



**CANCER
PROGRAM
SNAPSHOT:**

**SUCCESSES & CHALLENGES
IN PROVIDING CARE TO LUNG CANCER
PATIENTS ON MEDICAID**



Florida Hospital Cancer Institute
Memorial Medical Center

Daytona Beach, Florida





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Purpose and Background

In 2016 the Association of Community Cancer Centers (ACCC) launched a three-year initiative to develop an optimal care coordination model to serve Medicaid patients with lung cancer. This collaborative project is supported by a three-year grant from the Bristol-Myers Squibb Foundation.

In the first phase of the project, five Development Sites were selected from an applicant pool of 20 ACCC Cancer Program Members that demonstrated best practices in care coordination for patients with lung cancer on Medicaid. Applicants were evaluated by an Advisory Committee on the following criteria:

1. Volume of patients with lung cancer on Medicaid
2. Diversity of the patient population
3. Breadth and depth of patient services
4. Relationships with healthcare providers, Medicaid offices, and community partners.

Each Development Site hosted the ACCC staff team for a 2-day site visit during which interview sessions were conducted with multidisciplinary cancer center staff working across the continuum of care as well as with patients and referring practices (*see Appendix A*).

The interview sessions were used to explore the current care model for patients with lung cancer insured by Medicaid, including:

1. When and how these patients are screened, diagnosed, and treated;
2. Problems they may face in accessing timely, high-quality care;
3. What social supports they may need;
4. Whether and how they are involved in healthcare decision-making; and
5. Factors affecting their outcomes.

Through the interviews with the cancer center staff and patients, key problems in each of the above areas were identified, as well as solutions that have been put in place to overcome these barriers.



Site Overview

The Florida Hospital Cancer Institute (part of the Adventist Health System) has four cancer campuses in the Eastern Florida region (DeLand, Fish Memorial, Flagler, and Memorial Medical Center). Memorial Medical Center is the focus of this report. Memorial Medical Center has a primary service area in Volusia County, Florida, of 296,352 people and serves as a referral site for the other (smaller) cancer programs as well as over 20 clinics within the area.

Florida Medicaid Overview

The state of Florida has not opted to participate in Medicaid expansion; however, Florida follows a Medicaid managed care model, enrolling most Medicaid-eligible patients into this model. In addition, a traditional Medicaid program provided through the state is still available; however, patient eligibility for this program is very limited. To be considered for any Medicaid program in Florida, basic requirements include: being over age 65, or if younger, having a qualifying disability; living in a household with minors; and meeting income and asset restrictions. These basic requirements can prove challenging for Florida residents when compared to states with expanded Medicaid options.

Florida's Agency for Health Care Administration has divided the state into 11 regions. Florida Hospital Cancer Institute–Memorial Medical Center is located in Volusia County in northeast Florida; Volusia County is in Region 4, along with 6 other adjacent counties. There are 4 Medicaid managed care health plans available in Region 4: Molina Healthcare of Florida, UnitedHealthcare of Florida, Staywell, and Sunshine Health. Patients in Florida cannot change Medicaid insurance plans at-will, unlike in some other states. Mandatory enrollees will be assigned to a specific plan; they routinely are not able to choose the plan they prefer. Voluntary enrollees are eligible to choose the plan that best fits their needs. However, both groups may only change plans within the first 120 days of enrollment for any reason; after this time, patients must wait to change until the next open enrollment period.

At Florida Hospital Memorial Medical Center (FHMMC), there are 5 full-time staff members who assist in submitting initial Medicaid applications on behalf of patients. FHMMC accepts all 4 Medicaid managed care plans. These staff estimate that combined with their partner hospital, Florida Hospital Flagler, each month they submit 200 applications for patients seen on an outpatient basis and 100 applications for patients seen on an inpatient basis. This estimate is across all patient populations, not just oncology patients. Per hospital institutional policy, the pre-registration and registration teams also re-verify all patients' insurance for every visit to ensure coverage. This is an important step to ensure payment of services will occur for every visit.



Florida Medicaid managed care programs within Region 4 require that a participant be registered with a primary care provider (PCP), but referrals are not always required for specialty services. Once a patient is enrolled into a managed care plan, many services are covered at little or no cost to the patient. This includes oral and intravenous (IV) chemotherapy agents, home anti-emetics, and prescription narcotics. However, these managed care plans place the onus on the cancer center to obtain prior-authorization for these medications. At FHMMC, this step is done by clinical staff (nurses and social workers). If a patient has traditional, state-based Medicaid (rather than Florida managed care Medicaid), prior-authorizations are not generally needed.

Radiation services are also covered by all Medicaid plans. After prior authorization is obtained, these services require a small copay at each visit and then are covered at 100%.

Low-dose CT (LDCT) scans used for screening patients for lung cancer are typically covered without major issues at FHMMC. Patients may be rescheduled until a prior authorization for the LDCT scan is obtained, but this is a covered benefit by the Medicaid plans.

Obtaining insurance approval for PET/CT scans is more challenging. All Florida Medicaid plans follow National Comprehensive Cancer Network (NCCN) guidelines for scanning type and frequency. To assist with the approval process for PET/CT scans, additional medical documentation is routinely needed, which FHMMC will provide to the insurers.

All Florida Medicaid plans provide coverage for transportation for patients to attend appointments at the cancer center. The plans cover costs for transportation companies, which provide community van services that supply direct transportation to/from medical appointments. Transportation companies available to patients are dictated by the Medicaid plan, as each plan is contracted with specific companies.

Coverage for supportive services for patients varies depending on the need. Home health services, such as physical therapy, occupational therapy, and nursing services are routinely covered by Medicaid plans. Hospice services are also well covered by Medicaid plans. However, supplemental nutrition (e.g., Ensure, Boost, etc.) is not routinely covered by any of the Medicaid plans.

Drugs used in an investigational or experimental way are not a covered benefit by any of the Medicaid programs in Region 4, with the exception of Molina Healthcare, which notes in its plan coverage that providers can attempt to obtain a prior authorization for investigational or experimental drugs. This offers some hope that Medicaid patients under this health plan may be able to participate in a clinical trial.



Site Demographics

Most of the population of Volusia County is located within urban clusters (79%). In terms of race/ethnicity, Memorial Medical Center's patient population is predominantly white. Indeed, the patient population is below average for minority populations compared to the nation and to the state of Florida overall: 7% of the service site population is African American (compared to 16% for the state of Florida overall) and 4% is Latino (compared to 23% for the state of Florida overall). The vast majority of the population is English-speaking (99.9%). By contrast, the population has high rates of unemployment compared to the national and state averages (12.1% vs. 5.8% and 6.5%, respectively). Volusia County also experiences higher rates of chronic adult smokers compared to the state of Florida overall (23% vs. 17%).

Lung/Medicaid Demographics

Overall, 8.2% of the patient population at Memorial Medical Center is on Medicaid. In 2015, lung cancer represented 211 of 885 (24%) total new analytic cancer cases at the cancer center. Among new analytic lung cancer cases in 2015, only 2.1% of patients were on Medicaid (most, 68.8%, are on Medicare). Demographics of lung cancer patients as well as lung cancer patients with Medicaid did not differ significantly from the overall patient population, with the exception that Medicaid patients with lung cancer were more than twice as likely to be unemployed (30% of lung cancer patients with Medicaid were unemployed vs. 10.9% of all lung cancer patients). The majority (114 of 180) of new lung cancer cases in 2015 presented with multiple chronic conditions and half (99) came into treatment with late-stage lung cancer. The cancer center did not have statistics on diagnosis, other chronic conditions, or loss to follow-up by insurance type.

Highlights

- Memorial Medical Center conducted a community health needs assessment in 2012 which found that Volusia County ranked in the 3rd or 4th quartile compared to other counties in Florida in cancer and tobacco use, among other health indicators.
- According to the American Cancer Society 14% of all new cancers diagnosed are lung cancer – the rate for new cases in 2015 at the Memorial site was nearly twice as high at 24%.



I. Patient Access to Care

Challenges

- Primary Care Providers (PCPs) must make a new referral for each specialty consult, this creates tremendous delays in care, especially when PCP requires in-person visit to make this referral.
- Medicaid patients given lower priority for PCP visits, number of Medicaid patients capped by each practice.
- Most lung cancer patients with Medicaid are stage III-IV when they are finally seen by the Cancer Center.
- **No standard process** for referrals; many Medicaid patients enter the cancer center through referrals from the Emergency Department (ED) or urgent care. Patient may be referred to pulmonologist or directly to oncologist (disagreement among providers as to who should be first point of entry).
- Patients often **referred/accessing care at multiple locations** for different specialists (due to pre-existing physician relationships).
- Cancer center has been struggling to convince pulmonologists in the community to refer patients to Florida Hospital; this is due to recent, significant changes in contract model for radiology and medical oncology, they do not yet feel comfortable with the new providers and are opting to send patients to larger academic centers further away for care.
- To get to diagnosis, Medicaid patients must receive PCP referral for CT scan or biopsy. However, low numbers of PCPs and specialists in the area accept Medicaid.
- Patients sometimes **lost to follow-up** due to Medicaid requirements, **lack of reliable phone numbers or contact information** for patients.
- True referral pattern difficult to ascertain with current record-keeping systems. No data on loss to follow-up. Doctors lose track of patients that enter ED.

Solutions (in progress)

- **Imaging navigators** are being hired to coordinate care with referring PCPs and provide support beginning at abnormal scan in order to get patients into system/prevent loss to follow-up.

Solutions (implemented)

- **Radiation oncologists meet with PCPs** and encourage them to refer patients with suspicion of lung cancer directly to medical oncology or radiation oncology.
- **Any thoracic malignancy gets next available surgical slot.**



2. Prospective Multidisciplinary Case Planning

Challenges

- Lack of **coordination of appointments**, which leads to poor attendance rates.
- Lack of **communication between inpatient and outpatient teams** leads to lack of communication about patients who enter ED (lack of integrated EMR is part of problem).

Solutions (in progress)

- Lung Nodule Clinic is currently being developed. This clinic will be a collaborative project between a pulmonologist and the nurse navigator. This clinic will be utilized not only for primary lung nodule diagnosis but also for incidental lung nodule findings noted in the emergency room, inpatient and outpatient spaces. The “go-live” goal is by fall 2017.
- Lung Navigation Checklist (a clinical care pathway for lung navigators) is being developed as part of a Cancer Committee project. A standardized clinical care pathway is being developed and was expected to be completed by the end of November 2016.

Solutions (implemented)

- **Tumor Boards** meet monthly and are attended by physicians across specialties (pulmonology, thoracic surgery, medical oncology, radiation oncology, radiology, pathology) along with navigators and other support staff. The goal is to provide a **forum for multidisciplinary treatment planning** and discussions with physicians (generally pulmonologists) presenting patients after biopsy (pre-surgery), although challenging in practice.
- When possible, especially for patients with transportation issues, the cancer center **coordinates multiple specialist visits on same day**.

“I think Tumor Board discussions should be documented, and they should be passed on to the primary care doctor and what the plan is for the patient. That’s the multidisciplinary plan. When I trained, that is what we did...but we don’t do that here...If you want to keep the primary care team involved we would love for them to get the multidisciplinary team note as early as possible so they say, ‘Oh yeah it looks like all these guys met and they talked about the case. My patient’s going to get a biopsy, and they may get chemo radiation.’ I think that would be awesome. Otherwise they are going to get pieces of notes—one from me and one from radiation. They may not get one from surgery because we didn’t send them, but they may think that they are going to get one from surgery because they don’t know the plan. That is one of the things that I think might be helpful.”



3. Financial, Transportation, and Housing

Challenges

- **Transportation options covered by Medicaid take hours of staff time** to coordinate; it can often take several days to set up pick-up and drop-off for treatment at the cancer center.
- Issues with transportation coverage for patients who need to **receive care across county lines**.
- Takes 2-4 weeks to get on Medicaid, no ability to fast-track, not even for stage IV NSCLC patients.
- Working with patients in the Florida “Share of Cost” program is a particular challenge. For those who are uninsured or on self-pay the center will see if they are Medicaid eligible, but cases can take time to open up and there is not a dedicated person for this role (which would be an additional position and salary); this causes delays in care and decreased access to supportive care drugs.
- Requirement to re-apply for Medicaid is significant barrier to providing treatment.
- Mixed levels of awareness among support staff regarding charitable/ community resources available to patients.
- For patients, biggest financial burden is cost of **transportation**.
- **Patients with Medicaid managed care plans (99%) do not qualify for nutrition supplements.**

Solutions (implemented)

- Memorial Medical Center has a dedicated financial team on site with counseling services available to patients.
- Financial services team on site with **linkages to multiple charitable and community partners**.
- American Cancer Society provides vouchers to patients for transportation (bus system), grocery shopping and other nonmedical needs to eliminate barriers for patients. Cancer center can also refer patients in need of overnight stays to the ACS hotel partnership program as well as the Hope Lodge program.
- Memorial Medical is a full-service cancer center offering care to a full spectrum of patients. Panels noted benefits to having more services in one place for transportation-challenged patients.
- **Physical Medicine & Rehabilitation Department** on site (although low awareness of this service among staff).
- Palliative care and **hospice** services provided in home and inpatient settings.



4. Management of Comorbid Conditions

Challenges

- Large number of **comorbidities** among Medicaid patients leads to coordination difficulties between cancer center and PCPs, and to treatment delays as these conditions need to be managed.

Solutions (implemented)

- Patients encouraged to use American Cancer Society (ACS) binder provided at the start of treatment to curate their own medical records across providers, including records related to co-morbidities and medications.



5. Care Coordination

Challenges

- **Nursing staff cannot refer** patients for navigation.
- Single lung navigator on staff to cover patients across all 4 locations
- Lung navigator not typically seeing patients until they enter Memorial location for radiation.
- **Lack of knowledge about navigator role** across continuum of care (internal politics) as well as lack of training/empowerment and lack of metrics to measure navigator performance.
- **Inpatient floor nurses struggle to articulate the value of navigators;** navigators feel they have to prove their value to other nursing staff.
- Lack of **coordination between navigators and community case managers** (hard to reach).
- State Medicaid office has case managers but cancer center staff have not been informed about how to access them.
- **Guest liaisons** in the front lobby are responsible for supporting the entire patient experience, including providing a positive and welcoming entrance and waiting area environment for patients and acting as a patient advocate providing additional physical and emotional support to patients.

Solutions (in progress)

- **Imaging navigators** are being hired for support and coordination beginning at abnormal scan, through biopsy. Malignant biopsy will be the trigger to transition care coordination to the lung navigator.

Solutions (implemented)

- **Lung Navigator** available to lung cancer patients to help improve follow-up through survivorship. Physicians with high-needs patients can reach out to lung navigator for assistance with care coordination.
- **Lung navigator gets weekly list of all new consults from medical oncology, as well as list of patients being seen by thoracic surgeon.**
- **Lung navigator regularly visits inpatient nursing staff** to promote the services navigators are able to provide.
- **Screening process used at initial patient encounter** to determine whether patients with complex care coordination needs are eligible for hospital's Community Care program (the screening looks at socioeconomic status, education, adherence potential, psychosocial stressors, and support). The program provides home visits and coaching.
- **Social worker will write referral orders for PCPs** to sign to accelerate care for Medicaid patients.



- Navigator works to get patients into radiation first so they can do chemo after because chemo is likely to wipe them out. If patients go to chemo first, they may feel too exhausted to go their radiation appointment and will skip.



6. Treatment Team Integration

Challenges

- Once in diagnosis and treatment phase, there are challenges to keeping the inpatient, outpatient, and referring/PCP teams up-to-date.
- Tumor Board meeting **minutes not shared with referring PCPs.**

Solutions (implemented)

- **Tumor board meetings open to all physicians** (pulmonologists, radiation oncologists, medical oncologists, palliative care, etc.) and supportive care team members (including navigators, social workers, hospice, etc.) within the cancer system.
- **Daily huddles** of the radiation oncologist, navigator, social worker, front desk staff, and nurses to review the day's cases.
- **Regional Pulmonary Program Governance Committee** launched in the spring so that the cancer center could offer LDCT. Committee voting core is pulmonology, thoracic surgery, interventional radiology, radiation oncology, medical oncology. Committee meetings are facilitated by the Cancer Program Administrator and PCPs and other healthcare providers (HCPs) involved in care are invited to attend.

A vertical decorative bar on the left side of the page, featuring a repeating pattern of white icons on a teal and light blue background. The icons include human figures, lungs, pills, smartphones, tablets, speech bubbles, and arrows, representing healthcare and digital technology.

7. Electronic Health Records (EHRs) and Patient Access to Information

Challenges

- All patient records are electronic but are stored on **different EMR systems depending on the department and are not integrated.**
- **Patient portals are not integrated and are underutilized;** staff, across the care continuum, unclear on capabilities of the existing patient portal.
- Medicaid patients and older lung cancer patients are not typically able to access or are not comfortable with accessing patient portals.

Solutions (implemented)

- The navigators have the ability to view information in the medical oncology and radiation oncology EMR systems. In addition, the **Cordata Nurse Navigation System** has just been made available for the team to use.



8. Survivorship Care

Challenges

- Patients are **lost to follow-up** post-treatment (no formal way of keeping track of them, contact information changes, etc.).
- Cancer care team doesn't receive regular reports from PCPs during surveillance period.

Solutions (implemented)

- All patients provided with **Survivorship Care Plan**; this is also forwarded to all physicians involved in their treatment.
- **Spiritual services** provide continual support/follow-up to patients from entry through survivorship.
- Cancer center hosts an **annual Survivorship Day** that provides patients and caregivers with the opportunity to meet with their care team members and peers in an informal setting.
- Cordata, nurse navigation software, was built and is now operational.



9. Supportive Care

Challenges

- Lack of **referrals/understanding of palliative care by other care team staff.**
- In some Florida Hospital locations, physicians refuse to refer patients to palliative or hospice care.
- Screening tool for **palliative care is not widely used and entry to care requires referral** from physician (nurse cannot make referrals).
- Low awareness (low rates of referrals) among clinical staff of additional services offered leading to delays in care (particularly for rehab services).
- Difficult to get **coverage for a full month's supply of supportive care medication for Medicaid patients** – leads to frequent ED visits and hospital admissions for pain management and nausea.
- Drug diversion – many patients have their supportive care/pain medications stolen by friends and family.
- **Psychosocial distress screening scores are not shared across providers.**
- Patients unclear on the value of advanced care planning early in treatment.
- Medicaid patients often on hospice less than one week.
- Process not standardized and fully implemented to notify treating medical oncologist and radiologist when patient is referred to hospice on the inpatient side.

Solutions (in progress)

- Team is looking at working to create EMR triggers for automatic consult to palliative care.
- Hospice team working to establish auto-consult for hospice care in ED to avoid unnecessary hospital admissions.
- Creation of clinical care pathway to ensure referral of cancer patients who meet criteria.

Solutions (implemented)

- **Palliative Care screening tool** available for determining eligibility.
- **Secure prior authorization for multiple supportive care medications at initial submission** to make it easier to switch when something isn't working.
- Both radiation oncologists are **board certified in palliative care.**
- Inpatient hospice allows the patient to end life in a familiar environment with a familiar care team.
- Infusion nurse provides patient and caregiver education; encourages patients to contact cancer center before going to the ED for issues such as dehydration and nausea.



- Medical oncologists conduct comprehensive social history to assess potential barriers to adherence to the treatment plan.
- **Psychosocial distress screening** of all patients is conducted prior to radiation therapy as well as prior to chemotherapy by social worker. Distress tool uses NCCN thermometer to look at both emotional and physical symptoms. Scores are not compared – rather patients are assessed and counseled based on the assessment at that point in time.
- Side effect management.
- **Staff Spiritual Ambassador program** trains and designates staff and physicians as “spiritual ambassadors” to provide greater spiritual outreach/support to patients as well as expand opportunities/avenues to link patients to key services and resources.
- **Pet therapy program** available to patients with at least 2 pets on site per day. Pet therapists sit and talk with patients, provide support. Anecdotally, the program has helped to lower distress scores (pain, depression) among high distress patients (though not formally measured).
- **American Cancer Society provides many resources and services to support patients through the cancer center.** ACS partners with the cancer center on three programs:
 - Cancer Resource Center (on site)
 - I Can Cope class that meets monthly, coordinated by site’s social worker
 - Look Good, Feel Better class that provides support to patients
 - ACS representative also partners with lung support groups to coordinate presentations and provide resources and information for distress and psychosocial needs specifically for lung cancer patients.
- **ACS representative invited to attend Cancer Committee meetings** to collaborate on psychosocial survivorship standards.



10. Tobacco Cessation

Challenges

- **High rates of tobacco use** among Medicaid population.
- **Lack of community resources** and early education about tobacco use.

Solutions (implemented)

- Some referring practices using **Physician Quality Reporting System** that prompts physician to address tobacco cessation at every visit.
- Cancer center provides smoking cessation **education pamphlets** to referring PCPs.
- Collaborates with AHEC, a state-sponsored smoking cessation program, to offer different forms of smoking cessation activities including classroom didactics, telephonic counseling, and nicotine patch for free.



II. Clinical Trials

Challenges

- Concerns around **complex written consent process and educational materials** for trials, as well as compliance issues (additional labs, imaging required).
- **State does not cover costs** of certain imaging (e.g., PET scans) that may be needed for Medicaid patients to participate in certain clinical trials.

Solutions (implemented)

- **Research nurse** hired by medical oncology to oversee assessment of patient eligibility and enrollment.
- **Clinical trials are vetted** to ensure that there is nothing outside of the standard of care that would not be covered by insurance/drug companies.



12. Physician Engagement

Challenges

- Diagnosis and **referral to CT/biopsy made by PCP without input from pulmonologist, oncologist or multidisciplinary cancer team.**
- Hospitalists manage care for all oncology patients who come into the ED but they do not routinely contact medical oncologist and/or radiation oncologist actively treating these patients.
- Prior to the reorganization of Florida Hospital's cancer service line, **radiation oncology services were provided on a contractual basis.** During the transition to full-time staff on site, radiation oncology was staffed by locums leading to **distrust among referring physicians.**

Solutions (in progress)

- **Share cell phone numbers of all providers across the team:** medical oncology, radiation oncology, ED physicians, hospitalists, navigators.

Solutions (implemented)

- **Cancer program administrator and lung navigator regularly visit** referring PCPs to provide greater education/awareness around ordering LDCT scans (including billing codes) and market the cancer center services, including the role of the navigator in helping to maintain/coordinate the patient's relationship with his or her PCP.
- During Florida Hospital's regionalization process, **the cancer service line was reorganized**, and the hospital now partners with Florida Cancer Specialists (FCS) for medical oncology services. Medical oncologists that were employed by Florida Hospital were absorbed by FCS during this process ensuring continuity (same team but employed by a different entity). In addition, the hospital added its own radiation oncology team (employed through Florida Hospital Medical Group), replacing services that were previously provided on a contractual basis.



13. Quality Measurement and Improvement

Challenges

- RQRS reporting metrics not specifically used to understand Medicaid population.
- **Extracting referral data from cancer registry** is a challenge. Need to better define what a referral is in order to get a better picture of patterns of patients coming in and out of the cancer center.

Solutions (in progress)

- Conducting special study on timeliness of care.
- Implementing an imaging navigator to speed up front end and not lose patients from the treatment cycle.

Solutions (implemented)

- National care guidelines used to shape discussions around patient care during Tumor Boards.
- Share results from QI measures specific to lung cancer at Cancer Committee and Performance Improvement Committees; this has resulted in change in labeling of specimens and improved communication with surgeons and pathologists.
- In 2015 the cancer center implemented an assessment of analytic lung cancer patients to determine the average number of days from biopsy to the start of treatment using cases from 2013-15 (as compared to NCBC and NCDB benchmarks). The study also looked at timing of consults with medical oncologist, radiation oncologist, and thoracic surgeons. Several QI measures were identified based on the data including implementation of a lung navigation checklist and providing greater education around treatment coding to minimize discrepancies.
- Measure patient satisfaction with care (HCAPHS, Press Ganey).

APPENDIX A

Site Interview Participants

Panel	Participants
Program Overview	Imee Unto, Administrator Clarissa Moholick, Cancer Registrar
Flow of Patient Care	Denise Norfolk, Nurse Navigator Holly Soucy, Nurse Navigator
Medicaid Patients with Lung Cancer	1 patient
Patient Care	Dr. Shravan Kandula, Radiation Oncologist Linda Misko, Nurse Educator Ann DeCarr, Nurse Navigator Jenny Ketring, Social Worker Deb Duvall, Social Worker Amy Seymour, Nursing Director Denise Norfolk, Nurse Navigator
Supportive Care	Jennifer Robinson, Dietitian Vonetta Pottinger, Hospice Marshall Hughey, Pharmacy Abigail Badger, Clinic Nurse Mary Bowman/Jesse McGinnis, Inpatient Nurse Debra Allison, Respiratory Therapist
Psychosocial Care	Jenny Ketring, Social Worker Farzad Nourian, Spiritual Provider Stephanie Holland, Financial Advocate Lenore Papier, Cancer Center Volunteer Joanne Koury, Health Coach Barbara Kilgore, Hospice PetPartner Irene deJesus, Community Health
Care Coordination and Communication	Dr. Eric Harris, Medical Oncologist Dr. William Hamp Johnson, Thoracic Surgeon Dr. Shravan Kandula, Radiation Oncologist
Referring Facilities	Dr. Joanna Wierzbicki, Family Medicine Physician Dr. Victor Melgen, Medical Oncologist



Association of Community Cancer Centers

This publication is a benefit of membership.

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OPTIMAL CARE COORDINATION MODEL

For Lung Cancer Patients on Medicaid



Bristol-Myers Squibb Foundation

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