying solely on mobile only are not benefiting from digital applications due to limited data plans and restricted access

9

Food Insecurity

Reference:
hungersolutions.org



10

The Rural Cancer Gap

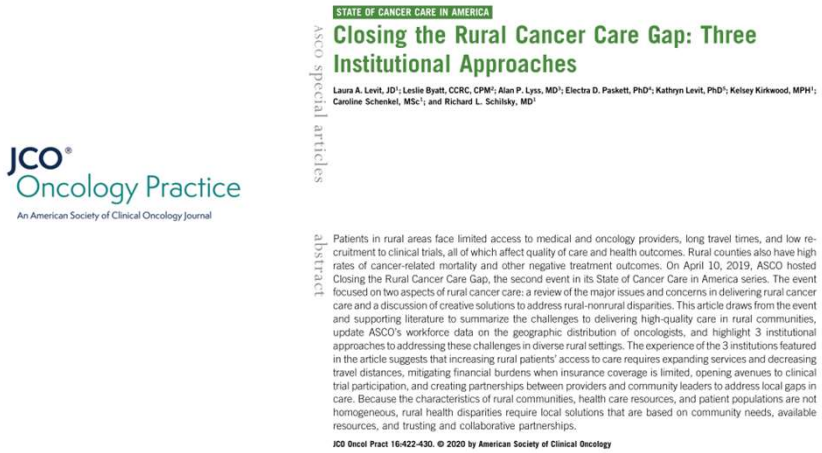
American Society of Clinical Oncology (ASCO)
President Monica Bertagnolli, 2018 – 2019

"Caring for Every Patient, Learning From Every Patient"

Recognizes that ASCO must work on behalf of every single patient with cancer, **no matter what his or her geographic location**, socioeconomic status, age, or ethnicity.

11

The Rural Cancer Gap


JCO® Oncology Practice
An American Society of Clinical Oncology Journal

asco special articles

STATE OF CANCER CARE IN AMERICA

Closing the Rural Cancer Care Gap: Three Institutional Approaches

Laura A. Levit, JD[1]; Leslie Byatt, CCRC, CPM[2]; Alan P. Lyss, MD[3]; Electra D. Paskett, PhD[4]; Kathryn Levit, PhD[5]; Kelsey Kirkwood, MPH[1]; Caroline Schenkel, MSc[1]; and Richard L. Schilsky, MD[1]

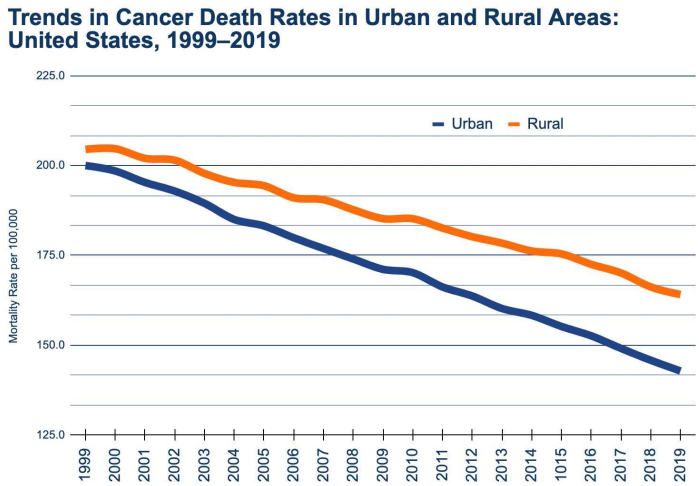
abstract

Patients in rural areas face limited access to medical and oncology providers, long travel times, and low recruitment to clinical trials, all of which affect quality of care and health outcomes. Rural counties also have high rates of cancer-related mortality and other negative treatment outcomes. On April 10, 2019, ASCO hosted Closing the Rural Cancer Care Gap, the second event in its State of Cancer Care in America series. The event focused on two aspects of rural cancer care: a review of the major issues and concerns in delivering rural cancer care and a discussion of creative solutions to address rural-nonrural disparities. This article draws from the event and supporting literature to summarize the challenges to delivering high-quality care in rural communities, update ASCO's workforce data on the geographic distribution of oncologists, and highlight 3 institutional approaches to addressing these challenges in diverse rural settings. The experience of the 3 institutions featured in the article suggests that increasing rural patients' access to care requires expanding services and decreasing travel distances, mitigating financial burdens when insurance coverage is limited, opening avenues to clinical trial participation, and creating partnerships between providers and community leaders to address local gaps in care. Because the characteristics of rural communities, health care resources, and patient populations are not homogeneous, rural health disparities require local solutions that are based on community needs, available resources, and trusting and collaborative partnerships.

JCO Oncol Pract 16:422-430.

12

The Rural Cancer Gap



13

What Causes The Rural Cancer Gap?

Limited access to medical and oncology providers
Long travel times
Low recruitment to clinical trials
Higher rates of behavioral risk factors
Lower access to preventive care
Higher rates of obesity, disability, and smoking

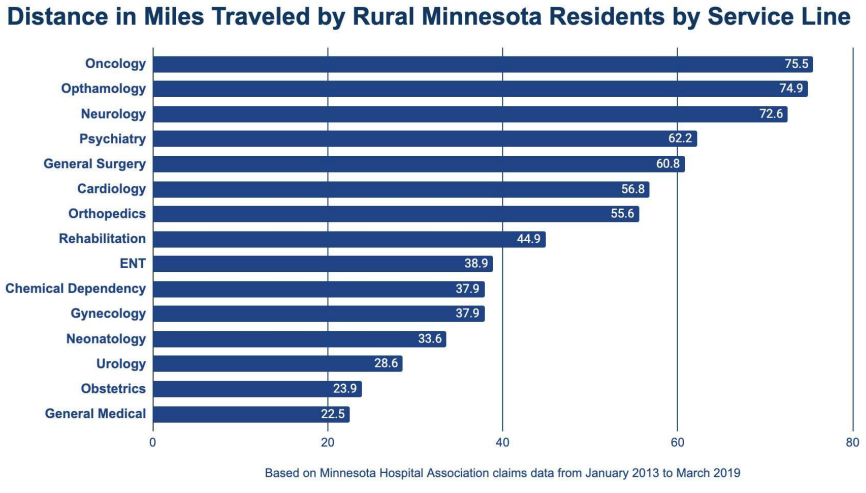
14

What Causes The Rural Cancer Gap?

- Rural patients tend to be older, sicker, and poorer
- Lower education and income levels
- Differences in health literacy and cultural trust
- Rural America also faces more hospital closures, physician shortages, recruitment challenges, and an aging workforce

15

The Rural Cancer Gap



16

The Rural Cancer Gap

66% of rural counties have no oncologist

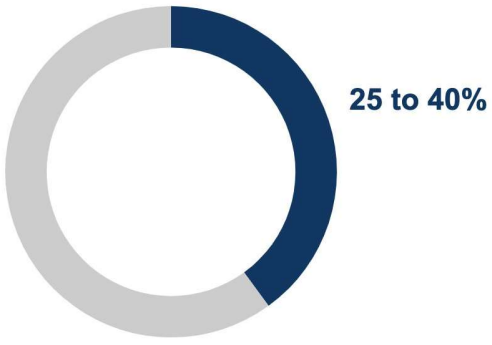
10% of U.S. oncologists work in just 3 counties

21% of U.S. oncologists left patient care in 7 years (2015-2022)

17

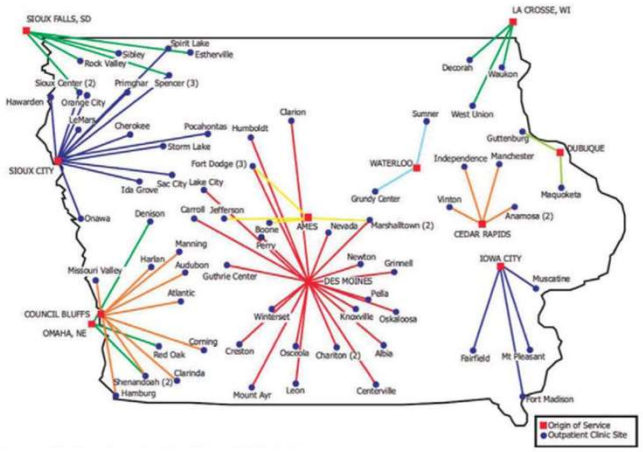
The Rural Cancer Gap

Estimated Contribution of Cancer Services to U.S. Health System Profit Margins



18

Solutions?



19

The Rural Oncology Home

NEJM Catalyst | Innovations in Care Delivery

ARTICLE

The Case for Decentralizing Cancer Care: The Rural Oncology Home

Wade T. Swenson, MD, MPH, MBA, FACP, Missy Lindow, MBA, Joe Reycraft, Lisa Bjerga, CPA, MBA, Zachary Schroeder, Abigail P. Swenson, Emily Westergard, DO

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DOI: 10.1056/CAT.23.0344

20

Implementation

- Utilizing Financial Tools of CAH and Rural Health Clinics
- 340B Drug Pricing Program
- Focus on Oncology Case Management
- Palliative Care
- Hospice Care
- Financial Navigator
- Partnerships: Cancer Rehabilitation, Clinical Trials

21

340B


LETTERS

HealthAffairs

Global Lessons From COVID-19

Lessons From Using Models To Set Policy — Page 1630

Economic & Health Trade-Offs In Latin America — Page 1647

Effects Of Care Disruptions In Latin America — Page 1657

Global Vaccine Equity Requires Addressing Access & Hesitancy — Page 1681

Tracking Policies To Protect Vulnerable Populations — Page 1689

Equity — Page 1697

Adolescent Social Outcomes Worsened In Bangladesh, Jordan & Ethiopia — Page 1726

Review Of Misinformation Intervention Effectiveness

Israel's Approach To Boosters Could Have Saved Lives In The US

DOI: 10.1377/hlthaff.2023.01092

Bridging The Rural Health Care Gap: The 340B Program

Rural communities face challenges in accessing health care, but the safeguards for rural health care stand on precarious ground. The role of the 340B Drug Pricing Program is essential in ensuring equitable health care access. It is imperative to spotlight programs that have a tangible impact on countless lives.

Kelsey M. Owsley and Cathy J. Bradley (June 2023) demonstrated correlations among the 340B program, Medicaid expansion, and the capacity of rural hospitals to deliver oncology services. Peiyin Hung and colleagues observed that from 2008 to 2017, the percentage of critical access hospitals offering chemotherapy services declined, whereas the percentage of those providing radiation services saw a modest rise.[1] The financial influence of oncology services on an institution's operational margins directly affects additional services rendered.

Lakewood Health System, in Staples, Minnesota, is an example of how the 340B program affects rural cancer care delivery. Its service scope is anchored to financial support from the 340B program, which enables Lakewood to deliver an array of services and support.

Lakewood's financial analysis indicates that the 340B program yields savings nearing $1.3 million annually. For an establishment providing almost $1.9 million in uncompensated care each year, such savings are crucial. A significant 66 percent of Lakewood patients enroll in Medicaid or Medicare or are uninsured, which necessitates use of the 340B program to bridge gaps for the most vulnerable patients.

The benefits extend beyond drug pricing, as savings are channeled into service enhancement and expansion. Tangible outcomes for Lakewood include an oncology center; a prominent orthopedic group partnership; and the bolstering of palliative, hospice, and obstetrics care. Food insecurity initiatives, such as Food Farmacy, Fresh Delivered, and Meals at Discharge, underline the societal benefits of the 340B program.

The 340B program isn't merely a policy; it promises better health care access and a healthier future for rural America.[2]

Wade T. Swenson
Lakewood Health System
STAPLES, MINNESOTA

NOTES

1 Hung P, Shi K, Probst JC, Zahnd WE, Zgodic A, Merrell MA, et al. Trends in cancer treatment service availability across critical access hospitals and Prospective Payment System hospitals. Med Care. 2022;60(3):196–205.

2 To access the author's disclosures, click on the Details tab of the article online.

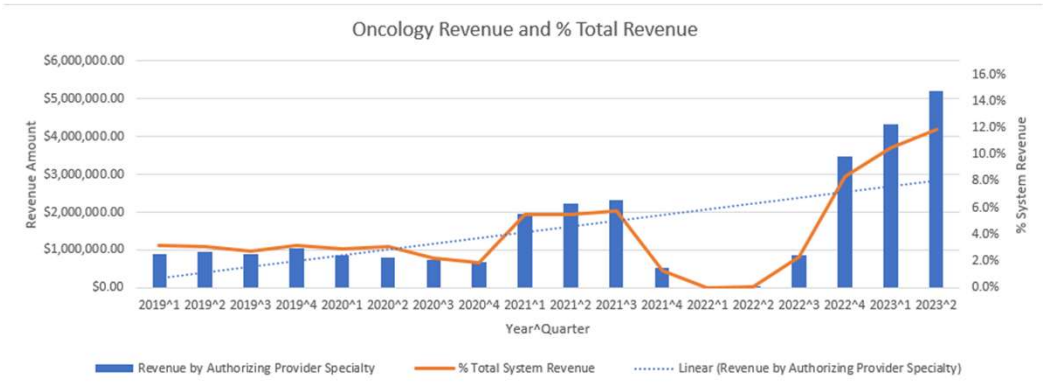
22

Financial Navigator

- Free oral oncology medications 92 patients ($1,013,238)
- Free oncology infusion medications 25patients ($509,781)
- Estimated $229,970 in uncompensated care
- Provided co-payment assistance to115 patients ($114,606)
- Secured $40,012 in community assistance for 54 patients
- With a patient panel of 609 patients, the Financial Navigator provided services to 249 patients (40.9%)

23

Financial Sustainability



24

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26

References

27

More Information

Rural Cancer Institute
An Independent Research and Advocacy Organization

RuralCancer.org

wade@ruralcancer.org

28

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ARTICLE

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29