Abstract #273

CREATING AN OPTIMAL CARE COORDINATION MODEL FOR LUNG CANCER PATIENTS ON MEDICAID

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INTRODUCTION

The Association of Community Cancer Centers (ACCC) created an Optimal Care Coordination Model (OCCM), that addresses access to high quality cancer care for patients with lung cancer on Medicaid. The overarching goal of this project is to provide patients, healthcare providers, and payers a scalable plan for outreach and treatment to serve as a pilot for cancer programs nationwide.

The purpose of the OCCM is to provide practical guidance to cancer programs in their efforts to achieve patient-centered, multidisciplinary, coordinated care for patients with lung cancer on Medicaid across the care continuum. The OCCM is a comprehensive self-assessment tool designed to orient cancer programs to the range of activities and tasks available to improve care for this target population.

The OCCM is beneficial to all cancer programs, regardless of size, resources, or location. It was tailored to specifically evaluate areas of high impact, optimal care for lung cancer patients on Medicaid. Although there are clinical pathways for lung cancer, many tend to focus on the treatment within the disease specialty, and do not consider critical supportive care elements of the care pathway, such as distress screening and financial advocacy.

METHODS

An environmental scan was produced by ACCC in April 2016. Major findings include: the financial and social barriers that Medicaid beneficiaries face are detrimental to outcomes and unaddressed; multidisciplinary teams are key to improving care coordination; and improvement is needed in timely access to supportive services for Medicaid patients.

Five cancer programs that are ACCC member programs were then identified as Development Sites, used to explore current care models for lung cancer and Medicaid patients. From May-October 2016, each site hosted the ACCC team for a two-day site visit during which interview sessions were conducted with multidisciplinary cancer center staff working across the continuum of care. Patients and referring practices also participated. Reports were written to capture the successes and challenges of each site.

From August 2016-February 2017, 4 individuals with extensive experience participating in and implementing the NCI Community Cancer Centers Program's (NCCCP) Multidisciplinary Care (MDC) Assessment Tool [1] formed the project's Technical Expert Panel (TEP). The MDC Tool included 7 Assessment Areas that were identified as impactful to establishing multidisciplinary care and contains an evaluation matrix, as seen in Table 1.

TABLE 1
MDC ASSESSMENT TOOL[a]

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

[a] Reproduced from [1]

RESULTS

Using the MDC Assessment Tool as a starting point, the TEP incorporated the latest best practices and knowledge obtained from the environmental scan and the Development Site visit reports to create a beta version of the OCCM.

The number of Assessment Areas is expanded to 13 compared to the MDC Assessment Tool, as seen in Table 2. This is to better capture current care coordination philosophies. It also is inclusive of topics specific to lung cancer patients (Assessment Areas 4 and 10), as well as Medicaid patients (Assessment Area 3 and 4).

TABLE 2
OCCM 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***

The beta OCCM still utilizes a Level 1-5 evaluation matrix; Table 3 highlights the evaluation criteria.

TABLE 3
EVALUATION CRITERIA

Level 1	Optimal care coordination for lung cancer care has a low priority as evidenced by fragmented care
Level 2	Early progress in coordinating care is underway
Level 3	Reflects average or typical care coordination
Level 4	Exceeds the average and reflects a cancer program's ongoing commitment to the pursuit of optimal care coordination
Level 5	Defined by optimal care coordination with a patient-centered focus. Depending on the assessment area, achieving Level 5 performance will require significant time, effort, and resources

Compared to the MDC Assessment Tool, multiple evaluation criteria are routinely included within each Level of an Assessment Area.

A new feature of the OCCM showcases quality measures and metrics that may be applicable for each Assessment Area. Optimal care coordination requires analysis and development of an action plan for continuous improvement. Table 4 provides an example of an Assessment Area.

TABLE 4
OCCM ASSESSMENT AREA EXAMPLE

Tobacco Cessation: This assessment area addresses factors related to evaluation of tobacco use and provision of tobacco cessation activities. Tobacco cessation has a direct impact on survival from cancer and other comorbid conditions. Tobacco use is 37% in the Medicaid population compared to 15% in the general population.

Level 1	Level 2	Level 3	Level 4	Level 5	Patient Focus	Quality Measures/Metrics
☐ Patient tobacco usage not assessed	☐ Patient tobacco usage assessed ☐ No formal cessation discussion documented	☐ Patient and household member tobacco usage assessed ☐ FDA-approved medication prescribed to assist with cessation ☐ No internal formal cessation counseling provided, patients referred to outside activity	☐ Patient and household member referred to a variety of evidence-based interventions, including national or state cessation assistance program (e.g., NCI), integrative therapies	☐ Formal cessation counseling provided on site throughout treatment course to patient and household member ☐ Patient and household member referred to peer support cessation program	*Tobacco cessation proves 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 members who use tobacco can benefit from a variety of cessation methods.*	Measure 11 Measure 12 Measure 13 Measure 14 Measure 15 Measure 16 Measure 17 Measure 18

CONCLUSIONS

Seven cancer programs that are ACCC member programs are currently assessing the feasibility of the OCCM. Each cancer program has implemented at least one program-specific quality improvement project focused on improving within an assessment area. Project implementation is 12 months in duration. All programs are collecting extensive data to determine the impact of their QI projects. Final data analysis will be available in early 2019.

REFERENCES

[1] Association of Community Cancer Centers. Expanding Multidisciplinary Care in Community Cancer Centers. *The NCCCP: Enhancing Access, Improving the Quality of Care, and Expanding Research in the Community Setting.* 2012, pp 40-44. `

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