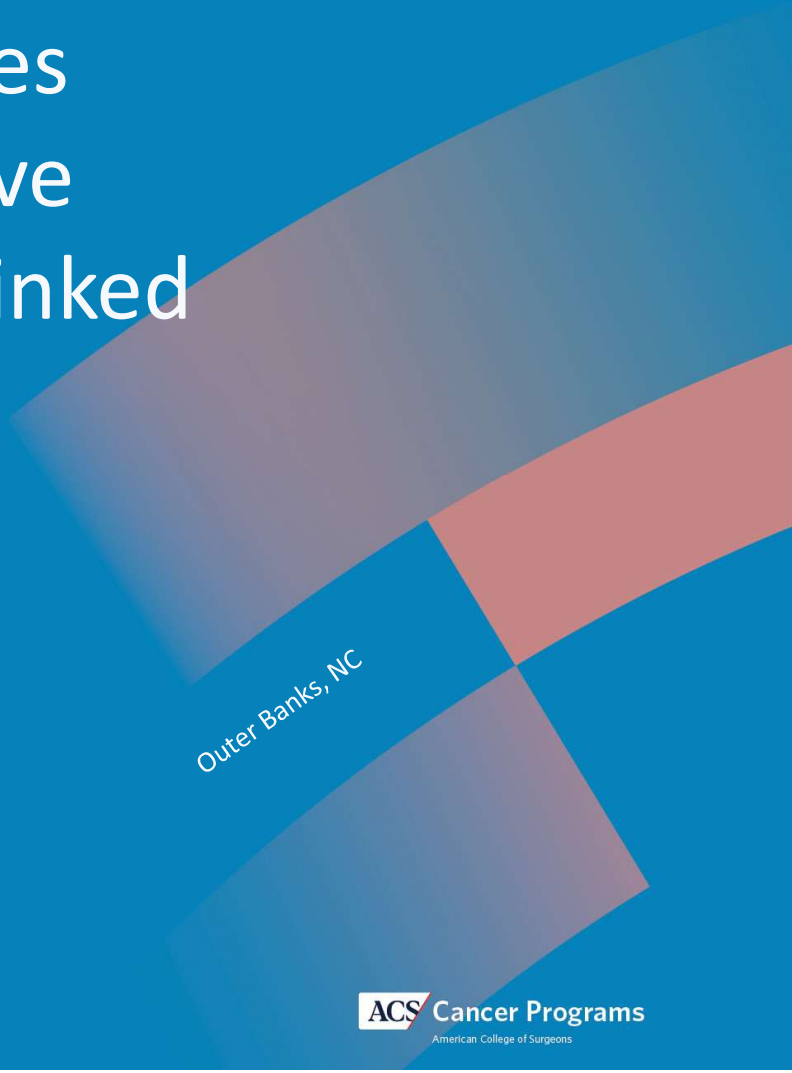
How COC Collaboration Increases Rural Volumes and Helps Remove Disparity in Cancer Outcomes Linked to Geography

Rural Perspective
10y Following Accreditation



Disclosures

- None

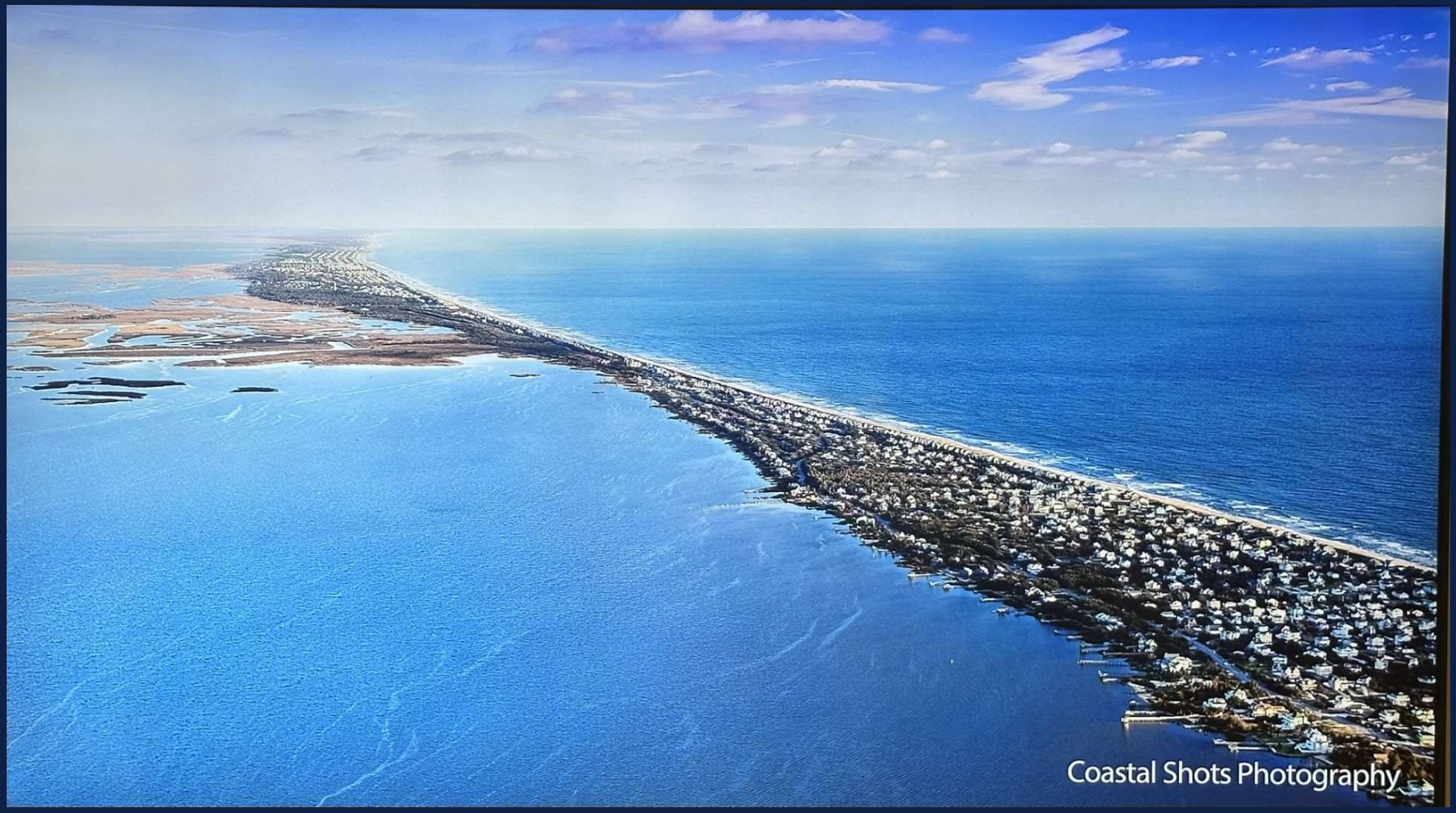
- Benefits of presentation
  - *we are young hospital (23 years), smallest in COC*
  - *we are able to show metrics pre-COC and post-COC*
  - *we lack many resources (collaboration is key)*
  - *together we can change cancer*

Outline: Harnessing the Power of Collaboration

A. Rural Care With Mostly Urban Referrals:
   1. we get by
   2. volumes and outcomes stink

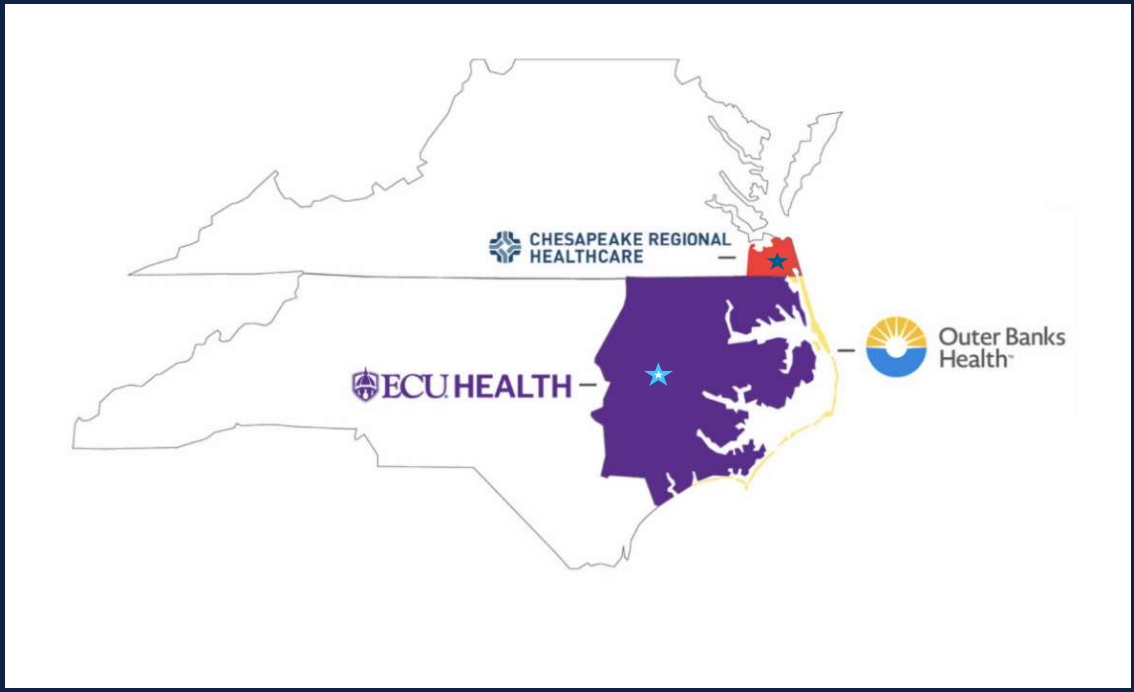
B. Rural Care Post RURAL-URBAN Collaboration On Cancer:
   1. we get better (COC)
   2. volumes and outcomes improve
   3. Facilities follow

C. Models of Collaboration (We) CAN Remove Disparity
   1. Networks (INCP, MCCAN, I CAN)
   2. New Rural Standards encourage COC Collaboration
   3. The 'COC effect' reduces distances 5-10X



Critical Access Hospital is product of Rural-Urban Collaboration

NC has 2nd largest Rural population in US = 3.5M



2 Urban Partners:

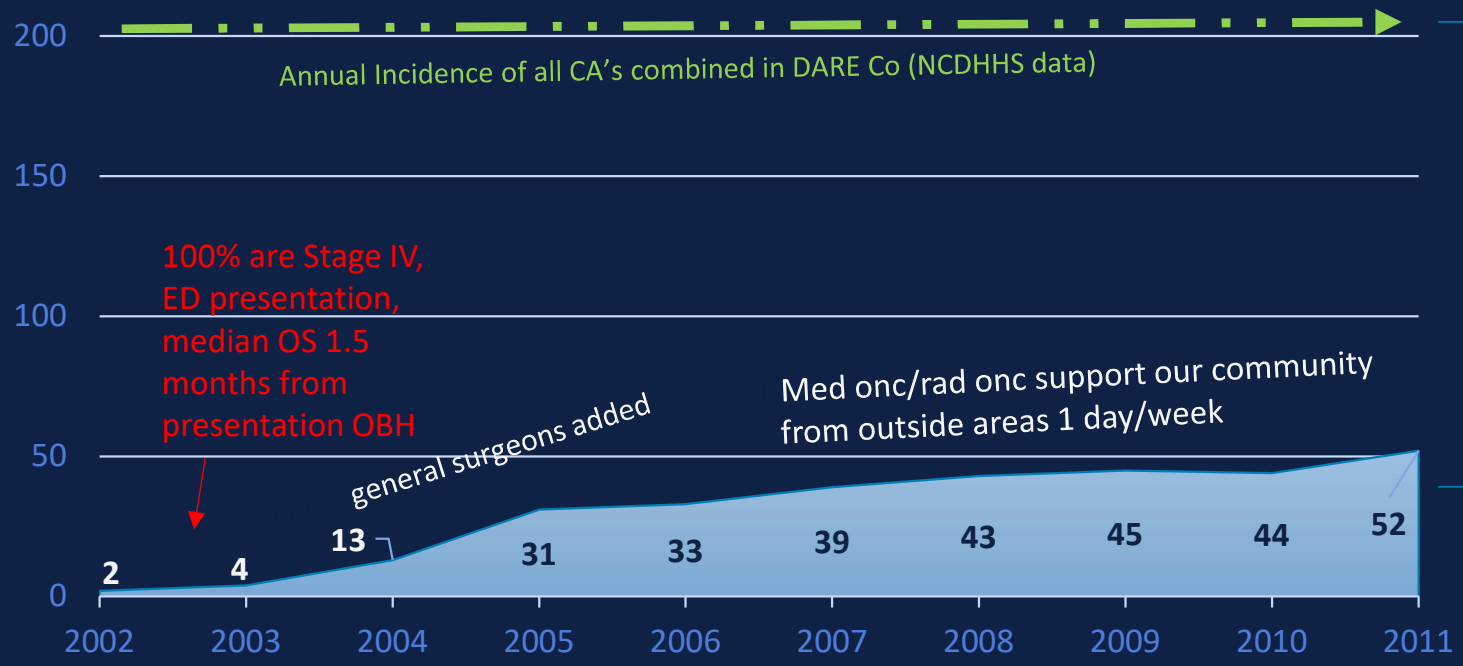
-Chesapeake VA (340 beds)
-ECU Greenville (1140 beds)

Both are COC programs

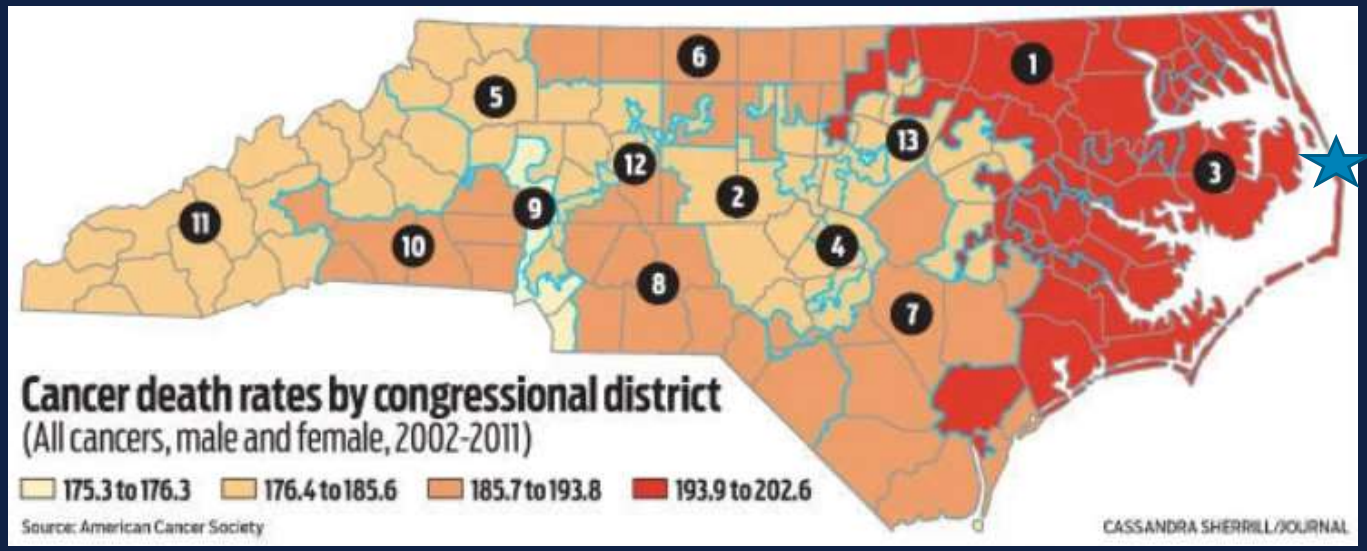
We are mostly a triage hospital (not acute care hospital)

- Spoke (Rural)-to-Hub (Urban) network
- Some essential care provided at home: emergencies 24/7, low acuity inpatient, <96h
- *All higher level care is sent elsewhere*

Cancer at Rural Critical Access Hospital: Decade 1



10-Yr Mortality Rates : Disparity Linked to Geography



We are among worst

10-year CA Mortality Rates in NC (2002-2011)

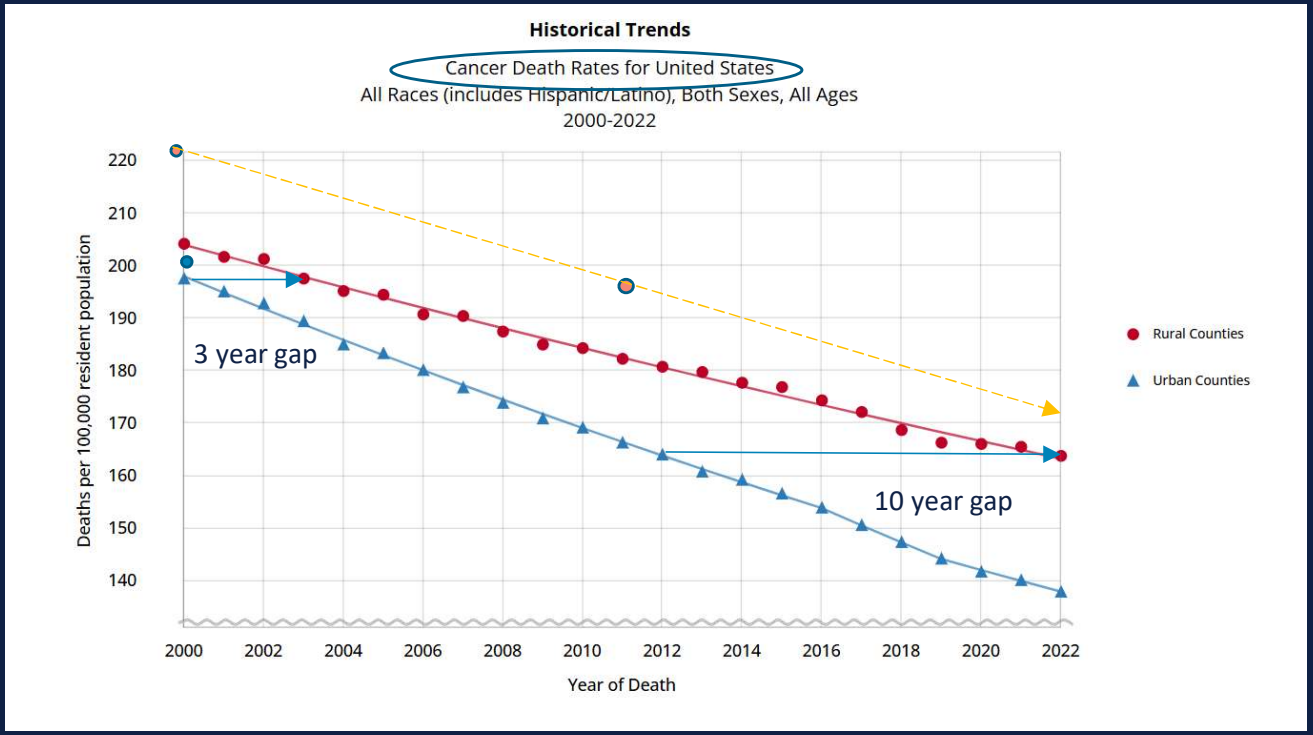
Mortality and Survival (before Collaborating on CA)

- Our Hospital impacts very little of local county CA incidence:
  - -15% of cancers in rural county impacted 1st 10y (median OS 40 mos)
  - -85% of patients in county go elsewhere (urban) for CA care
  - AND our CA mortality rates in (rural) DARE stink!

Low volumes/Poor outcomes: Root Causes

- *Care is fragmented*
- *Late stages @ presentation*
- *Patients mostly self navigate*
- *Part time oncology* coverage *not enough*
- Rural care is **"reactive"**
- *No program approach to cancer*
- *Poor trust in local care*
- *Minimal Collaboration on Cancer with providers*
- *Distance to Cancer Treatment Center (COC/NCI) = 80-200 miles!!!*

This is the state of (all of) US



https://hdpulse.nimhd.nih.gov/data-portal/mortality/historical-trends

This gap widens more unless we change something

Having a hospital in your community is NOT ENOUGH

Why Collaborate on Cancer?

- Cancer is major of death
- Rural areas older, vulnerable
- We have care gap that *basic access to a small hospital won't fix*
- ONE AND DONE MODEL for Surgery at Large Urban Programs does not work: Cancer is multi-modality, time consuming, and daunting with distances to CA programs for all of the care
- Not everyone can travel large distances

Collaboration on Cancer

Collaborare (Latin): to work together

Onkos (Greek): mass or bulk (i.e. tumor)

Cancer (Latin), Carcino(ma)s (Greek karkinos): cancer (tumors that look like crabs)

COC

Individually, we are one drop. Together, we are an ocean

Ryunosuke Satoro

Get Collaborating On Cancer!

- As a 'have not', we formed collaborations with others who 'have'

  -Collaboration with ACAD's- *UNC, Duke, ECU, EVMS, UVA*

  -Collaboration with partner owner hospitals (ECU/Chesapeake) tumor boards, access to specialists and services (surgical oncology, pathology, radiology)

- 2012 OBH admin acquires CON for RadTx, hires FT med onc and rad onc, consolidates services, and **decide to be a cancer program**
- We **use COC** Manual as guide (they already invented this wheel!)
- 2013 Cancer Committee: DO what **WE CAN**, refer out the rest with proper NAVIGATION
- 2016, 2019, 2023 COC Accreditation
- 2022, 2025 NAPBC Accreditation

Key theme…refer out what you need

members

Palliative care services on-site will vary depending on the scope of the program, local staff expertise, and patient population. The cancer committee will define and identify in a policy and procedure the following:

- On-site and off-site palliative care services
- The palliative care team available on-site
- Criteria for referral to a palliative care specialist

Palliative care services not provided on-site at the facility must be provided through a referral relationship to other facilities and/or local agencies.

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

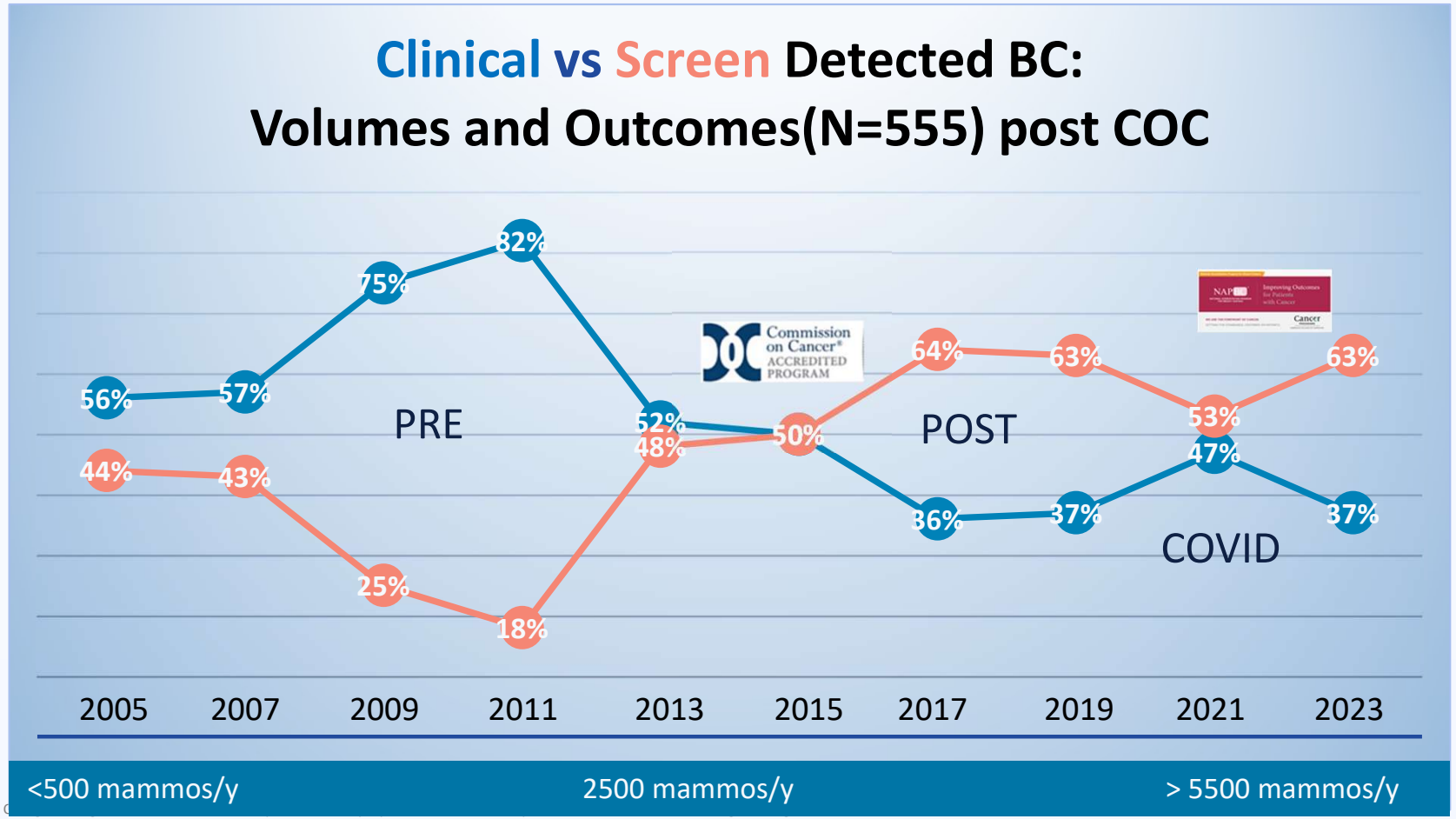
1. Palliative care services are available to cancer patients either on-site or by referral.
2. A policy and procedure is in place regarding palliative care services that includes all required elements.
3. The process for providing and referring palliative care services to cancer patients is monitored and evaluated. A report is given to the cancer committee, contains all required elements, and is documented in the cancer committee minutes. The report meets the requirements outlined on page V under "Standards Requiring Annual Review."

DATA

- No program can call itself a ‘quality program’ until it has data to validate outcomes against industry (peer) standards
- *This is the value of COC accreditation to us*
- COC (NCDB) provides real world data for us since first accreditation (patient retention, outmigration, stage shift, timeliness metrics)
- Data (comparison) has been endless fuel for patient-centered outcome improvement based on OUR program gaps
- Data fosters COLLABORATION

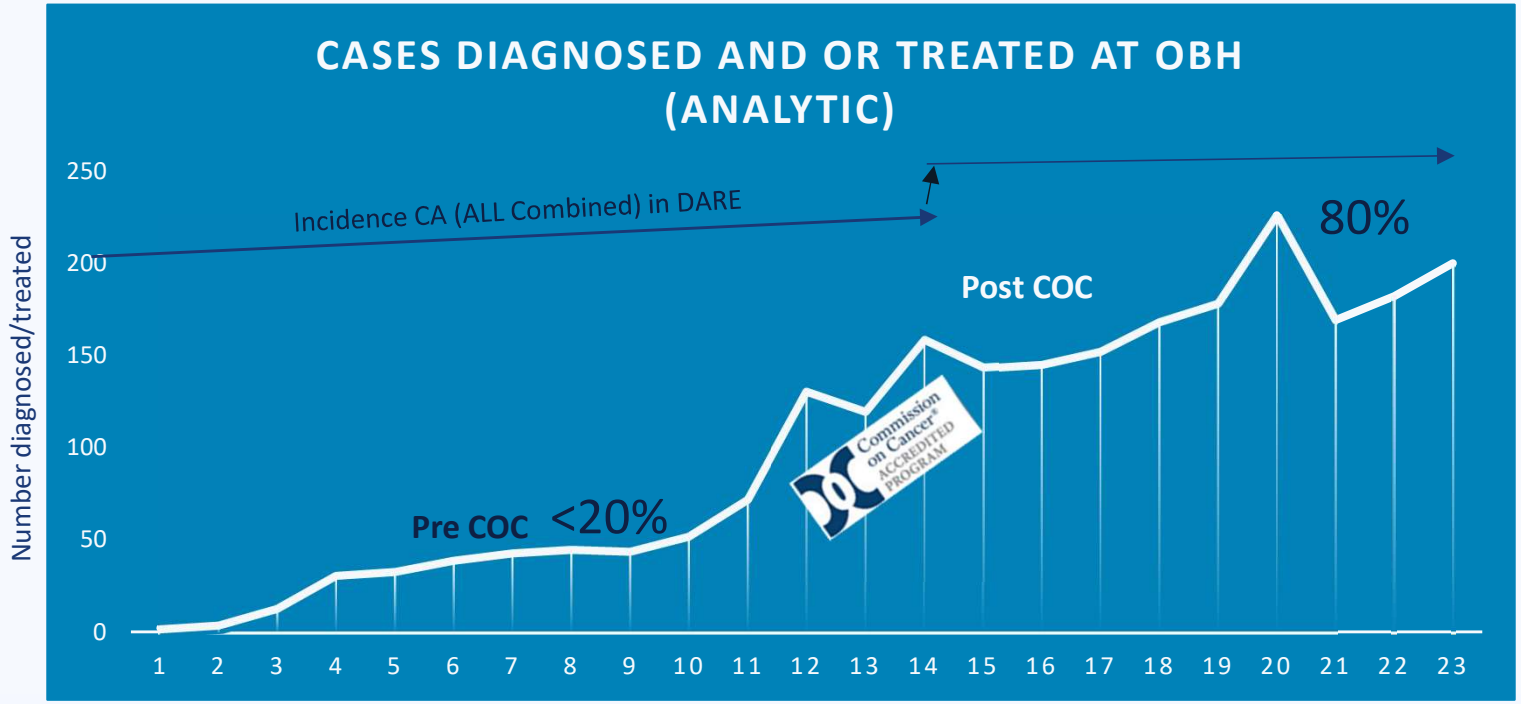
Breast Cancer Detected Differently @ OBH

BC detected by years @OBH



75% of BC is now stage 0/I OBH

★ WE Increase Analytic CANcer Volumes post COC ★



Years following opening of Rural Hospital

Measures of COC Impact @ Rural Hospital

	Total OBH Analytic CA	Analytic CA /year	Incidence Dare Co/yr	% Pts impacted OBH	Median OS (mos) OBH	Dare (Rural CA) Mortality	NC all CA Mortality (N=100)
Pre COC	378	34	205	15-20%	40	196.1	192.3
Post COC	1970	164	230	70-80%	>73	147	153.1
Relative Ratio	5.2	4.8	1.12	4.0-5.0	>1.83	0.75	0.80

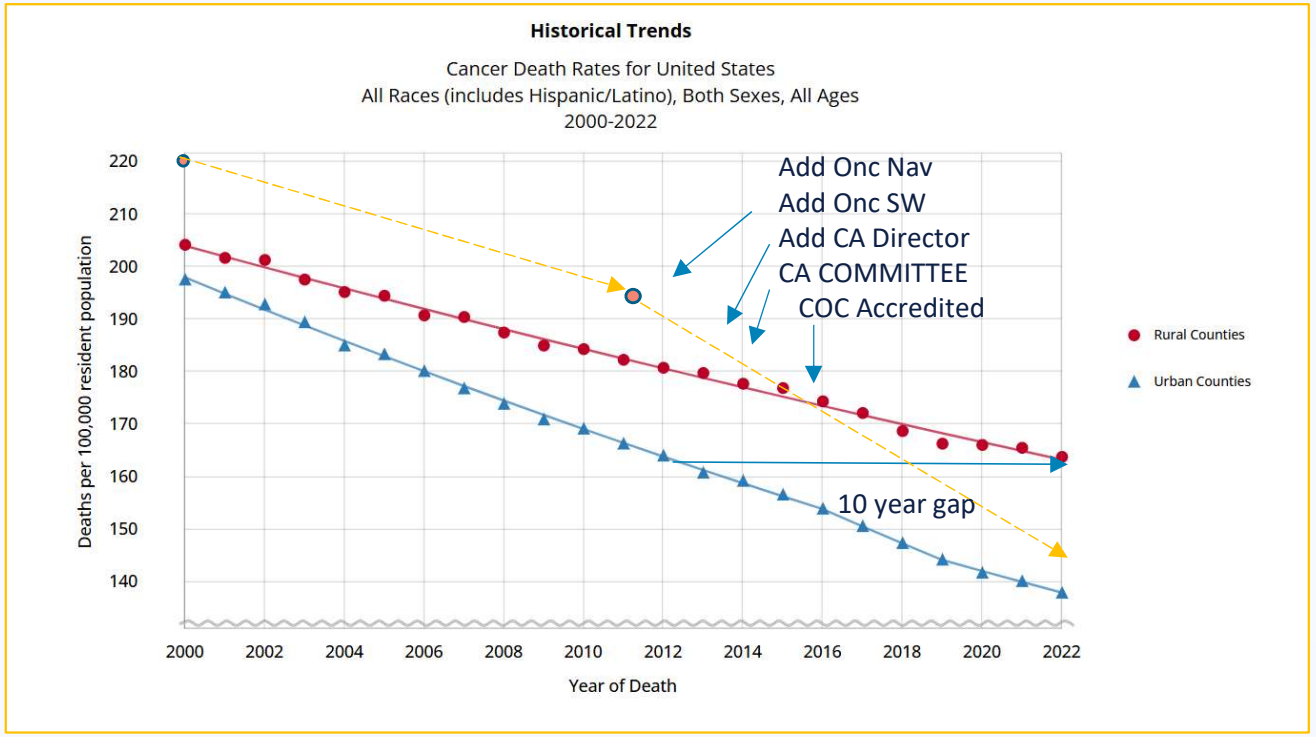
Volumes increase → **Outcomes improve**

Rural Hospital- OBH

Commission on Cancer® ACCREDITED PROGRAM

PARITY for County

This is the state of US now



We Open Rural Cancer Center in 2024

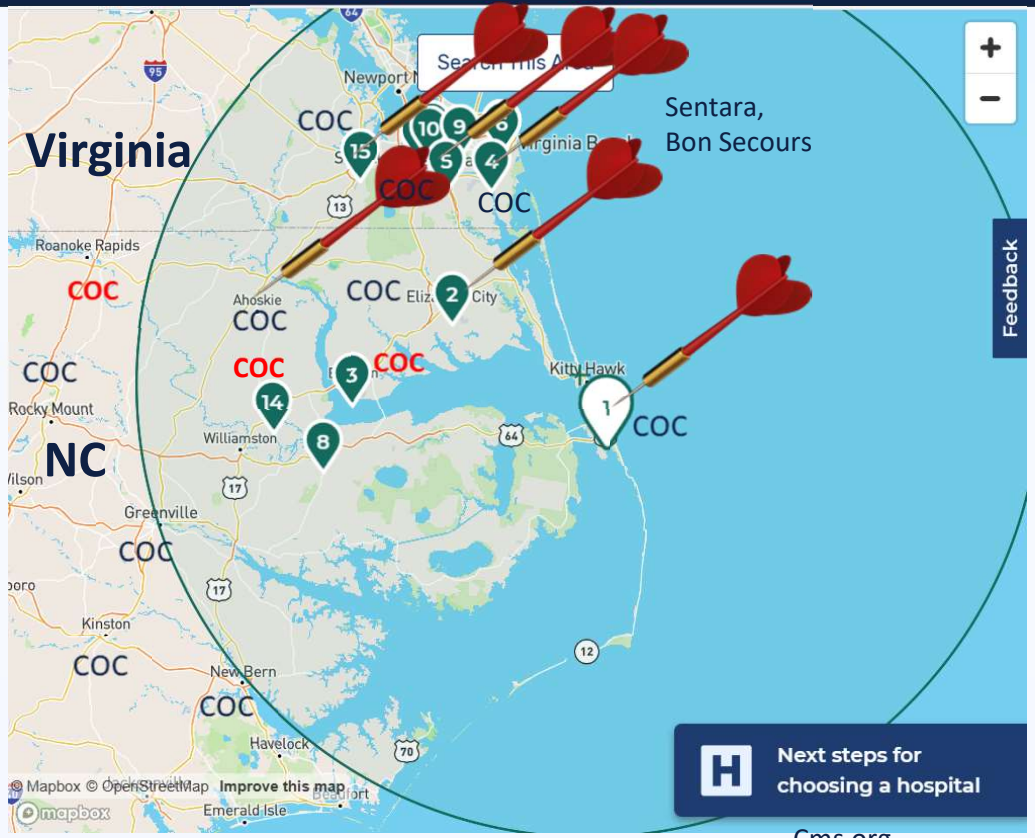
How do WE harness this power so others CAN?

- COLLABORATE - learn from those who invented the wheel (COC)
- AFFILIATE
  - Iowa- Cancer Affiliation Networks (I CAN)
  - Markey Cancer Center Affiliated Networks (MCCAN)
- INTEGRATE
  - Integrated Network Cancer Programs (COC category)
- INNOVATE
  - Make it Easier to Become Rural Cancer Program
    - New COC Standards for Rural Hospitals
  - Mentorships with Programs
  - Telehealth Virtual Models of Collaboration (Cancer Conferences)

COC Effect: Distance to a COC program now 5-10 x closer

COC INCP in 2025/6

COC Already



Cms.org

22 hospitals within 100 miles of Dare

Majority are COC accredited through a network or an affiliation

Avg. distance to any COC facility now is 10-20 miles in our area = 5-10X less than @ baseline

Key Points

- Rural–Urban **Collaboration** on **C**ancer improves care
- **COC** accreditation adds Quality Metrics (timeliness, etc.)
- *Volumes treated locally change* favorably (post COC = 5x more)
- *Outcomes significantly change (post COC)* when this is done programmatically (survival)
- In our rural region **COC accreditation** (distance to a COC program now = 5-10x less) is the great equalizer (75% of patients now within 25 miles COC)
- With integrated network cancer programs, cancer affiliation networks (I-CAN, MCCAN) and *new rural accreditation standards*, equity is now more achievable
- Together **WE-CAN**


Thank You
for what
You do