Panel IV: Linkage to Healthcare and Retention in the Cancer/Specialty Care Consortium

Moderator: Chelsea Kroll, MSM, LMSW, OSW-C

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Specialty Care for Vulnerable Populations
Care Collaborations & Patient Support

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Lung Cancer Prevention in Vulnerable Populations

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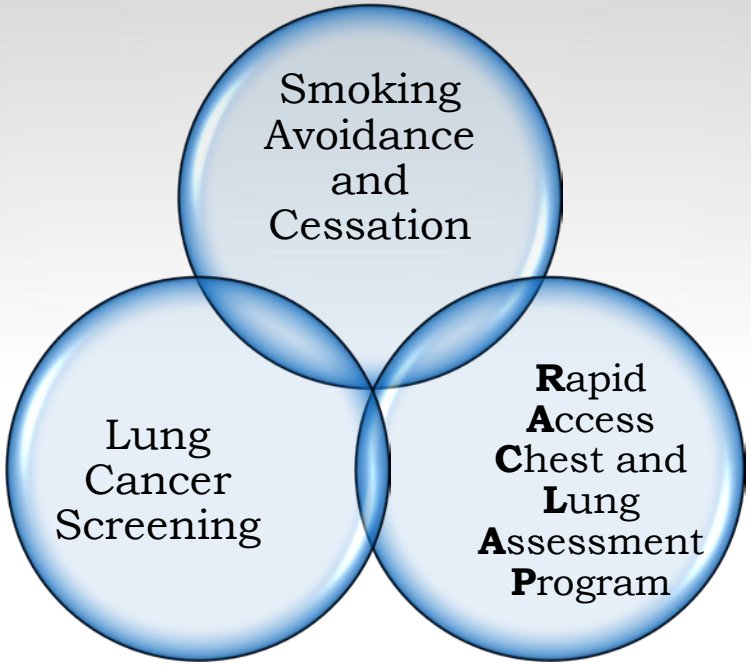
Stephen Cattaneo, MD, FACS
Maria Geronimo MSN, MBA
DeCesaris Cancer Institute
Anne Arundel Medical Center

Kasia Sweeney, BS, MBA
Arati Patel, MD
Calvert Memorial Hospital

Project Goals and Objectives

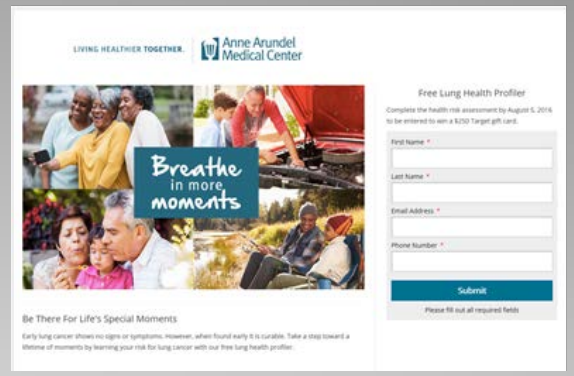
Expand program for primary and secondary lung cancer prevention in vulnerable populations in Anne Arundel, Calvert, and Prince George's Counties



Smoking Prevention

Smoking Cessation

Are you at Risk?



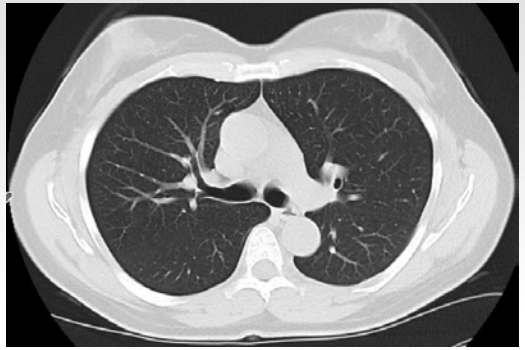
Lung Cancer Screening

Current Smoker

Anne Arundel Medical Center

Calvert Memorial Hospital

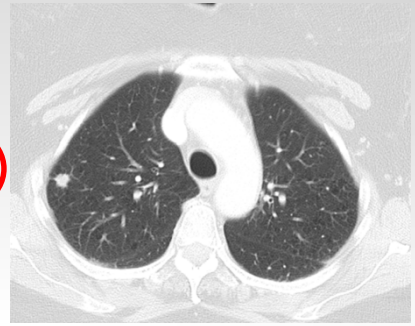
- CT



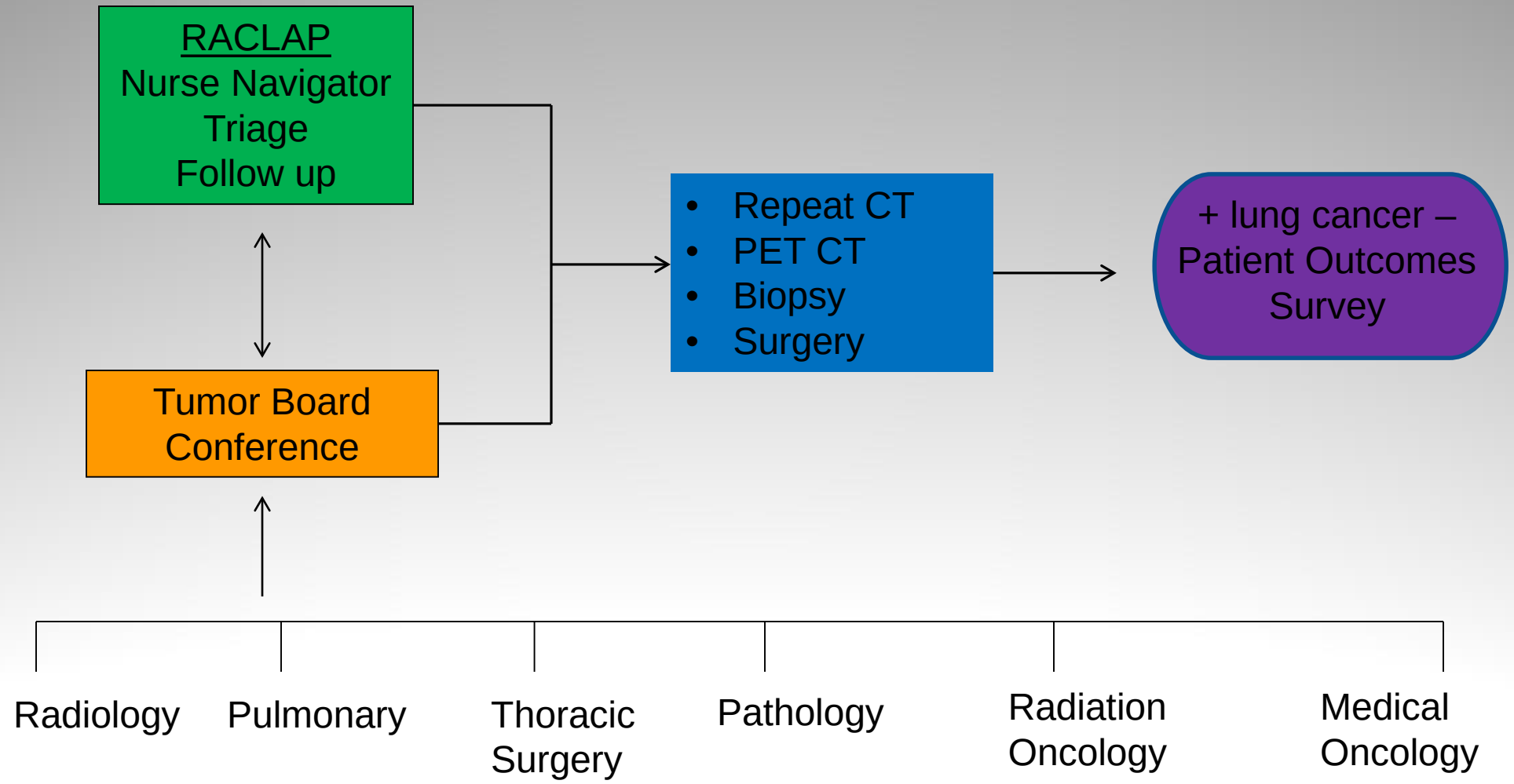
LRAD 1& 2 - **PLEASE** return in 1 year!

OR

+ CT



LRAD 3- repeat in 6 months
LRAD 4 – RACLAP


RACLAP
Nurse Navigator
Triage
Follow up
Tumor Board
Conference
Repeat CT
PET CT
Biopsy
Surgery
+ lung cancer –
Patient Outcomes
Survey
Radiology
Pulmonary
Thoracic
Surgery
Pathology
Radiation
Oncology
Medical
Oncology

Key Lessons

Successes

- Implementation of lung cancer screening program at CMH
- Outreach and education to community
- Replicated NLST outcomes in a community setting
- Statewide Initiative for lung cancer screening (DHMH)

Barriers

- Adherence to annual follow up
- Difficulty obtaining completed patient outcome surveys
- Hispanic population
- Follow up for + CTs underinsured/uninsured
- Incomplete documentation
- Administrative turnover
- Competing Interests
- Fragmented care in Prince George's county

https://vimeo.com/208714420

Creating an Optimal Care Coordination Model for Lung Cancer Patients on Medicaid

Association of Community Cancer Centers (ACCC)
Amanda Kramar, Chief Learning Officer

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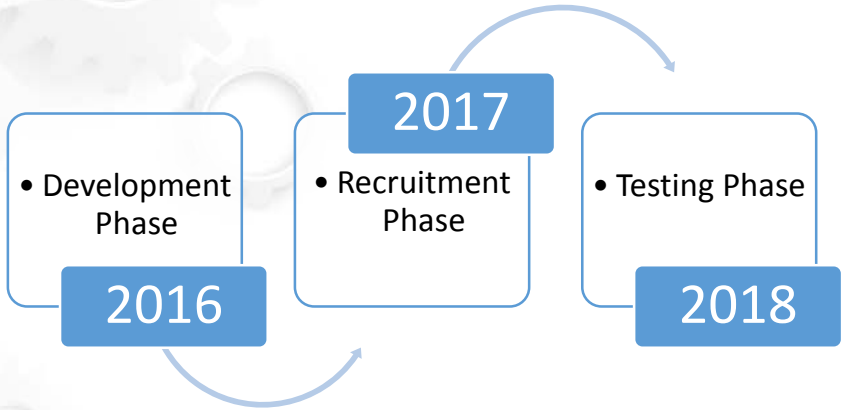
Project Goal and Timeline

- Goal
  - Create an Optimal Care Coordination Model (OCCM) that reduces disparities related to access to care for lung cancer patients on Medicaid
- Timeline
  - ✓Phase I: January 2016-December 2016
    - ✓Development Phase
  - ➢**Phase II: January 2017-September 2017**
    - ➢**Recruitment Phase**
  - ➢*Phase III: October 2017-December 2018*
    - ➢*Testing Phase*



Why develop the OCCM?

- Provide practical guidance to cancer programs to achieve patient-centered, multidisciplinary, coordinated care for lung cancer patients on Medicaid
- Designed to be used by any cancer center, regardless of program size, location, and resource level
- Focuses on 13 high-impact areas of patient care

Summary of Phase I Milestones

- Development Phase
  - January 2016-December 2016
  - Accomplishments
    - ✓ *Drafted Environmental Scan*
    - ✓ *Selected 5 ACCC Cancer Program Member Sites to serve as Development Sites*
      - Development Sites:
        - Florida Hospital Memorial Medical Center, Daytona Beach, FL
        - Mary Bird Perkins-Our Lady of the Lake Cancer Center, Baton Rouge, LA
        - MaineGeneral Health-Harold Alfond Center for Cancer Care, Augusta, ME
        - Genesis HealthCare System, Zanesville, OH
        - Sidney Kimmel Cancer Center-Methodist Hospital, Philadelphia, PA

    - ✓ *Held In-Person Advisory Committee and Technical Expert Panel Meetings*
    - ✓ *Recruited Lead Clinical Research Consultant*
      - Dr. Raymond Osarogiagbon, MBBS-Baptist Cancer Center, Memphis TN

Developing the OCCM

- Builds directly upon the Multidisciplinary Care Assessment Tool created by the NCI Community Cancer Centers Program (NCCCP)
- 13 Assessment Areas
  1. Patient Access to Care**
  2. Prospective Multidisciplinary Case Planning**
  3. Financial, Transportation, and Housing**
  4. Management of Comorbid Conditions
  5. Care Coordination**
  6. Treatment Team Integration**
  7. Electronic Health Records and Patient Access to Information**
  8. Survivorship Care
  9. Supportive Care
  10. Tobacco Cessation
  11. Clinical Trials
  12. Physician Engagement
  13. Quality Measurement and Improvement

**Designated as priority Assessment Areas by the Advisory Committee

MDC Assessment Tool

Assessment Area	Evolving MDC (Level 1)	Developing MDC (Level 2)	MDC (Level 3)	Moving towards Excellence (Level 4)	Achieving Excellence (Level 5)
Case Planning	Care planning is asynchronous with patient presenting to multiple physician offices without a shared medical record.	Care planning is asynchronous with patient presenting to multiple physician offices with a shared medical record.	Most care planning is asynchronous, but some patient care plans are discussed in multidisciplinary conferences, which occur on a weekly basis.	All patient care planning is done through a multidisciplinary conference, which occurs on at least a weekly basis.	All patient care planning is done through a multidisciplinary conference, which occurs while the patient encounters care.
Physician Engagement	Diagnostic and treatment physician belong to multiple independent groups, with little interaction, and a representative from some groups is engaged with the cancer center.	Diagnostic and treatment physician belong to multiple independent groups, with little interaction, and at least one representative from each group is actively engaged with the cancer center.	The MDC has a physician agreement of participation, and physicians are actively engaged in developing treatment standards.	Same as prior, with the addition of engagement in quality improvement initiatives and strategic direction.	Same as prior, with the addition of physicians have operational and financial authority for the MDC.
Coordination of Care	Patient care is episodic. Patient has to present to multiple locations on multiple days for treatment and or diagnostic modalities. Information is stored in multiple locations, and difficult to coalesce.	Patient care is episodic, but some treatment and diagnostic modalities are coordinated. Information is coordinated and is readily available to physicians and staff.	MDC has some dedicated diagnostic and treatment abilities to meet patient's care needs. Information is readily available to physician and staff.	MDC is fully integrated with treatment and diagnostic modalities, and all information is available from a single source.	Same as prior, with the addition of ancillary services such as education, support groups, and wellness programs for patients and families.
Infrastructure	Limited physical infrastructure with limited information system support. Hospital, physician office model.	Limited physical infrastructure with integrated clinical and administrative information systems used by all.	Some dedicated physical facilities, which do not cover the full spectrum of care, with independent clinical and administrative information systems.	Some dedicated physical facilities, which do not cover the full spectrum of care, with integrated clinical and administrative information systems.	Dedicated center with ability to provide full service to patients with integrated information systems.
Financial	Billing is episodic, based on encounter with facility or physician. No facility fee is applied.	N/A	Physicians bill separately. Introduction of facility fee for MDC. Communication between MDC and physician offices.	N/A	Global bill for MDC billing, inclusive of facility fee.
Clinical Trials	Patient not reviewed for eligibility for clinical trials. No literature given to patient on clinical trials.	Some patients reviewed for eligibility. No formal process to review patients for clinical trials. Clinical trial literature given to patient.	2% of patients participating in clinical trials. There is a formal accrual and recruitment plan. Clinical trial literature given to all patients.	4% of patients participating in clinical trials. There is a formal accrual and recruitment plan. Clinical trial literature given to all patients.	6% of patients participating in clinical trials. There is a formal accrual and recruitment plan. Clinical trial literature given to all patients.
Medical Records	Paper chart plus some EMR with isolated pockets.	Mainly for documentation reasons only. Medical information is not integrated. Little to no sharing. Mixture of paper and electronic.	Mixture of paper and EMR. Starting to share labs, radiology, medical history, treatment plans, and medications.	75% of hospital system and physician offices is integrated electronically across the continuum.	Fully integrated electronic record across the continuum with access to information.

Level 1—Evolving MDC Program
This level describes organizations that meet regulatory requirements and Association of Community Cancer Centers (ACCC) guidelines. There are a few performance improvement initiatives underway, and some centers of excellence. The leadership vision for quality is unclear. The organization lacks sufficient personnel and financial resources to administer a fundamental program that supports conducting MDC initiatives designed to attain improvements in patient care, quality, safety, and efficiency.

Level 2—Moving Towards MDC Program
Organizations at this level have some of the fundamental structures and processes for achieving MDC initiatives. The leadership vision for quality is under development. Some personnel and financial resources are available to support the organization attain some improvements in patient care, quality, safety, and efficiency, but they are insufficient for a comprehensive program.

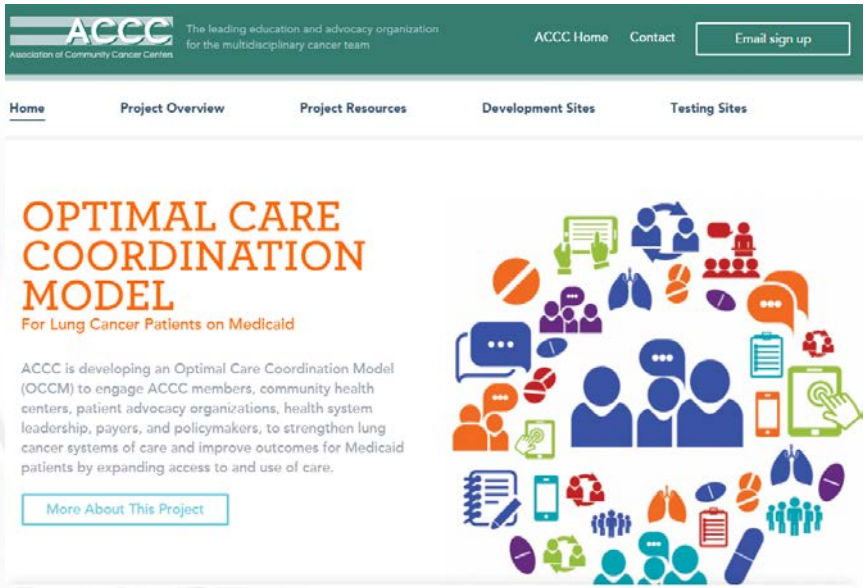
Level 3—MDC Program
Organizations at this level have many of the fundamental structures and processes for running MDC initiatives. Leadership's vision for quality is known to many in the organization. Personnel and financial resources are available to support the organization in attaining a number of changes in the improvement of patient care quality, safety, and efficiency, and changes largely are driven by the cancer center staff.

Level 4—Moving Towards MDC Excellence
Organizations at this level have many significant structures and processes for deploying MDC initiatives. Personnel and financial resources are available to support the organization in attaining many important changes and improvements in patient care, quality, safety, and efficiency. Some staff outside the cancer center play lead roles in fostering initiatives.

Level 5—Achieving MDC Excellence
Organizations at this level have many best of class structures and processes deploying MDC initiatives. Personnel and financial resources are spread throughout the organization and available to support the attainment of many important, leading, and creative changes and improvements in patient care quality, safety, and efficiency. Many staff outside the cancer center play lead roles in fostering initiatives and achieving results. This level also provides organizations with stretch goals.

Phase II

- Recruitment Phase
  - January 2017-September 2017
  - Accomplishments
    - ✓ *Launched Updated Project Website*
    - ✓ *Released RFA to ACCC Cancer Program Members to Participate in Testing Phase (Phase III)*
  - In Progress
    - ❑ *Select Testing Sites Applicant Pool*
      - *Applicants will propose quality improvement (QI) projects for their individual cancer centers to test OCCM*



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Phase III

- Testing Phase
  - October 2017-December 2018
  - Plans
    - *Selected Testing Sites Will Assess Usability and Feasibility of OCCM by Implementing Their Proposed QI Projects*
      - 12 month testing phase (October 2017-September 2018)
    - *Technical Reports*
      - *Will draft reports based on testing data collected for possible publication*

Linking West Virginia Lung Cancer Patients to Case Management Support

A Partnership Between the Patient Advocate Foundation and WVU Cancer Institute

Shonta Chambers, PI
Stephenie Kennedy, PI
Jenny Ostien, Project Manager
Amie Muraski, Project Coordinator

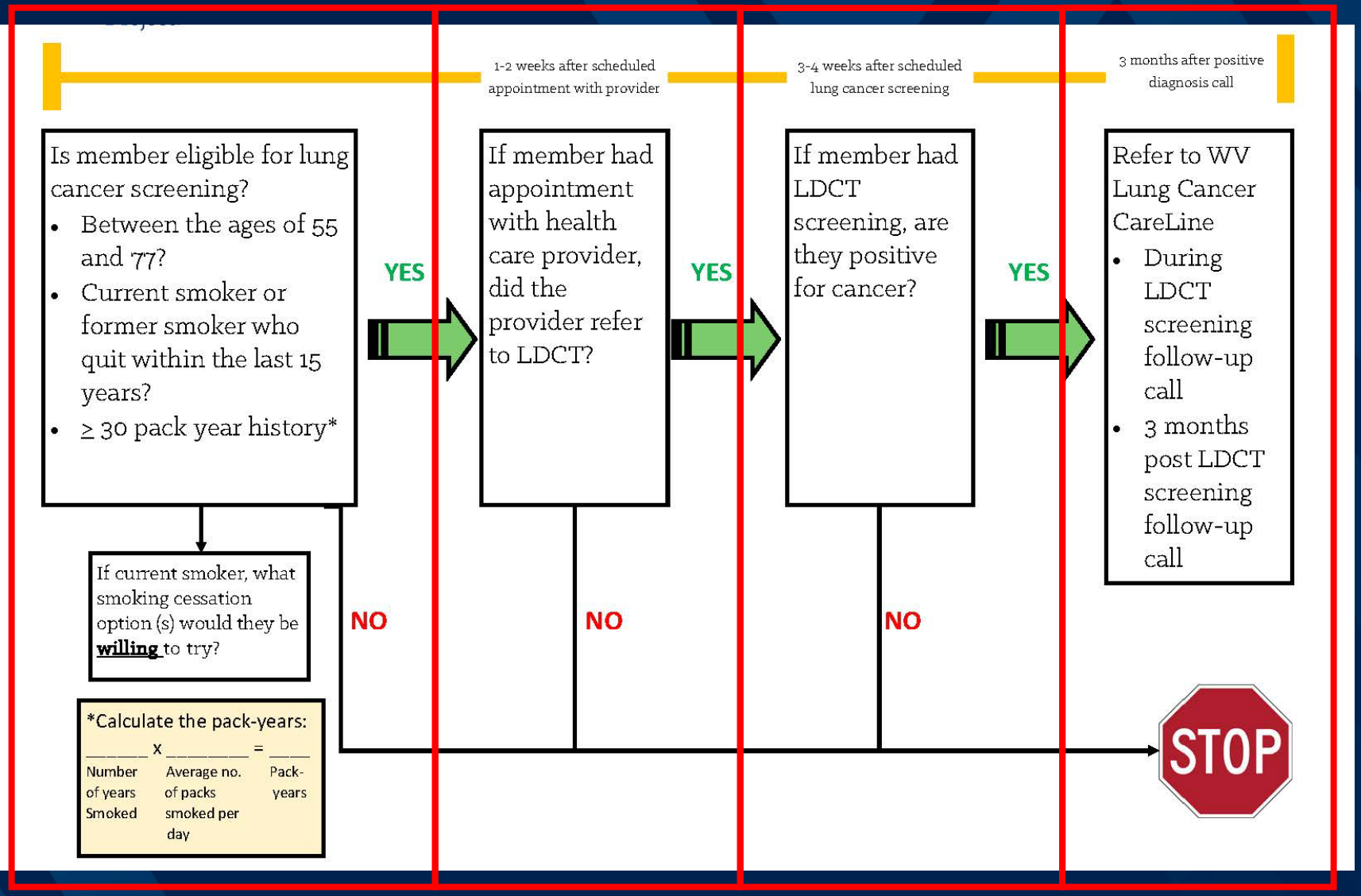
WestVirginiaUniversity.

Purpose

- Decrease lung cancer mortality
- *Increase early diagnosis of lung cancer
- Provide specialized support for WV lung cancer patients
- Educate health care providers and the public about lung cancer screening

WestVirginiaUniversity.

Strategic Outreach



Four Phases:

1. Pre-screening
2. Clinical encounter follow-up
3. LDCT follow-up
4. CareLine follow-up

Patient Stories

- 64 yo female
- 30 pack-year history
- Spot on LDCT

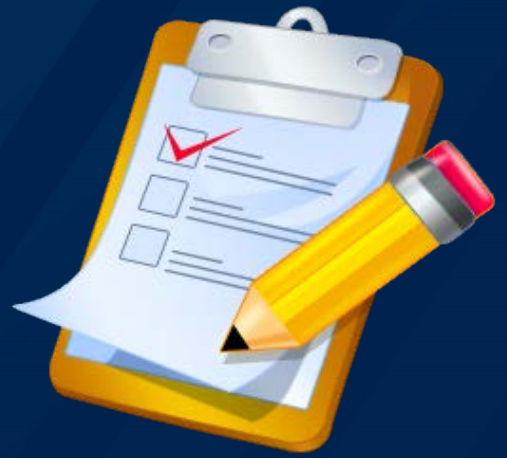
- 59 yo male
- 46 pack-year history
- Mass pushing against esophagus and heart

Progress

- Current smokers identified: 170
- Smokers not reached: 5

} 97% contacted

- Average pack year history: 34.60
- Members eligible for LDCT: 44
- To date, scheduled for referral appointment: 19
- To date, scheduled for lung cancer screening: 4
- To date, completed screening: 2



Strategic Outreach Protocol

- Unique tool development
  - Developed with stakeholder involvement
  - Pilot tested
  - Revised and disseminated
- Template for remaining partners

Mobile Outreach Retention & Engagement
Doing MORE for HIV

Whitman-Walker Health

Krishna Kothary, Malachi Stewart, & brittany walsh

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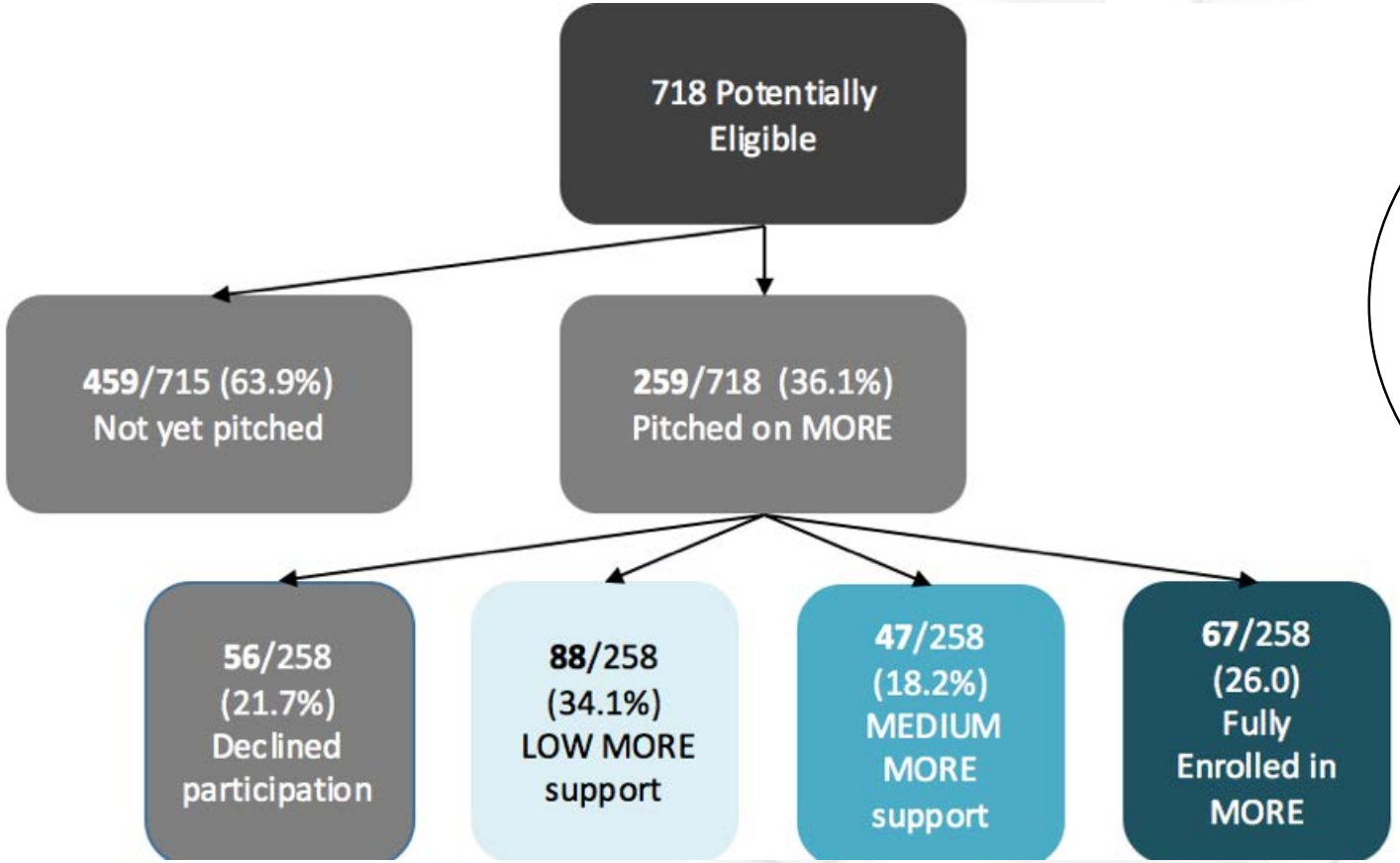
MORE: Summary

MORE takes care out of the four walls of a health center to, literally, wherever the patient is. By providing mobile support in addition to clinical care in a non-traditional setting, we increase access to health education, navigation, lab work, and medical service while we build relationships that allow for greater collaboration. When we get to know patients in their homes, we better identify resources and opportunities to work with them towards their best health.

Project Results: Recruitment Flow (first year)



- *Team Roles*
  - *Care Navigator*
  - *Medical Provider*
  - *Health Educator*
- *Service Flow*
  - *Intake and Referrals*
  - *Scheduling*
  - *Graduation*

Lessons Learned

Of 202 participants in 1st year….

- **45% were between the ages of 35-54**, followed by 20-34 (34%), and 55+ (21%).
- **84% live in DC**, with the highest percentages in Ward 5 (12%), Ward 7 (15%), and Ward 8 (16%).
- **82% identified as African American**, followed by white (11%).
- **7% identified as Hispanic or Latino**.
- **46% identified their sexual orientation as gay, lesbian, homosexual**; followed by heterosexual (31%); bisexual (7%); other (7%); or not reported (8%).
- **27% are in temporary (17%) or unstable (10%) housing** situations.
- **Almost two-thirds receive Medicaid (60%),** followed by Medicare (18%).
- **60%** have mental health diagnosis or substance abuse history

Program showed **decreased VL and increased access to labs** across all groups

Lessons Learned

- Trust building
- Power of community
- Ability to educate and counsel patients
- Patient gratitude
- Appreciation to learn from clients environment
- We can make a difference!

Challenges & Areas for Improvement

Challenges

- Social determinants of health
- Medical complexity difficult to address in the field
- Mental health and substance abuse
- Emotional involvement with difficult cases
- Varying levels of engagement
- Funding

Areas for Improvement

- Expansion of services: vaccinations, other shot administration
- Mental health staff
- Ongoing navigation of the health care system
- Rapid point of care testing
- General knowledge of other health conditions

Questions?

Thank you