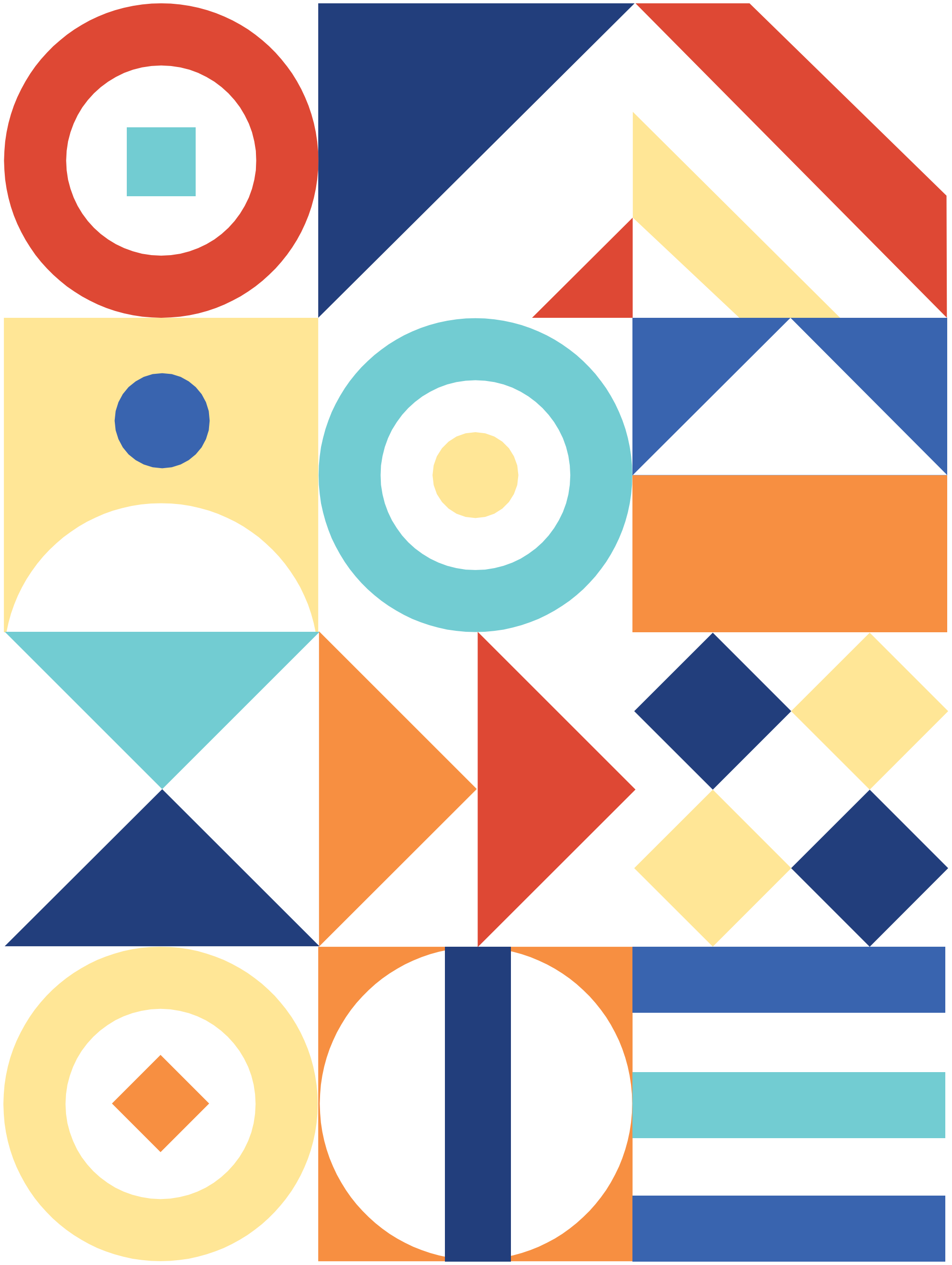


Improving Care Coordination

A Model for Lung Cancer Patients on Medicaid

Updated in 2023

Association of Community Cancer Centers

Contents

The Association of Community Cancer Centers (ACCC), through a grant from the Bristol Myers Squibb Foundation (BMSF), has developed an Optimal Care Coordination Model (the Model) for improving care coordination for patients with lung cancer covered by Medicaid. The Model provides a framework for improving access and quality across the entire continuum of care for patients on Medicaid with lung cancer. The ACCC Model builds upon the Multidisciplinary Care (MDC) Assessment Tool created through the National Cancer Institute Community Cancer Centers Program (NCCCP).

Model Purpose and Design

The Model is intended as a tool for cancer programs to objectively assess how lung cancer care is provided at their institution and as scaffolding for building quality improvement initiatives to improve care coordination—not only for patients on Medicaid—but for all patients with a lung cancer diagnosis. Cancer programs can employ the Model to measure strengths and improvement opportunities while conducting continuous assessment of care coordination in pursuit of optimal patient outcomes. **Although the Model was developed for the lung cancer population, many components of the Model may be used across the cancer care delivery system independent of patient tumor type.**

Overarching principles guiding the design of the Model include:

- Patients' needs and preferences must determine how the health system organizes and provides care. Throughout the cancer care continuum, proactive, essential, and continual patient education and engagement with the goal of shared decision-making is key. Patients facing literacy and health literacy challenges should have these addressed and supported.
- Culturally competent care delivery across the care continuum must be a normative expectation of each team member. Creation of culturally competent teams supports mutual respect, trust, understanding, and patient engagement so that care is provided according to patients' varied beliefs, behaviors, and values.
- Data and evidence must be an integral part of all assessment areas to ensure that the Model is responsive and relevant to national, state, public, and private directives that are focused on quality measurement and improvement and cost effectiveness.

The Model is designed for use by all cancer programs—regardless of setting, size, or level of resources—to improve lung cancer care for patients with Medicaid. The Model is not intended to evaluate every aspect of care; rather, the Model focuses on 12 areas with high impact on optimal care. Care coordination is assessed from the time of initial patient referral to the cancer program through survivorship and end of life. The Model does not address population-level primary prevention or management of comorbid conditions; however, optimal care coordination requires interdisciplinary collaboration in the best interest of the patient, including care coordination to prevent and effectively manage comorbidities throughout the cancer care continuum.

Process for Model Development

Development of the Model was a 3-phase process. The first phase was foundational and included a literature review, environmental scan, and interviews with experts from the project's Advisory Committee, ACCC-member cancer programs, and a lung cancer survivor patient advocate. In the second phase, this information was used to develop qualitative and quantitative interview guides for site visits to capture real-world, real-time understanding of current care coordination for patients with lung cancer on Medicaid in the community. Through an application process ACCC recruited 5 cancer program members to serve as Development Sites and participate in 2-day site visits. These programs were named Development Sites because their collaboration helped in the development of the beta Model. The final component of this research phase of model development included an in-person meeting of the project's Advisory Committee and Technical Expert Panel to discuss findings and further refine the Model's development. In phase 3, through an application process, ACCC invited cancer program members to submit proposals for quality improvement initiatives employing the Model. Seven sites were selected to test the Model through design and implementation of these quality improvement projects over a 12-month period. Experiences of each Testing Site were then used to further revise the Model with a goal of ensuring ease-of-use and utility across of the range of cancer care settings. The Model was updated to include new quality measures and metrics in 2023. The process of updating and distributing the Model was supported by Regeneron.

How the Model is Structured

The Model is a framework for evaluation and quality improvement planning. It includes 12 assessment areas, each with 5 levels. Within each level are service-asset criteria. In all 12 assessment areas, Level 1 represents the most basic provision of care and Level 5 represents the optimal best practice for care coordination *(see Fig. 1)*.

The Model is intended to help cancer programs improve to any achievable target level within a selected assessment area. Resources, infrastructure, leadership and administrative support, organizational priorities, and experience with treating the Medicaid lung cancer population vary from cancer program to cancer program. Thus, each cancer program's starting point in using the model will differ, as will its target level for near- and long-term improvement. Depending on the assessment area, the goal for some programs may be achieving a measurable improvement from Level 1 to Level 2. Note that the Model assumes that progress from one level to the next includes cumulative service assets for patients. Even if a higher level's criteria do not re-state everything included in the lower level, it is assumed these are achieved and continue to occur.

When a cancer program employs the Model to assess its current state of care coordination, it is likely to find its performance includes some components of one level and some of another. As a framework, the Model's purpose is to help cancer programs objectively identify where opportunities exist to improve care coordination for patients, rather than be concerned if current performance reaches Level 3 or Level 4 in one specific assessment area. Although the Model is intended as an internal evaluation and program development tool, programs may also benefit from having an unbiased evaluator from outside the cancer program complete the self-assessment.

The 12 assessment areas should be evaluated on their own merits. However, as a cancer program begins to work with the Model, it is likely to find that improvement in optimal care coordination in one assessment area often depends on a simultaneous improvement in other areas. Conversely, improvements in one assessment area will often lead to synergistic improvements in other areas.

FIGURE 1. The Model's Levels of Care Coordination for Patients with Lung Cancer

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
Optimal care coordination for lung cancer care is not a high-focus area as evidenced by fragmented care.	Early progress in coordinating care is underway.	Reflects average or typical care coordination as seen in most cancer programs.	Exceeds the average and reflects a cancer program's ongoing commitment to the pursuit of optimal care coordination.	Defined by optimal care coordination with a patient-centered focus. Depending on the assessment area, achieving Level 5 performance may require significant time, effort, and resources.

Patient Focus: Optimal care coordination must be patient centered. This requires an understanding of what is important to patients and their caregivers, including their knowledge, goals, needs, desires, social connections, and resources for care. To achieve and maintain this understanding requires the cancer program to educate and engage patients and caregivers to facilitate shared decision-making and patients' participation in their care.

Quality Measures and Metrics: Optimal care coordination requires analysis and development of an action plan for continuous improvement. Each of the 12 assessment areas requires at least one measurable parameter. These parameters should include both evidence-based and institution-specific benchmarks that address patient outcomes, patient experience, and cost effectiveness. These measures and metrics should be continuously assessed and reported to key institutional stakeholders for ongoing quality improvement.

Model Overview

This 2-page spread (pages 6 and 7) shows the Model's design with 12 assessment areas each with 5 levels. Note: Due to space limitations this visualization of the Model includes only one service-asset criteria per level. In the full Model each level typically has multiple service-asset criteria.

Pages 8-19 provide full descriptions of each assessment area's 5 levels. The Model assumes that progress from one level to the next includes cumulative service assets for patients. Even if a higher level's criteria does not re-state everything included in the lower level, it is assumed that these are achieved and continue to occur.

Assessment Areas

1. Patient Entry Into Lung Cancer Program
2. Multidisciplinary Treatment Planning
3. Clinical Trials and Biomarker Testing
4. Supportive Care
5. Survivorship Care
6. Financial, Transportation, and Housing
7. Tobacco Education
8. Navigation
9. Treatment Team Integration
10. Physician Engagement
11. Electronic Health Records (EHR) and Patient Access to Information
12. Quality Measurement and Improvement

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• Limited relationships with referring providers.	• Initial consult is available within 1 week of referral.	• Initial consult is available within 72 hours of referral.	• Initial consult is available within 48 hours of referral.	• Initial consult is available within 24 hours of referral.
• Treatment planning is done on an individual provider basis with no input from multidisciplinary team.	• Treatment planning is done through a multidisciplinary team approach at some point during treatment.	• 60-79% of cases are screened following formal, written institutional criteria for consideration of presentation for multidisciplinary team treatment planning.	• 80-94% of cases are screened following formal, written institutional criteria for consideration of presentation for multidisciplinary team treatment planning.	• >95% of cases are screened following formal, written institutional criteria for consideration of presentation for multidisciplinary team treatment planning.
• Lung cancer clinical trials are not available.	• A limited number of lung cancer clinical trials are available.	• Portfolio of available lung cancer clinical trials is matched to patient population and psychosocial barriers for patients are minimized.	• 75-94% of new, progressed, or relapsed patients are screened for clinical trials.	• ≥95% of new, progressed, or relapsed patients are screened for clinical trials.
• No needs assessment is conducted (physical symptoms, distress and/ or depression screening).	• Informal needs assessment is conducted.	• Standardized needs assessment is conducted at least once.	• Standardized needs assessment is conducted at change in patient status.	• All patients are assessed for referral to a dedicated supportive care team at the time of diagnosis with ongoing screenings as needed.
• No information is provided regarding surveillance or survivorship care.	• Surveillance information is inconsistently provided, often through verbal discussion during a routine office visit.	• 50-74% of patients treated with curative intent are provided with a written treatment summary/survivorship care plan from oncology treatment team within 3 months of completing active treatment.	• 75-94% of patients treated with curative intent are provided with a written treatment summary/survivorship care plan (from the oncology treatment team within 3 months of completing active treatment.	• ≥ 95% of patients treated with curative intent are provided with a written treatment summary/survivorship care plan from oncology treatment team within 3 months of completing active treatment.
• Patient insurance is verified at initial referral.	• Patient insurance is routinely verified every 6 months.	• Patient insurance is routinely verified once every month.	• Financial counselors meet with patients before the start of treatment to discuss insurance benefits and financial responsibility.	• Financial counselors meet with patients before the start of treatment to discuss insurance benefits and financial responsibility, enrolling patients into Medicaid programs as needed.
• Patient tobacco use is assessed at initial visit.	• Verbal assessment of patient readiness to quit is conducted.	• Patient tobacco use is reassessed at every visit.	• Patient and household member(s) are referred to external resource for formal cessation counseling.	• Formal cessation counseling is provided on site throughout the patient's treatment course to both the patient and household member.
• No navigators in place.	• Non-disease-site-specific navigators in place, but they are not integrated with lung cancer services.	• Disease-site-specific navigators in place and are integrated with lung cancer services.	• 50-94% of patients are screened following formal written institutional criteria for navigation.	• 95% of patients are screened following formal written institutional criteria for navigation.
• There is no practice or organizational plan or focus on team-based care.	• A cancer services team is in place that includes medical oncology, radiation oncology, surgery, nutrition, and social work.	• Standard criteria and processes are in place for referral to allied health services.	• Allied services are used concurrently and integrated into treatment.	• Allied services are integrated and offered in cancer program's own allied health clinic program.
• Physician is not board certified or preparing for boards.	• Physician is certified in their subspecialty.	• Physician attends MDC regularly and presents 75-94% of them own lung cancer cases following institutional criteria.	• Physician takes an active role in MDCs and presents 95% of them own lung cancer cases prospectively (before the start of treatment).	• Physician plays leadership role in all MDC activities assuring focus covers complete care continuum from active treatment to survivorship and end-of-life care.
• EHR is increasingly used, but some paper records still exist, and the EHR is not oncology specific.	• All patient records are in an EHR that has basic oncology- specific functionality.	• Use of an oncology specific EHR with computerized physician order entry (CPOE).	• Entire MDC team uses the same oncology specific EHR so that records are integrated; enhanced CPOE functionality.	• Oncology-specific EHR is completely integrated with all providers in the geographic region, including referring providers, PCPs, and ED/ hospital; includes enhanced CPOE functionality.
• No quality metrics are in place.	• External quality metrics are in place and are evaluated at least annually.	• External and internal quality metrics are in place and are evaluated at least annually.	• Program-wide use of external and internal quality metrics are evaluated monthly and compared with previous metrics.	• Program-wide commitment to QI, with a system in place to use data to improve patient outcomes, experience, and cost effectiveness (evaluated at least monthly).

1

Patient Entry into Lung Cancer Program: This assessment area addresses factors related to the patient's entry into the lung cancer program including the referral sources, the referral process, and for the purpose of providing patient-centered, timely access to appropriate care—the strength of relationships between the referral source and the cancer program.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• Limited relationships with referring providers. • No formal system is in place for tracking referrals. • Patient is given next available appointment.	• Initial consult is available within 1 week of referral. • Program obtains patient medical records.	• Initial consult is available within 72 hours of referral. • Referring providers have direct contact information for lung cancer specialist physicians. • Formal system is in place for tracking and reporting referral information internally. • Formal system is in place for tracking and reporting no-show data.	• Initial consult is available within 48 hours of referral. • Quality Improvement activities in place based on reported referral information. • Navigation services are in place for new patients entering the system	• Initial consult is available within 24 hours of referral. • Non-traditional appointment availability (ie, beyond M-F 8-5 face-to-face). • "One call" access to the lung cancer program. • Cancer program referral liaisons communicate directly with referring providers facilitating entry and providing information about best practices for accessing the Lung Cancer Program. • Well-established relationships with all local safety-net providers in addition to all other referral sources. • Second opinion only telehealth services are available

Patient Focus: Timely and seamless access from initial diagnosis to entry into the cancer program is integral to the patient's care coordination and experience. Staff should ensure that the patient sees a clear path from initial diagnosis to entry into the cancer program.

Quality Measures and Metrics: *Please see page 20.*

2.

Multidisciplinary Treatment Planning: This assessment category addresses factors related to multidisciplinary evaluation of the patient and input provided on the treatment plan, including range of providers who contribute, establishment of process for making and capturing treatment recommendations, and the development and dissemination of a collaborative treatment plan.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• Treatment planning is done only on an individual provider basis with no input from multidisciplinary team. • Patient is not involved in treatment decision-making. • Final treatment plan is not shared across multidisciplinary team.	• Treatment planning is done through a multidisciplinary team approach at some point during treatment. • Patient is evaluated by individual providers—no coordination of appointments among providers. • Patient is informed of final treatment decision and has limited input to care plan. • Final treatment plan is disseminated only to treatment providers, not entire multidisciplinary team.	• 60-79% of cases are screened following formal, written institutional criteria for consideration of presentation for multidisciplinary team treatment planning. • 80% of cases that meet these institutional criteria receive a treatment recommendation from the multidisciplinary team before the start of treatment. • Multidisciplinary treatment recommendation is disseminated to multidisciplinary team. • Multidisciplinary treatment recommendation is entered in EHR as a discrete entry where appropriate. • Patient is informed of all treatment options but has no formal input to care plan.	• 80%-94% of cases are screened following formal, written institutional criteria for consideration of presentation for multidisciplinary team treatment planning or agreed upon treatment pathway. • >80% of cases that meet these institutional criteria receive a treatment recommendation from the multidisciplinary team before the start of treatment. • Initial comprehensive patient needs assessment is conducted that may be used to develop treatment plan. • Patient is informed of all treatment options and has some input to care plan. • Final care plan is disseminated to multidisciplinary team and referring provider.	• >95% of cases are screened following formal, written institutional criteria for consideration of presentation for multidisciplinary team treatment planning. • >80% of cases that meet these institutional criteria receive a treatment recommendation from the multidisciplinary team before the start of treatment. • Initial comprehensive patient needs assessment is conducted and findings are used to inform treatment options, which are presented to patient for shared decision-making. • Final care plan disseminated to multidisciplinary team, referring provider, and patient/caregiver.

Patient Focus: Staff should determine patient preference for active engagement in and level of understanding of the diagnosis and treatment of the disease; ability to follow the treatment plan; and potential barriers to engagement, understanding, and treatment adherence. Family and caregivers' level of involvement and understanding should be assessed. Staff should assess the patient's needs and goals for care and ensure these are communicated to the care team. All areas should be continually assessed to ensure that patient expectations for ongoing communication with the care team about their treatment are addressed.

Quality Measures and Metrics: *Please see pages 21 – 22.*

3.

Clinical Trials and Biomarker Testing: This assessment area addresses factors related to overcoming cultural, financial, and logistical barriers that patients face in accessing clinical trials and biomarker testing, including cultural competence of cancer program staff related to medical research, feasibility of protocols for this patient population, review of patients for eligibility, and support to patients during the informed consent process to assure understanding.

Level 1	Level 2	Level 3	Level 4	Level 5
Lung cancer clinical trials are not available. No assessment for lung cancer biomarkers.	1 to 5 lung cancer clinical trials are available. General clinical research information is available to patients upon request. <50% of patients are screened for clinical trials eligibility.	General clinical research information is provided to all patients within the first 3 visits. Dedicated clinical trials staff. 50-74% of new, progressed, or relapsed patients are screened for clinical trials. ≥80% of patients screened and determined eligible for an available trial are offered trial participation. All stage IB-IIIB NSCLC are assessed for EGFR All patients with first line stage IV non-small cell lung cancer are assessed for targetable lung biomarkers; adenocarcinoma: PD-L1, EGFR, ALK; squamous cell carcinoma: PD-L1	Portfolio of available lung cancer clinical trials are matched to patient population and psychosocial barriers for patients are minimized. 75%-90% of new, progressed, or relapsed patients are screened for clinical trials. ≥80% of patients screened and determined eligible for an available trial are offered trial participation. The clinical team (physicians, clinical trials staff and patient support staff) discuss trial participation with patients All patients with first line stage IV non-small cell lung cancer are assessed for broad molecular profiling (NGS panel: tissue or serum based)	≥90% of new, progressed, or relapsed patients are screened for clinical trials. ≥80% of patients screened and determined eligible for an available trial are offered trial participation. Clinical trials staff proactively review patient records for eligibility and participate in tumor boards. Formal process is in place to validate patient understanding of the clinical trial protocol during the informed consent process. All patients with first line stage IV non-small cell lung cancer are assessed for broad molecular profiling (NGS panel: tissue or serum based) and meet with a precision medicine steward to discuss results/treatment implications

Patient Focus: When standard of care treatment options is not the best option or are no longer viable, clinical trials are standard of care and may be an option. All patients should have the opportunity to be considered for a clinical trial. Many patients may be wary of clinical trials and believe they are being experimented on. Staff should address such fears and ensure that clinical trials are seen as a viable and appropriate option for treatment.

Quality Measures and Metrics: *Please see page 22.*

4.

Supportive Care: This assessment area addresses factors related to the evaluation of physical, emotional, mental, and spiritual symptoms and the cancer program infrastructure, resources, and established processes available to manage these symptoms throughout the continuum of care, including end-of-life care.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• No needs assessment is conducted (physical symptoms such as .pain, emotional health, energy levels, physical symptoms, health maintenance, distress and/or depression screening). • Goals of treatment, advance directives, and advance care planning are discussed. • Limited relationship exists with off-site hospice providers.	• Informal needs assessment is conducted. • Advance care planning documents are requested by the third appointment. • Patients with recognized need(s) are referred to supportive care resources at some point during their treatment. • Informal working relationship with off-site palliative care resources exist; patients are provided with referrals upon request. • Informal relationship exists with off-site hospice providers. • Prophylactic antiemetic therapy prescribed prior to first cycle of moderate-highly emetogenic chemotherapy in >95% of patients, aligned with guidelines.	• Standardized needs assessment is conducted at least once. • Established referral process exists for patients who screen positive for need by second visit. • Referral plan is documented in the medical record. • On-site palliative care resources are available to patients but are not integrated into treatment plan. • On-site advance care planning facilitators are available. • 40%-59% of patients have advance care planning documents in their medical record. • Established relationships exist with off-site inpatient and outpatient hospice providers.	• Standardized needs assessment is conducted at change in patient status. • Response from care team to referral plan for patients who screen positive for need is documented in the medical record. • On-site palliative care resources are available to patients and integrated into treatment plan. • 60%-79% of patients have advance care planning documents in their charts.	• All patients are assessed for referral to a dedicated supportive care team at the time of diagnosis with ongoing screenings as needed. • All stage IIIB, IIIC, and IV NSCLC patients are offered palliative care consultation at time of diagnosis. • Palliative care is embedded in the lung cancer program. • Goals of treatment, advance directives, and advance care planning are updated with change in condition or treatment plan. • ≥80% of patients have advance care planning documents in their chart. • Integrated inpatient and outpatient hospice services are available within the cancer center to all patients.

Patient Focus: Supportive care helps patients focus on overall goals of care during and after treatment. Advance care planning allows patients to voice their wishes if they are no longer able to when decisions must be made. Staff should ensure the patient, family, and caregivers understand the difference between palliative and curative intent. This understanding will help guide the patient's advance care plan.

Quality Measures and Metrics: *Please see pages 23 – 26.*

5.

Survivorship Care: This assessment area addresses factors related to ongoing surveillance for recurrence of the primary cancer; prevention and early detection of new health problems; management of latent and long-term toxicities associated with cancer treatments; and overall wellness from the time of patients' diagnosis through the balance of their lives, with an emphasis on care for those who have completed active treatment.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• No information is provided regarding surveillance or survivorship care.	• Surveillance or survivorship care information is inconsistently provided, often through verbal discussion during a routine office visit.	• Disease-specific goals for survivorship care are established and reviewed annually by a multidisciplinary team to meet the needs of the site's patient population and available services. • Education is provided annually to staff members providing supportive care services.	• Patients are referred to external and internal resources for supportive care services when available. • Patient's primary care provider (PCP) and other referrals are provided with patient-specific goals of survivorship care. • Formal program to enhance lifestyle and overall wellness is available.	• Disease Survivorship program with coordinator oversight is available that offers a minimum of 3 formal services each year

Patient Focus: Survivorship care helps patients understand the long-term implications of a cancer diagnosis and needed post-treatment care. Survivorship care presents important, positive health behaviors for patients following cancer diagnosis and treatment, information that otherwise patients and the primary care team might not be aware of. Staff should ensure that the patient understands the survivorship benefits and the follow-up care required over time to prevent and treat recurrences or new conditions due to treatment for cancer.

Quality Measures and Metrics: *Please see page 27.*

6.

Financial, Transportation, and Housing: This assessment area addresses factors related to financial barriers to care, including areas directly and indirectly related to coordination of care, and mechanisms in place to minimize associated financial hardships that can impact the patient's ability to follow the treatment plan, such as identifying and eliminating transportation and housing barriers to care.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• Patient insurance is verified at initial referral. • Financial counselors are not available or do not meet with patients. • No assessment of transportation, living situation, or food insecurity needs.	• Patient insurance is routinely verified every 6 months. • Financial counselors meet with patients only upon request (retrospective assessment). • Informal individual assessment of transportation, living situation, and food insecurity completed at the start of initial treatment.	• Patient insurance is routinely verified once every month. • Financial counselors meet with patients before the start of treatment to discuss insurance benefits and financial responsibility (prospective assessment.) • When appropriate, patients are enrolled in financial assistance programs after treatment is started. • Structured individual assessment of transportation, living situation, and food insecurity needs completed at the start of initial treatment. • Recommendations provided for transportation, housing, and food resources as available in the community.	• Patient insurance is verified at every visit. • Financial counselors included during treatment planning before start of treatment. • Patients are enrolled in financial assistance programs before treatment is started. • Structured individual assessment of transportation, lodging, and food insecurity needs is completed initially and upon change in patient status. • Transportation services are provided for patients, dependent on financial need.	• Financial counselors meet with patients before the start of treatment and upon change in patient status to discuss insurance benefits and financial responsibility, enrolling patients into Medicaid and other programs as needed. • Dedicated personnel are available to assist patients with accessing local transportation, housing, and food resources.

Patient Focus: Staff should assess the patient's perceived and actual ability to access all aspects of needed care without financial burden; assistance should be provided to the patient where financial gaps exist.

Quality Measures and Metrics: *Please see pages 26 – 28.*

7.

Tobacco Education: This assessment area addresses factors related to evaluation of tobacco use and provision of tobacco education including cessation strategies for patients diagnosed with lung cancer.

Level 1	Level 2	Level 3	Level 4	Level 5
• Patient tobacco use is assessed at initial visit. • No advice to quit or discussion of tobacco-cessation resources is documented.	• Household member(s)' tobacco use is assessed at initial visit. • Verbal assessment of patient and household member(s) readiness to quit is conducted. • Patient and household member tobacco user(s) advised to quit, including discussion on benefits of cessation and impact on treatment.	• Patient tobacco use is reassessed at every visit. • A structured instrument is used to assess patient and household member(s) readiness to quit. • No internal formal tobacco cessation counseling is provided; patients and household member(s) are referred to external resource for formal cessation counseling.	• Patient and household member(s) tobacco use is reassessed at every visit. • Patient and household member(s) are referred to internal resource for formal tobacco cessation counseling.	• Internal tobacco cessation counseling is provided throughout the patient's treatment course to both the patient and household member(s). • Patient and household member(s) are referred to peer-support tobacco cessation program. • Tobacco quit rate of lung cancer patient population is measured and reported.

Patient Focus: Tobacco cessation is important for overall treatment success and staff should ensure the patient understands that treatment will be more effective in the absence of tobacco. The patient and family member(s) who use tobacco can benefit from a variety of cessation methods.

Quality Measures and Metrics: *Please see page 28.*

8.

Navigation: This assessment area addresses factors related to identification of patient needs/barriers to care and strategies to minimize gaps in service among vulnerable groups who might otherwise be underserved. This includes a comprehensive, structured patient education process during their treatment. Of note, the educational background and licensure of care coordinators is not defined as this role may include a variety of disciplines (eg, nurses, social workers, and/or lay staff) depending on the institutionally defined role and specific needs of the population served.

Level 1	Level 2	Level 3	Level 4	Level 5
• No navigators are in place. • No structured treatment education is provided to patients.	• Non-disease-site-specific navigators in place, but they are not integrated with lung cancer services. • Non-English-speaking patients receive certified medical interpreter services during all points of medical communication • Structured education is provided to patients prior to starting anti-cancer therapy	• Disease-site-specific navigators in place and are integrated with lung cancer services. • A direct line of communication to the navigator is available for patients during business hours. • Navigation includes RN navigator for active treatment when challenges arise. • 50%-94% of telephone inquiries regarding medical care are answered/returned with 24 business hours	• 50%-94% of patients are screened following formal written institutional criteria for navigation. • 50%-94% of patients who meet institutional criteria are actively navigated. • A direct line of communication to the navigator is available for patients during normal business hours with some after-hours availability. • The navigator uses a standardized, structured process to document interventions that lessen barriers to optimal care in the EHR. • 95% of telephone inquiries regarding medical care are answered/returned with 24 business hours	• 95% of patients are screened following formal written institutional criteria for navigation. • 95% of patients who meet institutional criteria are actively navigated. • A direct line of communication to the navigator is available for patients 24 hours a day. • Navigation-specific software application is integrated into the EHR. • Program has designated a “precision medicine steward”—a navigation lead that serves as the point person for removing barriers to testing so all eligible patients are appropriately tested.

Patient Focus: Care coordinators are essential to ensuring that all patient needs are met throughout the course of treatment. Care coordinators and clinical and lay navigators can streamline patients' journey through care services that are often fragmented, provide a single point of contact for patients, and identify and address many barriers to care. This coordination benefits patients and the care team by reducing duplicative efforts and improving communication.

Quality Measures and Metrics: *Please see pages 20, 28 – 31.*

9.

Treatment Team Integration: This assessment area addresses the depth, breadth, and effectiveness of team collaboration through the care continuum. The specific members that are the focus of integration will vary based on the resources available at the cancer program. Intentional attention to developing a collaborative, consensus-driven mindset, clearly defined roles and responsibilities, established communication processes, and feedback loops within the team is essential for high-functioning expert teams in any setting of care.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• There is no practice or organizational plan or focus on team-based care.	• A cancer services team is in place that includes medical oncology, radiation oncology, surgery, nutrition, and social work.	• Standard criteria and processes are in place for referral to allied health services. • Formal use of allied health service assessment, recommendation, and care is documented in the medical record. • Communication among treatment team occurs but is inconsistent. • All cancer care team members receive training in the development of expert teams and are eligible to apply for resources to attend outside training. • Leadership demonstrates commitment to team care that includes: defining team members' roles; implementing standard communication procedures (including specifying huddle frequency); and maintaining a suite of allied services available on site.	• Allied services are used concurrently and integrated into treatment. • Communication among treatment team exists but is fragmented between EHR and email. • Weekly huddle is scheduled with key team members to identify patients at highest risk for non-compliance with treatment plan. • Standardized huddle board, or other visual tool, is used to aid in team collaboration.	• Allied services are integrated and offered in cancer program's own allied health program. • Established cancer program preferred communication protocol is used. • Physician and administrative leaders demonstrate a high level of commitment to treatment team integration; implementation of a formal process to incorporate the results of team training into routine practice for all team members. • Daily huddle of appropriate team members to identify patients at high risk for ED and hospital utilization and non-compliance with treatment plan. • Self-assessment, feedback, and improvement of team effectiveness occur on a regular basis.

Patient Focus: A comprehensive, communicative treatment team that assists the patient from initial diagnosis, during treatment, and after treatment completion greatly increases treatment compliance and ensures patient needs do not go unaddressed.Staff should ensure that the patient perceives that all members of the treatment team are effectively communicating necessary information to each other regarding the patient's disease and treatment.

Quality Measures and Metrics: *Please see page 31.*

10.

Physician Engagement: This assessment area addresses factors related to the physician's current specific disease expertise, availability to the patient and the care team, leadership, effectiveness at team science, effectiveness in communication, involvement in clinical trials and quality improvement activities, establishment of patient relationships, and formal commitment to programmatic expectations and the care team. The physician leadership role entails supporting continuous professional development and training for the entire care team.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• Physician is not board certified or preparing for boards. • Physician does not actively engage in case presentation or case discussion at multidisciplinary conference (MDC).	• Physician is certified in their subspecialty. • Physician attends MDC and presents 50%-74% of their own Stage I-III lung cancer cases following institutional criteria. • Physician pursues CME activity related to lung cancer. • Physician is member of an oncologic society. • Physician has completed training for inclusivity either as part of credentialing process or via outside organization	• Physician attends MDC regularly and presents 75%-94% of their own lung cancer cases following institutional criteria. • Physician uses supportive services teams, ie, social work, clinical and financial navigation, dietitians, chaplains, palliative care, etc., for patient support. • Physician has training on the impact of social drivers of health, and barriers to care either through institutional credentialing or outside agency	• For stage I-III, physicians consult with other MDC specialists as part of a conference, pathway review, or via sequential visits. Physician refers patients for clinical trials when appropriate trials are not available locally. • Physician actively participates in at least one quality improvement (QI) activity annually. • Physician engages in the planning and implementation of lung cancer care initiatives (programmatic and quality focused).	• Physician plays leadership role in MDC activities assuring focus covers complete care continuum from active treatment to survivorship and end-of-life care. • Physician trains or mentors' colleagues as well as members of the MDC team and presents CME activities to colleagues. • Physician champions QI/safety activity programs. • Physician champions clinical access and equity efforts.

Patient Focus: To ensure that all patients receive the highest quality coordinated care, cancer programs should have actively engaged qualified physicians with expertise (or access to others with expertise) in lung cancer.

Quality Measures and Metrics: *Please see pages 31 – 32.*

11

Electronic Health Records (EHR) and Patient Access to Information: This assessment area addresses factors related to facilitating interdisciplinary communication along the continuum of care through the capacity to access clinical information from physician practices, hospitals, outpatient clinics, and diagnostic centers. An optimized EHR provides a platform for documentation of clinical care, including patient adherence to the treatment plan, compliance with national standards and guidelines or best practice as reflected in quality measures, patient adherence to the treatment plan, support for billing of clinical services, and a mechanism for patients to access information regarding care delivered.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• EHR is increasingly used, but some paper records still exist, and the EHR is not oncology specific.	• All patient records are in an EHR that has basic oncology-specific functionality. • A patient portal is available; <50% of patients enroll. • EHR is updated to prevent information blocking; set up to allow patients immediate access to their PHI/EHI via patient portal except in circumstances allowed by law • Problem List and Medications Lists are reviewed and maintained at every visit	• Use of an oncology-specific EHR with computerized physician order entry (CPOE). • Between 50%-64% of patients enroll in the patient portal. • 95% medication administration is documented through dual barcode scanning ("Electronic MAR maintained with barcode scanning")	• Entire MDC team uses the same oncology-specific EHR so that records are integrated; enhanced CPOE functionality. • Basic clinical reporting capabilities are available for metrics extracted from EHR. • Between 65%-79% of patients enroll in patient portal. • Telemedicine/videoconference is integrated within EHR. • Utilize a "Health Information Exchange" or "clinical data repository"	• Oncology-specific EHR is completely integrated with all providers in the geographic region, including referring providers, PCPs, and ED/hospital; includes enhanced CPOE functionality. • Robust clinical reporting capabilities are available for quality metrics extracted from EHR. • ≥ 80% of patients enroll in patient portal. Patients are able to use the patient portal to communicate with their care team.

Patient Focus: With easy access to their records, patients are empowered to make treatment decisions and have a better understanding of their diagnosis. Considering literacy and variable access to technology, staff should not only ensure that the patients have access to their records, but also understand the key information discussed in the records.

Quality Measures and Metrics: *Please see pages 32 – 33.*

12.

Quality Measurement and Improvement: This assessment area addresses factors related to quality metrics, stratified by key patient demographics to reveal disparities (such as coverage type, socioeconomic status, gender, race, and ethnicity) to ensure that there is minimal variation in outcomes by patient type. A quality improvement program must be responsive to evidence-based guidelines, national directives on quality and payment, and program-specific challenges.

Level 1	Level 2	Level 3	Level 4	Level 5
○	○	○	○	○
• No quality metrics are in place. • Evidence-based, consensus-driven guidelines are not used to guide treatment.	• External quality metrics are in place and are evaluated at least annually. • National care guidelines are used as a framework for treatment decision-making.	• External and internal quality metrics are in place and are evaluated at least annually. • Evidence-based data are used to guide quality improvement initiatives throughout the cancer program. • One dedicated quality management individual is in place for the cancer program.	• Program-wide use of external and internal quality metrics that are evaluated monthly and compared with previous metrics. • Direct, individualized feedback is provided to each clinician monthly. • Metrics are maintained in an electronic database, with previous years archived. • Patient survey data (any type) are used to guide quality improvement initiatives and reviewed with executive decision-makers at least annually. • Dedicated quality management team in place for the cancer program (with some external training). • Patient advisory board meets quarterly and provides written input. • National care guidelines are used as a framework for treatment decision-making, and concordance is tracked.	• Program-wide commitment to QI, with a system in place to use data to improve patient outcomes, experience, and cost effectiveness (evaluated at least monthly). • Dedicated quality management staff is in place for cancer program (with annual external training, continuing education). • Structured process is in place to evaluate national care guidelines adherence. • Structured process is in place to guide quality improvement initiatives.

Patient Focus: Ensuring that patients can report perceived problems is important to a cancer program's success. Allowing patients to participate in problem solving provides a voice to patients to help enact positive change through quality improvement initiatives and participation in patient advisory councils/boards/committees.

Quality Measures and Metrics: *Please see pages 33 – 35.*

Measures

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Patient got appointment for urgent care as soon as needed	**AHRQ**	CAHPS Cancer Care Survey – Q14		1 — Patient Entry into Lung Cancer Program
Patient got appointment for non-urgent care as soon as needed	**AHRQ**	CAHPS Cancer Care Survey – Q16		1 — Patient Entry into Lung Cancer Program
Engagement of new Medicaid patients and follow-up	**CMS**	MIPS Improvement Activity ID: IA_AHE_1 (HIGH WEIGHTING)	*Sees new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.*	1 — Patient Entry into Lung Cancer Program
Closing the referral loop: Receipt of specialist report back to referring clinic or group to close referral loop	**CMS**	MIPS Improvement Activity ID: IA_CC_1 (MEDIUM WEIGHTING)	*Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.*	1 — Patient Entry into Lung Cancer Program
Setting expectations with referring clinicians	**NCQA**	Patient-centered Specialty Practice (PCSP) Standard RM 01 (CORE)	*Works with frequently referring clinicians to set expectations for information sharing and patient care.*	1 — Patient Entry into Lung Cancer Program
Agreements with referring clinicians	**NCQA**	Patient-Centered Specialty Practice Standard RM02 (1 Credit)	*Has agreements with a subset of primary care or other referring clinicians.*	1 — Patient Entry into Lung Cancer Program
Access for urgent needs	**NCQA**	Patient-Centered Specialty Practice Standard AC 01 (CORE)	*Ensures access and appropriate level of care for urgent patient needs.*	1 — Patient Entry into Lung Cancer Program 8 — Navigation

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Chemotherapy intent (curative vs. noncurative) documented before or within two weeks after administration	**ASCO**	QOPI Measure 10		2 — Multidisciplinary Treatment Planning
Cancer Committee membership	**American College of Surgeons**	CoC Standard 2.1	*The membership of the Cancer Committee is multidisciplinary, representing physicians from diagnostic and treatment specialties and non-physicians from administrative and supportive services. Cancer Committee coordinators, who are responsible for specific areas of cancer program activity, are designated each calendar year.*	2 — Multidisciplinary Treatment Planning
Monitoring Multidisciplinary Cancer Case Conference activity	**American College of Surgeons**	CoC Standard 2.5	*The Cancer Conference coordinator monitors and evaluates the Cancer Conference activities and reports the findings to the Cancer Committee, each calendar year.*	2 — Multidisciplinary Treatment Planning
Shared decision-making aids	**NCQA**	Patient-Centered Specialty Practice Standard KM 21 (1 credit)	*Adopts shared decision-making aids for preference-sensitive conditions.*	2 — Multidisciplinary Treatment Planning
Shared decision-making process	**NCQA**	Patient-Centered Specialty Practice Standard PM 07 (1 credit)	*Informs patients about treatment options and makes evidence available to them to ensure collaborative and patient-centric treatment decisions.*	2 — Multidisciplinary Treatment Planning
Written treatment plan	**NCQA**	Patient-Centered Specialty Practice Standard PM 03 (CORE)	*Collaborates with the patient/family/caregiver to develop and update a specialist's treatment plan and provides them access to the treatment plan.*	2 — Multidisciplinary Treatment Planning
Cancer care team involved family members or friends in discussions	**AHRQ**	CAHPS Cancer Care Survey Q10		2 — Multidisciplinary Treatment Planning
Doctor explained the advantages of each cancer treatment choice	**AHRQ**	CAHPS Cancer Care Survey SDM2		2 — Multidisciplinary Treatment Planning

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Doctor explained the disadvantages of each cancer treatment choice	**AHRQ**	CAHPS Cancer Care Survey SDM3		2 — Multidisciplinary Treatment Planning
Doctor asked patient for their opinion about each cancer treatment choice	**AHRQ**	CAHPS Cancer Care Survey SDM4		2 — Multidisciplinary Treatment Planning
Doctor talked about reasons patient might want each cancer treatment choice	**AHRQ**	CAHPS Cancer Care Survey SDM5		2 — Multidisciplinary Treatment Planning
Doctor talked about reasons patient might not want each cancer treatment choice	**AHRQ**	CAHPS Cancer Care Survey SDM6		2 — Multidisciplinary Treatment Planning
Doctor asked patient what cancer treatment choice was best for them	**AHRQ**	CAHPS Cancer Care Survey SDM7		2 — Multidisciplinary Treatment Planning
Doctor involved patient in cancer treatment decisions as much as they wanted	**AHRQ**	CAHPS Cancer Care Survey SDM8		2 — Multidisciplinary Treatment Planning
MIPS-eligible clinician leadership in clinical trials or CBPR	**CMS**	MIPS Improvement Activity ID: IA-AHE_5 (MEDIUM WEIGHTING)	*MIPS-eligible clinician leadership in clinical trials, research alliances, or community-based participatory research (CBPR) that identify tools, research or processes that can focuses on minimizing disparities in healthcare access, care quality, affordability, or outcomes.*	3 — Clinical Trials
Clinical research study accrual	**American College of Surgeons**	CoC Standard 9.1	*As prescribed for cancer program category, the required percentage of subjects is accrued to eligible cancer-related clinical research studies each calendar year. The Clinical Research Coordinator documents and reports clinical research information and the annual enrollment in clinical research studies to the cancer committee each calendar year.*	3 — Clinical Trials

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Patient and cancer care team talked about cancer-related pain	**AHRQ**	CAHPS Cancer Care Survey – Q28		4 — Supportive Care
Cancer care team advised patient or helped patient deal with pain	**AHRQ**	CAHPS Cancer Care Survey – Q30		4 — Supportive Care
Patient and cancer care team talked about changes in patient's energy levels	**AHRQ**	CAHPS Cancer Care Survey – Q31		4 — Supportive Care
Cancer care team advised patient or helped patient deal with changes in energy levels	**AHRQ**	CAHPS Cancer Care Survey – Q33		4 — Supportive Care
Patient and cancer care team talked about emotional problems	**AHRQ**	CAHPS Cancer Care Survey – Q34		4 — Supportive Care
Cancer care team advised patient or helped patient deal with emotional problems	**AHRQ**	CAHPS Cancer Care Survey – Q36		4 — Supportive Care
Patient and cancer care team talked about things patient could do to maintain health	**AHRQ**	CAHPS Cancer Care Survey – Q38		4 — Supportive Care
Medical and Radiation Oncology – Pain intensity quantified	**AMA (MIPS) CMS**	Physician Consortium for Performance Improvement (PCPI) Oncology Care Model - OCM-4a; QOPI 4a. MIPS Quality ID: 143	*Percentage of patient visits by patients with a diagnosis of cancer (regardless of patient age) currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.*	4 — Supportive Care

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Patient emotional well-being assessed by second office visit	**ASCO**	QOPI Measure 24		4 — Supportive Care
Action taken to address patient problems with emotional well-being by the second office visit	**ASCO**	QOPI Measure 25		4 — Supportive Care
Documentation of patient's advance directives by the third office visit	**ASCO**	QOPI Measure 25a		4 — Supportive Care
Anti-emetics prescribed or administered appropriately with moderate/high-emetic-risk chemotherapy	**ASCO**	QOPI Measure 29		4 — Supportive Care
Medical and Radiation Oncology — Plan of care for pain	**ASCO** **CMS** **CMS**	QOPI 3-6e MIPS - Quality ID: 144 Oncology Care Model - OCM-4b	*Percentage of visits for patients with a diagnosis of cancer (regardless of age) currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.*	4 — Supportive Care
Preventive care and screening: Screening for depression and follow-up plan	**CMS**	Oncology Care Model - OCM-5	*Percentage of patients aged 18 years and older screened during the measurement period for depression on the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen.*	4 — Supportive Care
Psychosocial distress screening	**American College of Surgeons**	CoC Standard 5.2	*Each calendar year, the Cancer Committee implements a policy and procedure for providing and monitoring psychosocial distress screening and referral for psychosocial care (on-site or by referral).*	4 — Supportive Care

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Advance care planning	**CMS**	MIPS - Activity ID: IA_PM_21	*Implementation of practices/processes to develop advance care planning that includes documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.*	4 — Supportive Care
Advance care plan	**NCQA**	HEDIS Care for Older Adults	*Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision-maker documented in the medical record or documentation in the medical record that an advance care plan was discussed, but the patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan.*	4 — Supportive Care
Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life	**ASCO**	QOPI Measure 49icu	*Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life.*	4 — Supportive Care
Proportion of patients not admitted to hospice	**ASCO**	QOPI Measures 42, 43a, 46 MIPS Quality ID: 456	*Proportion of patients who died from cancer not admitted to hospice.*	4 — Supportive Care
Chemotherapy administered within the last two weeks of life (Lower score - better)	**ASCO**	QOPI Measure 48 MIPS Quality ID: 453	*Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life.*	4 — Supportive Care
Proportion of patients admitted to hospice for less than 3 days	**ASCO**	QOPI Measures 44, 45 MIPS Quality ID: 457	*Percentage of patients who died from cancer who were admitted to hospice and spent less than 3 days there.*	4 — Supportive Care

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Proportion of patients who died from cancer with more than one Emergency Department visit in the last 30 days of life	**CMS**	QOPI Measure 49ed MIPS Quality ID: 454	*Percentage of patients who died from cancer with more than one Emergency Department visit in the last 30 days of life.*	4 — Supportive Care
Proportion of episodes ending in death in which the beneficiary was enrolled in hospice for at least 3 days immediately before death	**CMS**	Oncology Care Model - OCM-3		4 — Supportive Care
Connects to services in the community	**NCQA**	Patient-Centered Specialty Practice - Standard PM 16 (1 credit)	*Arranges or facilitates connection with relevant ancillary and community services.*	4 — Supportive Care x 6 — Financial, Transportation, and Housing
Practice Improvements that engage community resources to address drivers of health	**CMS**	MIPS Improvement Activity ID: IA-AHE_12 (HIGH WEIGHTING)	*Select and screen for drivers of health that are relevant for the eligible clinician's population using evidence-based tools. If possible, use a screening tool that is health IT-enabled and includes standards-based, coded questions/fields for the capture of data. After screening, address identified drivers of health through at least one of the following:* – *Develop and maintain formal relationships with community-based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or* – *Work with community partners to provide and/or update a community resource guide for to patients who are found to have and/or be at risk in one or more areas of drivers of health; or* – *Record findings of screening and follow up within the electronic health record (EHR); identify screened patients with one or more needs associated with drivers of health and implement approaches to better serve their holistic needs through meaningful linkages to community resources.* *Drivers of health (also referred to as social*	4 — Supportive Care 6 — Financial, Transportation, and Housing

			determinants of health [SDOH] or health-related social needs [HSRN]) prioritized by the practice might include, but are not limited to, the following: food security; housing stability; transportation accessibility; interpersonal safety; legal challenges; and environmental exposures.	
Survivorship Care Program	**American College of Surgeons**	CoC Standard 4.8	*The Cancer Committee oversees development and implementation of a survivorship program directed at meeting the needs of cancer patients treated with curative intent.*	5 — Survivorship Care
Transition to primary care	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard PM 04 (CORE)	*Identifies patients transitioning back to primary care and communicates with the patient/ family/caregiver about the care transition.*	5 — Survivorship Care
Living situation and utilities	**CMS**	Accountable Health Communities Health-Related Social Needs Screening Tool - Core Question 1 2 and 5	*Assesses living situation for stability, personal and environmental safety, and basic utility needs.*	6 — Financial, Transportation, and Housing
Food	**CMS**	Accountable Health Communities Health-Related Social Needs Screening Tool - Core Question 3 and 4	*Screens for economic and social barriers of food insecurity.*	6 — Financial, Transportation, and Housing
Transportation	**CMS**	Accountable Health Communities Health-Related Social Needs Screening Tool - Core Question 5	*Screens for reliable transportation to medical appointments, meetings, work, or essential activities of daily living?*	6 — Financial, Transportation, and Housing

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Connects to financial resources	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard PM 17 (2 Credits)	*Engages with patients regarding cost implications of treatment options, provides information about current coverage, and makes connections to financial resources as needed.*	6 — Financial, Transportation, and Housing
Obtaining financial assistance	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard PM 18 (2 Credits)	*Helps patients' complete documents required to obtain financial assistance.*	6 — Financial, Transportation, and Housing
Preventive care and screening—Tobacco Use: Screening & Cessation Intervention	**AMA** **MIPS**	Physician Consortium for Performance Improvement (PCPI) MIPS Quality ID: Quality ID: 226	*Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.*	7 — Tobacco Education
Cancer care team encouraged patient to contact them between visits	**AHRQ**	CAHPS Cancer Care Survey Q7		8 — Navigation
Cancer care team told patient to call immediately if experiencing certain symptoms or side effects	**AHRQ**	CAHPS Cancer Care Survey Q8		8 — Navigation
Cancer care team gave patient clear instructions about contacting them after hours	**AHRQ**	CAHPS Cancer Care Survey Q9		8 — Navigation
Patient got answer to medical question same day he/she contacted cancer center	**AHRQ**	CAHPS Cancer Care Survey – Q18		8 — Navigation

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Cancer care team explained things in a way that was easy to understand	**AHRQ**	CAHPS Cancer Care Survey – Q19		8 — Navigation
Cancer care team listened carefully to patient	**AHRQ**	CAHPS Cancer Care Survey – Q20		8 — Navigation
Cancer care team showed respect for what patient had to say	**AHRQ**	CAHPS Cancer Care Survey – Q22		8 — Navigation
Cancer care team spent enough time with patient	**AHRQ**	CAHPS Cancer Care Survey – Q23		8 — Navigation
Patient got interpreter when needed	**AHRQ**	CAHPS Cancer Care Survey Q41		8 — Navigation
Cancer stage documented within one month of first office visit	**ASCO**	QOPI Measure 2	*Staging documented within one month of first office visit.*	8 — Navigation
Patient Navigator Program	**CMS**	MIPS Improvement Activity ID: IA-CC_17 (HIGH WEIGHTING)	*Implement a Patient Navigator Program that offers evidence-based resources and tools to reduce avoidable hospital readmissions, utilizing a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for patients by making hospitalizations less stressful, and the recovery period more supportive by implementing quality improvement strategies.*	8 — Navigation
Timely clinical advice by telephone	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard AC 02 (CORE)	*Provides timely clinical advice by telephone.*	8 — Navigation

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Communicating referral request	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard RM 03	*Actively communicates receipt and status of referral requests, including all of the following: receipt and acceptance of the referral, date and time of patient appointments, and information the referring clinician can expect in the referral process.*	8 — Navigation
Verifies receipt of information	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard RM 04 (CORE)	*Verifies receipt of the necessary information from referring clinicians to determine how to proceed with the referral, and: tracks receipt of the clinical question to be answered, the referral type and urgency; assesses if the clinical question is within the scope of the practice; tracks receipt of pertinent demographic and clinical data, including test results and the current care plan; determines the clinician responsible for communicating with the patient/family/caregiver.*	8 — Navigation
Follow-up after missed appointments and cancellations	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard RM 06 (CORE)	*Has a process for handling missed appointments and cancellations, including appropriate communication with the referring provider for follow-up with the patient after a missed appointment.*	8 — Navigation
Individual patient care meetings/communication	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard TC 06 (CORE)	*Has regular patient care team meetings or a structured communication process focused on individual patient care.*	8 — Navigation
Cultural competence implementation measure	**RAND Corporation**		*Organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations that adhere to 12 of the 45 NQF-endorsed cultural competency practices prioritized for the survey.*	8 — Navigation

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Provide 24/7 access to MIPS-eligible clinicians or groups who have real-time access to patient's medical record	**CMS**	MIPS Improvement Activity ID: IA-CC_14 (HIGH WEIGHTING)	*Provide 24/7 access to MIPS-eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS-eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following:* • *Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care).* • *Use of alternatives to increase access to care team by MIPS-eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or* • *Provision of same-day or next-day access to a consistent MIPS-eligible clinician, group, or care team when needed for urgent care or transition management.*	8 — Navigation 11 — Electronic Health Record (EHR)
Relevant validated measure not available at the time these measures were collected.				9 — Treatment Team Integration
Cancer Committee attendance	**American College of Surgeons**	CoC Standard 2.4	*Each required cancer committee member or the member's designated alternate attends at least 75 percent of the cancer committee meetings held each calendar year. The cancer committee monitors the attendance of required members. It is recommended that the cancer committee also monitor attendance of non-required members.*	10 — Physician Engagement

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Cancer Liaison Physician responsibilities	**American College of Surgeons**	CoC Standard 2.2	*The CLP or the CLP's alternate identifies, analyzes, and presents NCDB data specific to the cancer program, with preference for areas of concern and/or where benchmarks are not met, to the cancer committee at a minimum of two meetings each calendar year.* *The CLP is present during the CoC site visit and meets with the site reviewer to discuss CLP activities and responsibilities*	10 — Physician Engagement
Physician credentials	**American College of Surgeons**	CoC Standard 4.1	*All physicians involved in the evaluation and management of cancer patients must be board certified (or the equivalent). Physicians who are not board certified must demonstrate ongoing cancer-related education by earning 12 cancer-related CME hours.*	10 — Physician Engagement
Documentation of current medications in the medical record	**CMS**	MIPS Quality ID: 130	*Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency, and route of administration.*	11 — Electronic Health Record (EHR)
External electronic exchange of information	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard CC 13 (Maximum 3 Credits)	*Demonstrates electronic exchange of information with external entities, agencies, and registries: regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients; immunization registries or immunization information systems; summary of care record to another provider or care facility for care transitions.*	11 — Electronic Health Record (EHR)
Patient portal	**NCQA**	Patient-Centered Specialty Practice (PCSP) – Standard AC 03 (1 Credit)	*Has a secure electronic system where patients can (must show at least three): request appointments, request prescription refills, view referrals, view test results, receive timely clinical advice through two-way communication.*	11 — Electronic Health Record (EHR)

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Certified EHR System	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard TC 05 (2 Credits)	*The practice uses a certified electronic health record technology (CEHRT) system.*	11 — Electronic Health Record (EHR)
RHC, IHS, or FQHC quality improvement activities	**CMS**	MIPS Improvement Activity ID: IA_PM_3 (HIGH WEIGHTING)	*Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as an improvement activity, requires MIPS-eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.*	12 — Quality Measurement & Improvement
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	**CMS**	MIPS Improvement Activity ID: IA_BE_6 (HIGH WEIGHTING)	*Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.*	12 — Quality Measurement & Improvement
Participation in CAHPS or another supplemental questionnaire	**CMS**	MIPS Improvement Activity ID: IA_IPSA_11 (HIGH WEIGHTING)	*Participation in the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).*	12 — Quality Measurement & Improvement

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Monitoring concordance with evidence-based guidelines	**American College of Surgeons**	CoC Standard 7.2	*Each calendar year, a physician performs an in-depth analysis of the diagnostic evaluation and treatment of individual patients to determine whether it is concordant with recognized evidence-based national guidelines. The study must be a retrospective review of individual patient evaluation and treatment information, which includes a patient medical record review. The study and results are presented to the Cancer Committee and documented in Cancer Committee minutes.*	≡ 12 — Quality Measurement & Improvement
Quality Improvement Initiative	**American College of Surgeons**	CoC Standard 7.3	*Under the guidance of the Cancer Liaison Physician (CLP), the Quality Improvement Coordinator, and the Cancer Committee, the cancer program must measure, evaluate, and improve its performance through at least one cancer-specific quality improvement initiative each year.*	≡ 12 — Quality Measurement & Improvement
Quality improvements	**American College of Surgeons**	CoC Standard 7.3	*Each calendar year, the Cancer Committee, under the guidance of the Quality Improvement Coordinator, implements two cancer care improvements. One improvement is based on the results of a quality study completed by the cancer program that measures the quality of cancer care and outcomes. One improvement can be based on a completed study from another source. Quality improvements are documented in the Cancer Committee minutes and shared with medical staff and administration.*	≡ 12 — Quality Measurement & Improvement
Clinical decision support	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard KM 17 (CORE)	*Adopts at least one diagnostic or therapeutic clinical decision support at the point of care relevant to the population served.*	≡ 12 — Quality Measurement & Improvement
Validated patient experience survey use	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard QI 02 (1 Credit)	*Uses a standardized, validated patient-experience survey tool with available benchmarking data.*	≡ 12 — Quality Measurement & Improvement

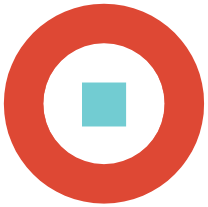
Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Vulnerable patient feedback	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard QI 06 (2 Credit)	*Obtains feedback from vulnerable patient groups on the experiences of disparities in care or services.*	☰ 12 — Quality Measurement & Improvement
Goals and actions to improve disparities in care/service	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard QI 07 (2 Credits)	*Sets goals and acts to improve performance on at least one measure of disparities in care or services.*	☰ 12 — Quality Measurement & Improvement
Improved performance for disparities in care/service	**NCQA**	Patient-Centered Specialty Practice (PCSP) Standard QI 08 (2 Credits)	*Achieves improved performance on at least one measure of disparities in care or services.*	☰ 12 — Quality Measurement & Improvement
Patient/family/ caregiver involvement in governance	**NCQA**	Patient-Centered Specialty Practice (PCSP) – Standard TC 04 (2 Credits)	*Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.*	☰ 12 — Quality Measurement & Improvement
Staff involvement in quality improvement	**NCQA**	Patient-Centered Specialty Practice (PCSP) – Standard TC 07 (CORE)	*Involves care team staff in the practice's performance evaluation and quality improvement activities.*	☰ 12 — Quality Measurement & Improvement
Rating of cancer care team	**AHRQ**	CAHPS Cancer Care Survey – Q39		Overall
Rating of overall cancer care	**AHRQ**	CAHPS Cancer Care Survey – Q42		Overall
Admissions and Emergency Department visits for patients receiving outpatient chemotherapy	**CMS**	Hospital Quality Initiative	*The measure estimates hospital-level, risk-standardized rates of inpatient admissions or ED visits for cancer patients (excluding leukemia patients) aged 18 years or older for at least one of the following diagnoses - anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis - within 30 days of outpatient chemotherapy treatment at a short-stay, acute care hospital.*	Overall

Area of Measurement	Steward/ Owner	Identifier	Brief Description	Recommended Assessment Area(s)
Risk-adjusted proportion of patients with all-cause Emergency Department visits or observation stays that did not result in a hospital admission within the 6-month episode	**CMS**	Oncology Care Model - OCM-2		Overall
Patient-reported experience of care	**CMS**	Oncology Care Model - OCM-6		Overall
Identifying unplanned hospital and Emergency Department visits	**NCQA**	Patient-Centered Specialty Practice (PCSP) - Standard CC 07 (1 Credit)	*Systematically identifies patients with unplanned hospital admissions and emergency department visits.*	Overall

Your Results

Fill in your assessment area levels for an overview of opportunities to improve care coordination for patients with lung cancer.

1.



Patient Entry Into Lung Cancer Program

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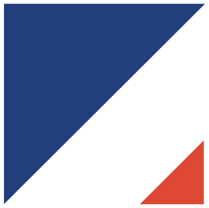
2.



Multidisciplinary Treatment Planning

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3.

Clinical Trials and Biomarker Testing

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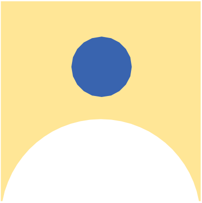

Supportive Care

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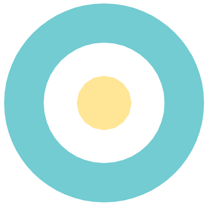
5.



Survivorship Care

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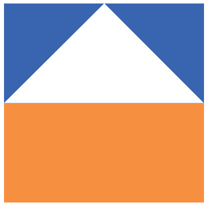
6.



Financial, Transportation, and Housing

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7.

Tobacco Education

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8.

Navigation

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9.

Treatment Team Integration

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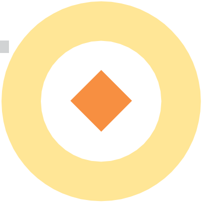
10.



Physician Engagement

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11.

Electronic Health Records (EHR) and Patient Access to Information

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1 2 3 4 5

12.

Quality Measurement and Improvement

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1 2 3 4 5

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ACKNOWLEDGEMENTS

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A publication from the ACCC initiatives, *Improving Care Coordination: A Model for Lung Cancer Patients on Medicaid (formerly titled, Optimal Care Coordination Model for Lung Cancer Patients on Medicaid)* and *Improving Care Coordination in Lung Cancer.* Learn more at accc-cancer.org/care-coordination.

The **Association of Community Cancer Centers (ACCC)** provides education and advocacy for the cancer care community. Founded in 1974, ACCC is a powerful network of more than 35,000 multidisciplinary practitioners from over 2,100 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit **accc-cancer.org**. Follow us on social media; read our blog, **ACCCBuzz**; tune in to our **CANCER BUZZ** podcast; and view our **CANCER BUZZ TV** channel.

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