Lung Cancer Prevention in Vulnerable Populations

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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 Avoidance and Cessation
- Rapid Access Chest and Lung Assessment Program
- Lung Cancer Screening
Smoking Prevention

Smoking Cessation

Are you at Risk?

Lung Cancer Screening

Current Smoker

- CT

OR

+ CT

LRAD 1 & 2 - PLEASE return in 1 year!

LRAD 3- repeat in 6 months
LRAD 4 – RACLAP

Anne Arundel Medical Center

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

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

accc-cancer.org
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

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**Table: OCCM Assessment Tool**

<table>
<thead>
<tr>
<th>Assessment Area</th>
<th>Expected MDG (Level 1)</th>
<th>Developing MDG (Level 2)</th>
<th>Reaching MDG (Level 3)</th>
<th>Exceeding MDG (Level 4)</th>
<th>Achieving Excellence</th>
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**Level 1—Expected MDG Program**

Organizations that have not yet met the expected outcomes for the OCCM are considered Level 1 programs. These programs are encouraged to develop processes and systems to address gaps in care and to improve the overall quality of care. The OCCM is designed to help organizations identify areas for improvement and achieve the expected outcomes.

**Level 2—Developing MDG Program**

Organizations that have met the expected outcomes for the OCCM are considered Level 2 programs. These programs are encouraged to develop processes and systems to further improve the overall quality of care and to address additional areas for improvement.

**Level 3—Reaching MDG Program**

Organizations that have met the expected and developing outcomes for the OCCM are considered Level 3 programs. These programs are encouraged to develop processes and systems to further improve the overall quality of care and to address additional areas for improvement.

**Level 4—Exceeding MDG Program**

Organizations that have met the expected, developing, and reaching outcomes for the OCCM are considered Level 4 programs. These programs are encouraged to develop processes and systems to further improve the overall quality of care and to address additional areas for improvement.

**Level 5—Achieving Excellence**

Organizations that have met the expected, developing, reaching, and exceeding outcomes for the OCCM are considered Level 5 programs. These programs are encouraged to develop processes and systems to further improve the overall quality of care and to address additional areas for improvement.

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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
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

West Virginia University
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
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
- 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

97% contacted
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
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

- 718 Potentially Eligible
  - 459/715 (63.9%) Not yet pitched
  - 259/718 (36.1%) Pitched on MORE

- 56/258 (21.7%) Declined participation
  - 88/258 (34.1%) LOW MORE support
  - 47/258 (18.2%) MEDIUM MORE support
  - 67/258 (26.0%) Fully Enrolled in MORE
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