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CLINICAL LINKAGES: A MODEL FOR PROVIDING CANCER CARE IN A RURAL SETTING

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This article outlines a successful model for improving cancer treatment linkages among tertiary and rural hospitals. With the help of the Robert Wood Johnson Foundation and a private, regional foundation, two hospitals based in South Carolina—Richland Memorial Hospital and Kershaw County Hospital—jointly developed a pilot cancer care outreach program that enables patients initially treated at a cancer center to return to their community for continued treatment.

Many rural hospitals in the United States are experiencing significant financial problems as a result of declining and fluctuating occupancy rates, low levels of reimbursement from both Medicare and Medicaid, and depressed local economies. Because rural hospitals are often served only by primary care physicians, cancer patients are frequently referred to specialists at tertiary hospitals. This referral pattern has further contributed to a declining inpatient census and decreased access to specialty services at the rural hospital level.

Moreover, many primary care physicians are reluctant to refer patients to specialists at tertiary care centers, because they do not believe those specialists will communicate with them about the patients' treatment and prognosis or send the patients back to the rural community for appropriate follow-up care.

Promoting Rural Care

In an effort to strengthen the ability of rural hospitals to provide high-quality health care, and to promote the financial stability of rural hospitals, the Robert Wood Johnson Foundation initiated the Hospital-Based Rural Care Program in 1987. South Carolina was one of the 14 initial sites selected for funding, because of its large rural population (approximately 46 percent of all residents) and a significant number of rural-based hospitals (36).

Although a variety of programs are being developed by South Carolina hospitals through this grant, a high priority has been assigned to improving organizational arrangements by forming linkages among tertiary and rural hospitals, enhancing access to specialists at the tertiary level, and expanding revenue bases at the rural level.

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The need for such linkages is obvious on the part of rural hospitals. However, such interactions also benefit teaching hospitals.

According to a study by the Health Care Advisory Board of Washington, DC, building relationships with physicians in outlying areas should be a key component of a tertiary hospital's marketing plan, because 58 percent of nationwide admissions result from referrals by primary care physicians. For specialties, such as hematology and oncology, the percentage of referrals is even higher.

Barriers to Access

The availability of specialized services, such as oncology, is limited at rural hospitals for a variety of reasons. First, it is extremely difficult to recruit sub-specialty physicians to rural areas that most likely do not have the population base to support a full-time practice. In addition, specialists, such as oncologists, view the professional isolation of a rural practice as a significant issue. Second, there is an acute nursing shortage in rural areas, which further impairs the development of specialized services. Third, many believe the mission of rural hospitals is to provide primary care, and that citizens will travel to urban areas for specialty services. However, with the increasing specialization of medical practice, rural citizens are finding that they must travel to tertiary care facilities—often at a distance of 50 to 70 miles each way—for more services, more frequently, than in the past. For many cancer patients, especially elderly patients who do not drive and patients who are already weakened as a result of active therapy, travel becomes a hardship that may affect compliance with therapy.

According to 1989 data from the South Carolina Department of Health and Environmental Control, cancer is a leading cause of death in the state; second only to heart disease. However, because of demographic patterns, many of the state's cancer patients live in isolated, rural areas. As a result, even though South Carolina is a relatively small state, both a lack of transportation and personal funds are limiting rural residents' access to specialized cancer care.

Given these realities, alternatives for delivering specialized services at the local level must be found. In researching this problem, the South Carolina Hospital Association discovered that other states with large rural areas, such as Kansas and Montana, were using facsimile (FAX) machines to facilitate communications between urban and rural doctors. Through this linkage, medical charts, laboratory tests, and other patient information is transferred to tertiary care centers when rural physicians need second or supporting opinions. Such consultations enable rural doctors to perform services which they might not otherwise feel confident in providing, and it allows patients to receive some services closer to home.

The South Carolina Experience

In an effort to improve urban-rural clinical linkages in South Carolina, plans were made to develop a pilot cancer outreach program in which patients treated by oncologists at a tertiary hospital would be returned to the rural hospitals in their communities for continued treatment. It was believed that such a pilot project would be immediately beneficial to the patients, the community, and the rural hospital, and would help to solidify the tertiary hospital's future referral base.

To improve urban-rural clinical linkages, plans were made to develop a pilot cancer outreach program in which patients treated by oncologists at a tertiary hospital would be returned to the rural hospitals in their communities for continued treatment

Richland Memorial Hospital (RMH)—a community teaching hospital in Columbia, SC—was identified as an excellent site for the pilot project, because half of the 1,000 new cancer patients treated at the facility each year resided outside of the greater Columbia area. After several exploratory meetings with the medical and administrative staff at RMH's cancer center, an analysis of cancer registry data was undertaken. The analysis showed that more than 100 patients per year were being referred from the rural community of Kershaw County, SC. Most of these patients were elderly, they had common forms of cancer (i.e., breast and colon) and, when indicated, they were being treated with standard adjuvant therapy.

In addition, a positive relationship already existed between members of the medical staffs at the two institutions and there was enthusiasm about the proposed project. The administrative staffs in both hospitals had worked together on several other projects in conjunction with the South Carolina Hospital Association, and the cancer center staff at RMH had the necessary expertise to help organize an outreach clinic at the Kershaw facility.

Finally, a private regional foundation agreed to provide funding for key equipment needs and staff training. In short, Kershaw County Hospital seemed to be an ideal site for a pilot cancer outreach clinic.

Program Development

At this juncture, the local project director established a planning committee. The cancer center's representatives included the program coordinator, the oncology clinical nurse specialist, the associate director of pharmacy, and members of the medical staff and the finance department, as needed. Members of the Kershaw staff included the administrator and associate administrator, the director and associate director of nursing, and a clinical pharmacist.

This group met several times during the summer of 1989 to develop operational policies and procedures, including a mechanism for educating members of the nursing staff at Kershaw in the therapeutic administration of chemotherapy. The planning committee also implemented a communications system linking tertiary physicians' offices with the Kershaw clinic via FAX machines, to ensure the transfer of pertinent patient records (physician orders, laboratory reports, and patient consent

PROGRAM GOALS

- ✔ To provide select chemotherapy, diagnostic studies, and supportive care to Kershaw County residents at the Kershaw County Hospital.
- ✔ To coordinate ongoing cancer care with local, referring physicians.
- ✔ To jointly develop other cancer services in Kershaw County as a means of returning treatment to the rural community setting.
- ✔ To solidify patient referrals to Richland Memorial Hospital's regional cancer center.
- ✔ To improve continuing medical staff education in the rural community and to reduce the sense of professional isolation experienced by physicians in a rural setting.
- ✔ To develop a model program of clinical linkages that can be replicated at other rural sites throughout the state and the nation.

PATIENT SELECTION CRITERIA

Eligible Patients

- ✔ Patients receiving ongoing chemotherapy who, after the first course of therapy is completed, are thought to be stable candidates for remote treatment.
- ✔ Patients requiring interim medications or chemotherapy between regular follow-up visits (e.g., days 2-5 of a treatment cycle, IV, antibiotics, etc.)
- ✔ Stable patients requiring transfusions with blood and/or blood products.

Ineligible Patients

- ✔ Patients on clinical trials who are still on therapy.
- ✔ Patients on complex treatment regimens that require close monitoring of their response.
- ✔ Patients who prefer to be treated at a tertiary care center.

forms, etc.). The committee established a six-month timeframe to allow for renovation of existing space, the procurement of a laminar flow hood, the development of needed administrative support, and the recruitment and training of nursing staff.

Concurrently, Robert Wood Johnson's project director and the program coordinator from Richland met with the medical staffs in both Columbia and Kershaw to negotiate a new relationship. Issues such as patient referrals, when to admit patients to the Kershaw clinic rather than Richland's cancer center, and the role of rural physicians within the clinic were addressed. Because little financial risk was involved, the medical staffs' opted for an informal, rather than a contractual, relationship.

A budget was established by both hospitals. Because existing space and educational programs were utilized, the start-up costs (including staff time) were minimal for each institution. Funding from the private foundation was used to cover capital, staff training, and incidental costs. No new staff were anticipated. Rather, nursing staff from the emergency room and a medical unit were trained. The ability to employ flex staffing was a critical element of cost containment and project feasibility.

Clinic Implementation

The clinic accepted its first patients in December 1989. Although accrual has been slow (a small group of 16 patients, most of whom have cancer, are now being treated at the outreach clinic), patient and family satisfaction with the quality of care at the outreach clinic has been consistently high. Because the clinic is close to home and operates by appointment, there is minimal travel or waiting time and ample individual attention to patients' needs.

Physician satisfaction has also been high. More physicians are participating in the program, and the referral network is growing. Newspaper articles linking the tertiary facility with the community hospital have resulted in image enhancement for both facilities and increased referrals from adjacent communities.

In addition to the chemotherapy service, the Kershaw staff now conducts patient education programs. They have offered several stand-alone programs as well as an "I Can Cope" series which more than 60 local patients have completed.

The outreach clinic has become a model of a new clinical service that can be successfully replicated by other rural hospitals. In fact, a second rural hospital has been selected to work with Richland Memorial Hospital. This second hospital is slightly larger, it has a more diversified medical staff, and it operates a weekly oncology clinic. As a result, it is anticipated that a broader selection of patients will be managed locally and have access to a wider variety of treatment protocols.

Given the experience gained at the Kershaw site, the planning and development phases have moved rapidly at the second site. Questions and barriers were anticipated and addressed during the initial meeting of the facilities' medical staffs.

In addition, an oncology unit is being established, and an oncologist at a neighboring institution has been appointed as its medical director. When the medical director is not on-site, local internists will manage patients with the aid of a communications system similar to that at the Kershaw facility. Critically ill patients, and those requiring complex treatment protocols, will still be admitted to the Richland Cancer Center.

Summary

This program is a model of specialty clinical linkage between a rural hospital and a tertiary hospital. Both hospitals believe it is a beneficial arrangement that will enhance future relationships. However, the true beneficiaries are the patients, who now have access to specialized cancer treatments in their immediate area; near the support of family and friends at a time when such support is most needed. ■

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Reimbursement Assistance

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