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INTRODUCTION

- Lung cancer remains the leading cause of cancer-specific mortality in the United States (U.S.)¹
- Gaps in the quality of cancer care delivery persist among certain patient populations owing to prevailing social determinants of health,² and contribute to suboptimal outcomes³⁻⁴
- In 2016, the Association of Community Cancer Centers (ACCC) launched a 3-year initiative to develop, test, and refine an Optimal Care Coordination Model (OCCM) to address disparities in lung cancer outcomes between Medicaid and non-Medicaid patients
 - The Model's design was adapted from the multidisciplinary care assessment tool of the National Cancer Institute Community Cancer Centers Program⁵

Figure 1: Assessment areas in the beta Model

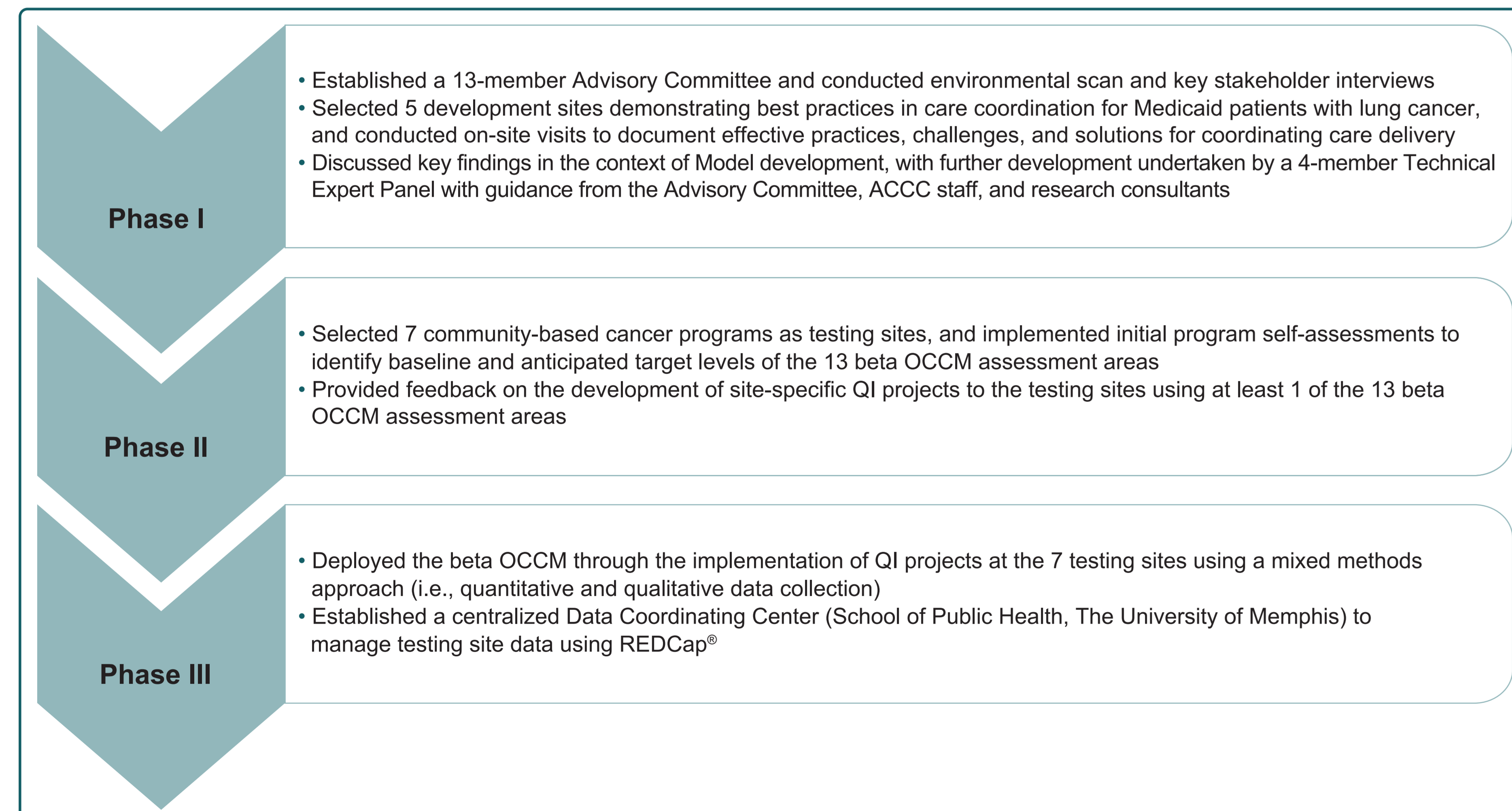
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| 1. Patient access to care | 8. Survivorship care |
| 2. Prospective multidisciplinary case planning | 9. Supportive care |
| 3. Financial, transportation, and housing needs | 10. Tobacco cessation, including evaluation of use |
| 4. Management of comorbid conditions | 11. Clinical trials |
| 5. Care coordination | 12. Physician engagement |
| 6. Treatment team integration | 13. Quality measurement and improvement |
| 7. Electronic health records and patient access to information | |

OBJECTIVES

- To understand how participating cancer programs use the Model to conduct self-assessments of care delivery supported by evidence-based, measurable quality metrics; identify the current level of care coordination and a corresponding target level (achievable or aspirational) to facilitate improvements; and ultimately, improve care delivery for Medicaid patients with lung cancer
- To ensure that the Model can offer practical and easy-to-use guidance to cancer programs interested in advancing multidisciplinary coordinated care for Medicaid patients with lung cancer

METHODS

Figure 2: Phases of the OCCM initiative



ACCC, Association of Community Cancer Centers; OCCM, Optimal Care Coordination Model; QI, quality improvement; REDCap, Research Electronic Data Capture.

- For quantitative analysis of data on patient demographics, baseline disease and care pathway characteristics, and quality benchmarks:
 - Summary statistics were computed; associations between categorical variables were compared using the chi-square test or Fisher's exact test, and continuous outcomes were compared across payer groups using analysis of variance, the t-test or the Mann-Whitney U test, or the Kruskal-Wallis test
- For qualitative analysis, testing site reports were reviewed manually to extract emerging themes, such as successes, challenges, transferable lessons, and sustainability plans

CONCLUSIONS

- The Model can serve as a valuable framework for cancer programs to evaluate lung cancer care delivery capabilities across high-impact areas, identify areas for improving care coordination, and implement solutions to advance multidisciplinary coordinated care delivery for lung cancer
- Prioritizing the unique care and treatment needs of Medicaid patients with lung cancer is an important step toward ensuring equitable health outcomes with non-Medicaid patients

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DISCLOSURES

- CSL reports consulting or advisory roles with Lilly and the Bristol Myers Squibb™ Foundation; other relationship with Targeted Oncology; honoraria from PER; and research funding from CVS Health
- RUO reports consulting or advisory roles with AstraZeneca and ACS; patents, royalties, other intellectual property (2 U.S. patents and 1 China patent for lymph node specimen collection kit and method of pathologic evaluation); other relationship with Oncobox; and stock and other ownership interests with Lilly, Pfizer, and Gilead Sciences
- MPS, LMB, AK, TMA, NRF, CFA, MAR, VGN, and RAO have no financial relationships to disclose

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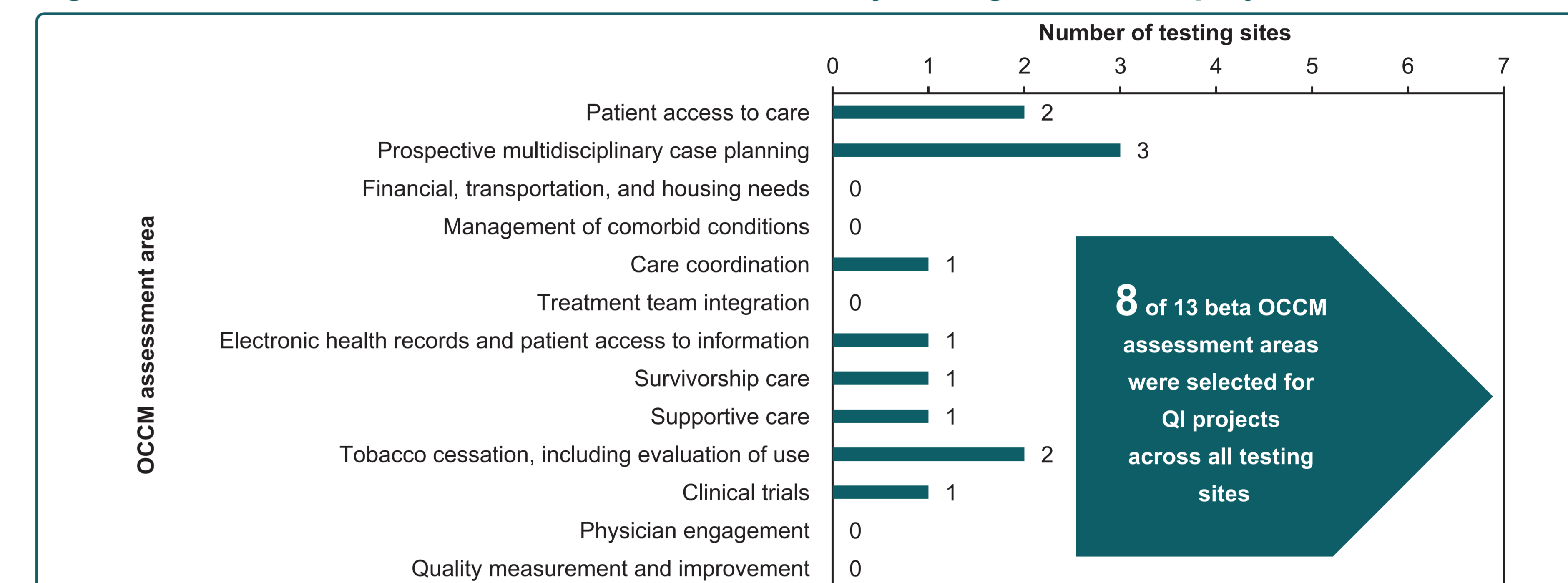


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RESULTS

- Of 926 enrolled patients, 257 (27.8%) had Medicaid insurance or dual-eligible status and 669 (72.2%) had non-Medicaid insurance, which included Medicare only, commercial insurance, and other (i.e., military insurance, none, or self-pay)

Figure 3: Selection of beta OCCM assessment areas by testing sites for QI projects



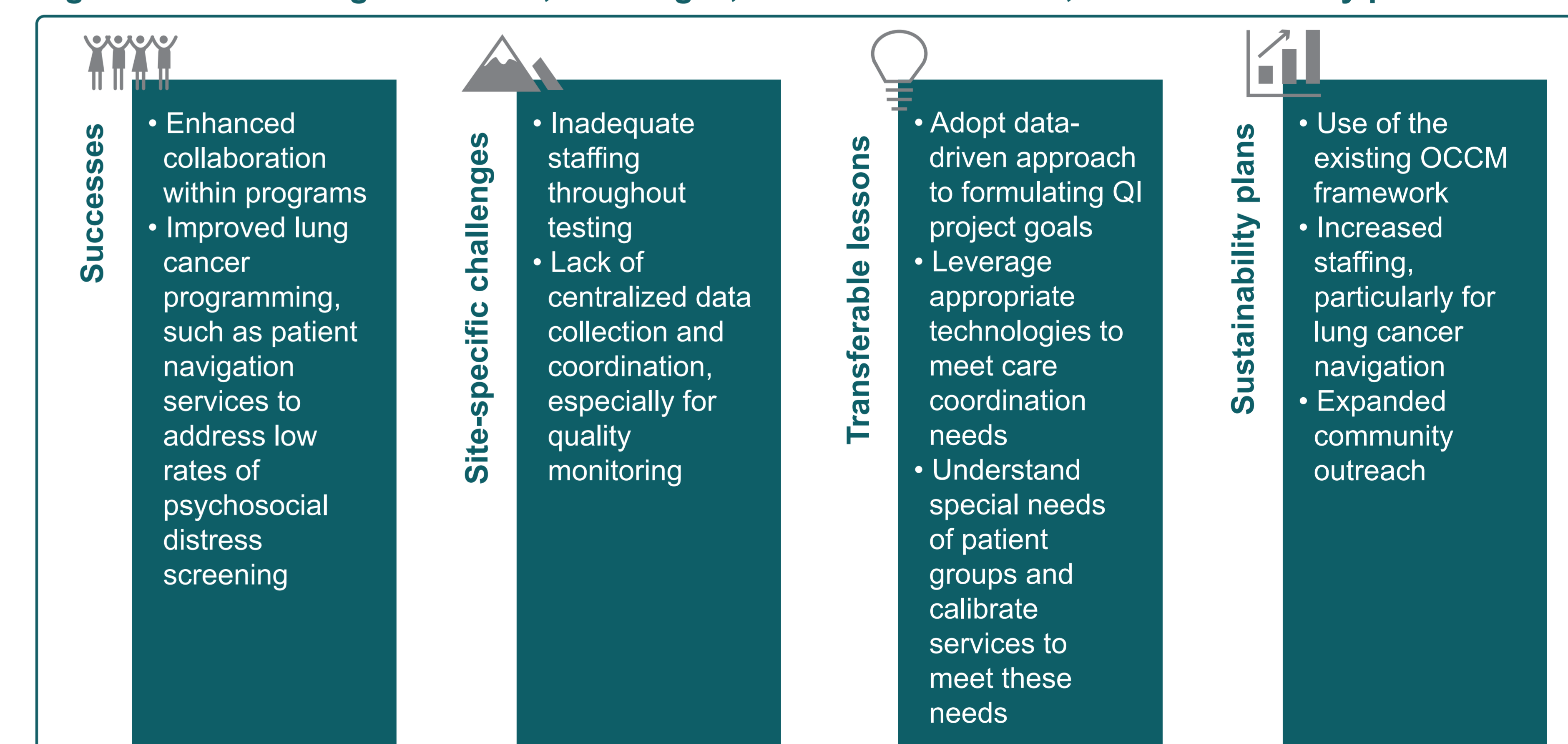
OCCM, Optimal Care Coordination Model; QI, quality improvement.

- Patient demographics and baseline clinical characteristics aggregated across all testing sites by Medicaid/dual-eligible vs. non-Medicaid payer status (Supplementary Table 1; scan QR code)

Statistically significant differences (P<0.0001) were observed by **race, employment status, smoking status, and median age at diagnosis** between Medicaid/dual-eligible and non-Medicaid patients

- Results for the 3 most frequently selected beta OCCM assessment areas are reported under Supplementary material, including Supplementary Figure 1 (scan QR code)
- The results and experiences of beta testing highlighted the different approaches adopted by participating cancer programs to use the Model to advance multidisciplinary coordinated care delivery for Medicaid patients diagnosed with lung cancer

Figure 4: Beta testing successes, challenges, transferable lessons, and sustainability plans



OCCM, Optimal Care Coordination Model; QI, quality improvement.

- Given the operational challenges around preparedness and implementation, cancer programs may need additional resources to evaluate patient outcomes

FUTURE DIRECTIONS

- The results and experiences of beta testing helped inform further refinements to develop a final version of the Model for nationwide dissemination (abstract 104)