

***Taking Aim at Cancer in Louisiana Kick-off Event– May 11, 2018***  
**Summary of Break-out Group Discussions**

**1. How should we define success within the new statewide cancer collaborative?**

- Across the New Statewide Cancer Collaborative:
  - For all measures, disparities are reported, investments are made in parishes/communities with poorest outcomes, and care gaps are aggressively addressed.
- Within the Colorectal Cancer Screening Intervention:
  - Increased proportion of early stage colorectal cancer diagnoses as measured by the tumor registry
  - Increase in the number of people screened
  - Increased perception by public that colonoscopy is a “wellness visit”
  - Increased adherence to protocols (risk assessment and screening guidelines of USPSTF, NCCN, etc.)
- Within the Breast Cancer Treatment Intervention:
  - Increased proportion of early stage breast cancer diagnoses as measured by the tumor registry
  - Increase in the number of women screened
  - Selection and reliable implementation of a few QOPI measures (such as appropriate use of Genetics in new diagnoses)
  - Percent of newly diagnosed patients who are presented to Tumor Boards and offered clinical trials, if appropriate

**2. What are the primary barriers that could limit success in addressing these initiatives in Louisiana, specifically considering:**

- Overarching barriers?
  - Availability of local resources
  - Travel time
  - Lack of transport
  - Time off work for screening or treatment
  - Cultural attitudes and fear regarding screening and treatment
  - Poor understanding of coverage/new coverage
  - Specific payment system barriers (e.g., genetic screening for Medicaid)
  - Lack of coverage/uninsured/out of pocket cost for all patient populations, with particular impact on those between 139-250% FPL
  - Lack of engagement with primary care physicians in the community
  - Lack of knowledge of physicians about changes and improvements in best practice
  - Lack of provider systems and no local providers, particularly specialists
  - Recidivism – lack of patient understanding that repeat tests are needed

- Expanding colorectal cancer screening, particularly with regard to populations with high risk factors related to race/ethnicity, income, lifestyle and urban versus rural residence?
  - Access to screening (colonoscopies) & treatment
    - Lack of Navigators
    - Lack of weekend / after hour screenings
    - Lack of survivor support
  - Financial reimbursement
    - Providers are not incented to perform colonoscopies
    - Copayments for diagnostic colonoscopies (which do not apply to screening colonoscopies)
    - Lack of philanthropic support to cover cost of screening/treatment for those who are uninsured
  - Stigma & fear
    - Need support to help patients navigate system of care
    - Need fast track to coverage for those who are uninsured
- Defining standards of care for breast cancer treatment in Louisiana, specifically in securing adoption and reporting on these standards?
  - Process barriers – no one has ever convened providers, payers and community groups to look at the data and opportunities for standardization
  - Providers need time to review and plan collective selection and phased implementation of QOPI guidelines, NCCN Guidelines, and Breast Cancer Guidelines
  - Lack of availability of breast clinician resources and full continuum of services
  - Lack of Navigators and certified genetic counselors
  - Lack of coverage for Navigators and certified genetic counselors
  - Lack of supportive services
  - Lack of understanding of what is available
  - Lack of financial support for improvement process
- What approaches can we take to address and overcome racial and geographic disparities? *(Stakeholders marked below in red: HS – Health Systems; HP – Health Plan; C – Community Organizations; G – Government; LP – Local Providers; COL – Collaborative)*
  - Delivering a compendium of community services for each parish: Describing what is available in the community to support screening, supportive services, survivorship, transportation, and cultural barrier reduction and psychosocial support **HS, C, LP**
  - Very targeted outreach to cancer to cancer “hot zones” – pick a small number as a test of change, and then get funding to go broader **HS, HP, LP, G**

- Carefully design all interventions to be culturally sensitive and appropriate  
HP, HS, LP, G, C
- Payer targeting of communications about screening and coverage to high risk populations – cell phones, text messages, etc. HP
- Broad based and targeted marketing and communications campaigns to “get the word out” to patients and providers statewide, using respected celebrities and trusted community leaders in communicating culturally sensitive messages – billboards, PSAs, “Super Colon”, etc. G, COL
- Assemble diverse stakeholders to select targets, plan interventions, and set goals – each committing what they can in support COL
- Partner closely with FQHCs – who are likely the care providers for these populations – connect with them via Grand Rounds, telemedicine, etc. COL, HS, HP, LP
- Begin with health systems in their “natural markets” HS
  - determine which system is targeting each parish
  - set common goals
  - allow them to implement in their own way
  - measure improvement (but keep data protected in the near term)
  - show each system their data
  - mobile vans for screening
- Support and execute a “hub and spoke/Centers of Excellence Strategy, supported by telemedicine, telenavigation, tele-Tumor Boards, etc. HS, LP, HP, C
- Providers target outreach – with Grand Rounds to community organizations, local hospitals, etc. HS, LP, C
- Payers provide financial incentives for meeting quality targets for providers and patients alike HP, G
- Elevate GI’s Medicaid reimbursement to be at Medicare rates G
- Provide coverage for navigators, transportation and certified genetic counselors HP, G
- Get grant and other funding for parts of the “system” that aren’t covered G

**3. What can different stakeholders do to overcome these barriers? (See stakeholder designations above.)**

- MOST IMPORTANT – Come together, plan together, and improve together – and keep natural competition out of the convenings COL
- Create a clear governance structure/framework for stakeholders to work together COL
- Become knowledgeable about, and use, existing resources COL
- Then, each party supports improvement in their own way and is incented only for real progress COL, HS, HP, C, G, LP

- A commitment to identify a unified set of goals and measures for quality colorectal and breast cancer care **COL**
- Enhance reimbursement for particular essential services (e.g., colonoscopies performed on weekends) **HP, G**
- Develop assistance programs to support insured patients facing barriers to care due to cost-sharing, particularly for the working poor **HP, G**

**4. What political, financial and operational resources do we need for a successful cancer collaborative? How can you and your organization support this statewide collaborative?**

- Devoted and high-quality staff support to do research, gather data, conduct analyses, provide clean targets and starting points, support roll out and report results
- Neutral party “honest broker” to bring people together
- Need to not lose momentum
- Monthly calls and quarterly meetings
- Need to all work in “good faith” and keep competition out of the room
- Need to keep any negative information close at hand until everyone becomes comfortable with collaborating
- Financial support for Collaborative functioning on an ongoing basis
- Common payment structures that incent and support best practice care
- Consumer/patient incentives to support screening and treatment adherence
- Health insurance benefits that are simple and easy for members to understand