Country Docs With City Technology Can Address Rural Cancer Care Disparities

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As technology has affected every segment of society, we in the oncology community have a responsibility to make every effort to utilize these advances to enable the broadest possible outreach to our patient population in a continual process of quality improvement.

As the national shortage of oncologists becomes more apparent over the next decade, the existing gulf in services between urban and rural patients will increase exponentially. Beginning with the basics of access to cancer care, 20% of the US population resides in rural areas, but only 3% of medical oncologists practice there. Two Iowa studies[2,3] documented an average one-way travel time of about 1 hour for chemotherapy and 90 minutes for radiotherapy for rural patients. This has resulted in patients making therapeutic choices based on employment and transportation issues rather than on health issues alone. A clear example of this is the increased frequency of mastectomy over breast conservation in rural communities.[4]

Rural patients also have more limited health insurance coverage than their urban counterparts. A striking observation is that nearly two-thirds of the rural uninsured who could have been covered by the Affordable Care Act (ACA) are living in states that are not expanding Medicaid, so they are not able to benefit from the health insurance exchanges.[5] This places an additional burden on rural oncologists in traditional fee-for-service private practices who may not be integrated into organized hospital-based healthcare delivery systems. It is much easier for an oncologist to limit a private practice based on insurance status in an urban setting where alternate providers exist than in a rural setting where there is no one else that the patient can see.

Rural patients also deal with diminished availability of a comprehensive set of psychosocial support networks, including palliative and hospice care. Financial support remains at the root of this problem. Charlton et al carefully identified multiple strategies to address these issues, including outreach clinics, teleoncology systems, virtual tumor boards, and workforce initiatives. All of these methods are of value and should be considered and adapted to local and regional realities.

The Lake Tahoe Experience

When creating our Tahoe Forest Cancer Program in Lake Tahoe, California, we had the advantage of having no legacy oncology services for a rural catchment area of 50,000 people. The closest city with cancer services was Reno, Nevada (45–90 minutes away), and the closest university cancer center was the University of California, Davis (UC Davis; 90–120 minutes away). We built our program as a hospital-owned facility, seeing our first patient in 2006. Within 2 years we joined the UC Davis Cancer Care Network and inaugurated our virtual tumor board program with them. UC Davis already had their weekly disease-specific tumor boards scheduled, so it was natural to expand them into a virtual network with four satellite facilities on their existing schedule of Monday—gastrointestinal, Tuesday—genitourinary, Wednesday—thoracic, and Thursday—breast (approximately 80% of all cancer cases come from these four tumor types). By focusing on these four tumor types, we were able to create the necessary infrastructure to manage the remaining tumor types quite well. Participating on these daily tumor boards allowed us to develop a truly collegial relationship with the medical and support staff of a National Cancer Institute–designated comprehensive cancer center, thereby facilitating second opinions, advanced surgical referrals, and advanced therapy such as stem cell transplantation, as well as accrual to active clinical trials both at...
UC Davis and locally. Preparation time for the tumor boards has now become quite minimal as our comfort level has stabilized.[6,7]

Once our physicians became more secure in front of a camera, we were able to establish four remote telemedicine locations. Each location is staffed by a nurse practitioner or physician assistant in an exam room outfitted with appropriate telecommunication equipment. Chemotherapy and radiotherapy are still given at our primary site, but the follow-up visits, including the “day-10 CBCs,” are done via telemedicine. Our patients greatly appreciate the ability to stay local instead of driving 1 hour in a snowstorm for a routine office visit. For those patients getting chemotherapy or radiotherapy, we obtained philanthropic support enabling our patients to have a hotel room for $25/night, which is often less than the cost of fuel.

Just as the needs of bush pilots in Alaska helped drive the development of current navigation and communication systems used throughout the world, addressing the needs of remote rural cancer patients can drive the creation of improved systems for all patients with a real or perceived disparity in access to quality care.

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**References:**


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