



**CANCER
PROGRAM
SNAPSHOT:**

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

Genesis Cancer Care Center

Zanesville, Ohio





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Purpose and Background

In 2016 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 20 ACCC member applicants who 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 health care 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 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 put in place to overcome these barriers.



Site Overview

Genesis Cancer Care Center is a comprehensive community cancer program **affiliated with the Genesis Healthcare System** in Ohio. The cancer center is located on the same campus as the Genesis Hospital, and opened its current facility in January 2015. Genesis Cancer Care Center serves the 6 southeastern Ohio counties, with an estimated population of 227,516 people and 22 referring practices.

Ohio Medicaid Overview

Ohio began participating in the Medicaid expansion as of January 1, 2014, and uses a managed care model to provide services. This expansion has extended coverage to more individuals. With the expansion inclusion criteria are as follows: anyone age 19 and older, having a household income less than 138% of the federal poverty level, and meeting a citizenship requirement. Unlike previous requirements, under expanded Medicaid, an individual does not need to be 65 years old or older, have a dependent child in the household, and financial assets are not accessed.

In Ohio there are 5 Medicaid managed care health plans that patients, once eligibility is confirmed, can choose from. These include Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Advantage, and UnitedHealthcare. Traditional, state-sponsored Medicaid is still in effect, but individuals are rarely placed in this program long-term; it is used more as temporary coverage immediately after an individual is deemed eligible for Medicaid coverage. Individuals then have a limited amount of time to transition from the traditional Medicaid plan to a managed care plan.

At Genesis Cancer Care Center, 3 full-time patient financial advisors (PFAs) are available to assist patients in completing an application for Medicaid. However, they do this less frequently now; anecdotally, this is because fewer patients are qualifying for Medicaid due to income requirements. However, the PFAs do refer patients to nearby Muskingum Valley Health Center, where certified insurance application specialists are on-site to help start the Medicaid enrollment process. By the time patients reach the cancer center, they are already likely to be enrolled in Medicaid if they were recently hospitalized at Genesis Hospital, as the hospital has on-site counselors who will also enroll patients in Medicaid during their inpatient episode.

Genesis Cancer Care Center accepts all 5 Medicaid insurance plans, but, anecdotally, most patients are enrolled in either Molina Healthcare or CareSource, as both have been in existence for several years and have name recognition. If patients do not select a managed care plan, they are typically



enrolled in the Buckeye Health Plan. This plan can be frustrating for the cancer center, as the insurer will only provide authorization notifications via regular mail; Buckeye Health Plan will not provide authorizations over the phone, via fax, or any other electronic communication source. Compared with other plans, Molina Healthcare has the slowest turnaround time to obtain treatment authorizations, which can significantly delay care. However, the cancer center will start treatment for a patient prior to receiving an official authorization from any of the managed care plans only if the PFAs and administration feel confident an authorization will be granted. If an authorization is denied by the managed care plan, the patient is not held financially responsible; instead, the cancer center must find an alternative payment source (free or replacement drug from the drug manufacturer) or write-off the complete treatment cost at their expense. Medicaid patients are never not treated because of an insurance authorization issue.

All Ohio Medicaid programs require that a participant be registered with a primary care provider (PCP), but referrals are not required for specialty services. Once a patient qualifies for Medicaid, 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, the onus is on the cancer center to obtain a prior-authorization for these medications. At Genesis, this is done by either the PFAs (for IV medications) or the nursing staff (for oral medications). Copays are generally not applied for any oral medications.

Genesis has a robust nursing staff that has divided tasks for obtaining oral medication prior authorizations between different nursing roles. The Nurse Navigators work to obtain the oral chemotherapy authorizations. Their responsibilities include following, tracking, and coordinating care for patients through the entire continuum of care, and they are the main points of contact for patients with questions or concerns. The Nurse Navigators also assist patients with identifying psychosocial barriers and finding assistance when possible. The Physician Nurses obtain authorizations for anti-emetics and narcotics. They are the back-up support to the navigators, however their main responsibilities include working on daily tasks for patients and physicians, such as acting as scribes for the physicians, triaging patient needs over the phone, and handling medication refills. These nurses also complete Family Medical Leave Act (FMLA) and disability paperwork when necessary.

All of the Medicaid plans cover radiation services very well. Occasionally, a peer-to-peer authorization may be needed to obtain coverage, but once the peer-to-peer is completed, radiation is almost always covered.

PET/CT scans are typically approved by the Medicaid plans, but require prior authorization. At Genesis, an outside third-party obtains scan authorizations for



routine scans, but the PFAs are responsible for obtaining STAT and urgent scan authorizations. The PFAs state that it is particularly challenging to obtain STAT scan authorizations, especially from the managed care plans that are slow to respond to authorizations. Genesis has made the decision in the past to obtain a scan when urgently needed, and handle the authorization process later.

All 5 Medicaid plans provide robust coverage for non-emergency transportation for patients to attend appointments at the cancer center. Patients can obtain free transit in the form of community vans through their managed care plan (most plans provide 30 round trips or 60 one-way trips per calendar year). Patients are expected to arrange transportation up to 2 days in advance, but can sometimes obtain transportation more urgently if needed. Medicaid-eligible patients can also take advantage of subsidized transportation via bus in the county they live in. Genesis has partnered with the local Cancer Concern Coalition to provide gas cards to patients if they exceed the number of Medicaid-covered transit opportunities.

Supplemental nutrition (e.g., as Ensure, Boost, etc.) is routinely covered by all the Medicaid plans, especially when medically necessary due to weight loss or a cancer diagnosis that impedes eating. The Nurse Navigators and Physician Nurses obtain authorizations for supplemental nutrition.

Drugs used in an investigational or experimental way are not a covered benefit by any of the Medicaid programs, so clinical trial participation for Medicaid patients may be difficult.

Hospice services are covered by Medicaid plans. However, patients must meet eligibility requirements to obtain prior-authorization to receive care. Home health services, such as physical therapy, occupational therapy, and skilled nursing services also require a prior authorization, but the Medicaid plans routinely authorize these services. The Physician Nurses at Genesis arrange for these services.

Site Demographics

Genesis Cancer Care Center's patient population is located within the six southeastern counties of Ohio and is entirely rural. In terms of race/ethnicity, the patient population has a lower percentage of minorities compared to the state of Ohio overall: 95% white, 2% African American, and 1% Hispanic (compared to 82.7% white, 12.2% African American, and 3.1% Hispanic statewide). Overall, the state of Ohio has a slightly lower rate of adult smokers (20.1%) compared to the national median of 21% (Centers for Disease Control, 2011).



Lung/Medicaid Demographics

In 2015 lung cancer represented 165 of 778 (21%) total new analytic cancer cases at the cancer center. Among new analytic lung cancer cases in 2015, 11% of patients were on Medicaid. Demographics of lung cancer patients as well as lung cancer patients with Medicaid did not differ greatly from the patient population overall. Of the lung cancer patient population, 100% speak English as their primary language. Lung cancer patients with Medicaid were more likely not to be in the workforce compared to the lung cancer patient population overall (32% vs. 25.5%).

Highlights

- A disease-specific navigator follows patients through the continuum of cancer care including survivorship or end-of-life care.
- Genesis has a palliative care program (both inpatient and outpatient) fully integrated into the cancer center. Palliative care referrals increased by 28% in 2015.



I. Patient Access to Care

Challenges

- Many Medicaid patients with lung cancer enter the system **through the ED/ hospital**.
- Most **PCPs in the area do not accept Medicaid** and most of those that do are not accepting new patients; so access is limited. Medicaid patients use FQHCs, but they have less communication with the cancer center than PCPs in the Genesis Healthcare System. Getting an appointment at the FQHC can take 2-3 months.
- Physicians not affiliated with Genesis may not understand the **multiple access points** (pulmonary clinic, radiologists, medical oncologists, etc.) to the cancer center. Some send patients to the ED when a mass is found, which causes delays in getting the patient to the appropriate physician at the cancer center.
- Some referring **physicians are still doing chest x-rays** because they are not convinced of the research supporting low-dose CT scans for lung screening.

Solutions (in progress)

- **Access to PCPs is improving** with FQHCs in 3 of the 6 counties the cancer center serves, but Medicaid's PCP referral requirement continues to be a barrier to entry for many patients.

Solutions (implemented)

- **Lung cancer screening program** using low-dose CT scans on-site. Scans are read by a radiologist and pulmonologist that same day, and patients are offered a same-day appointment with the pulmonologist to get results.
- **Referring centers (FQHCs and Genesis-affiliated PCPs) are on the same medical records system as the cancer center (Epic)**, enabling greater access to and transfer of patient records (labs, scans, pathology reports, etc.).
- Provider at FQHC **tracks all urgent referrals** in a red folder; her goal is to handle each of those within a week. She views follow-up as her role, not the patient's.
- Cancer center navigators track all patients with positive pathology to catch delays in entering the system. Pathology reports are sent to the navigators daily, who **reach out to the referring physician if a follow-up or appropriate referral is not scheduled in time**.



“The faster you get them connected the less chance that there is of losing them, or disconnection, or bad things happening. If you see something the same day and have a plan before they leave the office, it really helps.”



2. Prospective Multidisciplinary Case Planning

Challenges

- Many Medicaid patients are entering care during later stages of the disease (stage III or IV) due to **delayed care seeking**, lack of access to PCPs, and reluctance to participate in smoking-cessation programs.
- Diagnosed or undiagnosed **psychiatric illness** is a significant barrier to care among many Medicaid patients and community resources towards addressing this need are lacking.

Solutions (implemented)

- **Treatment algorithms are the same** regardless of insurance type, however, a patient's access to support, transportation, etc., may be taken into consideration when determining the appropriate treatment protocol. The navigator and palliative care team help identify those risks and communicate them to the physician.
- **Treatment plans are pre-built into the EMR system**, following evidence-based guidelines, and the cancer center has an internal peer review of treatments.
- Patients who are **Medicaid-pending receive treatment** during that process.

“One thing is just that we try to have an algorithm or protocol, or things that we follow, but every single patient is different. We just have to identify that early on. Whether they need to have their medications pre-packed, if they need to be call-in, whatever the case maybe, we try to accommodate that for them.”



3. Financial, Transportation, and Housing

Challenges

- **Many barriers to care for Medicaid patients:** food security, housing, transportation, “drug diversion,” and financial toxicity.
- Oral and IV chemotherapies are covered through separate prescription drug programs, and panelists report **delays approving and funding oral chemotherapies for Medicaid patients.**
- Medicaid patients have limited resources available within the broader community – financial assistance through cancer center can only go so far.
- Medicaid patients are not educated by the plans about their rights/coverage.
- The cancer center serves the surrounding 6 counties, so many patients **travel more than an hour** to receive care. Each county provides different transportation services.
- **Medicaid–subsidized transportation** is only available in 3 of the 6 counties served by the Cancer Center. Transportation must be scheduled 48 hours in advance and is unreliable, so patients often must wait.
- Many Medicaid patients are difficult to reach due to **unreliable access to phone and internet.**
- **No physician telemedicine** services for oncology patients.
- Medicaid patients often have **low caregiver involvement** (difficulty getting caregivers to come consistently to appointments).

Solutions (in progress)

- **Gas cards** are provided to patients through community resources and fundraisers, but they are a temporary solution.
- Developing a **centralized hotline** at the cancer center for patients to receive help with transportation from community resources.

Solutions (implemented)

- Resource counselors are employed by Genesis Financial Department and work closely with the cancer center to meet with every patient as financial advisors.
- Every patient completes a **community resource form** and meets with a **resource counselor on their first visit.** Counselor knows what the patient’s out-of-pocket cost will be before that meeting so patients never have to worry about their entire bill.



4. Management of Comorbid Conditions

Challenges

- **Lack of clear boundaries between PCP and treatment team** for managing comorbidities. Cancer center assumes all care for some patients, while others continue to receive care from PCP for treatment of comorbidities.
- Very few resources for **managing psychiatric illnesses**.

Solutions (in progress)

- **Treatment team manages comorbid conditions for patients who are not seeing a PCP** and would not otherwise receive that care.

Solutions (implemented)

- **Palliative Care physician communicates between cancer center and PCP** who is managing comorbid conditions.



5. Care Coordination

Challenges

- **Lack of a dedicated social worker on staff, while intentional, poses challenges.** Patient social and emotional needs are met by nurse navigator, financial resource counselors, and spiritual care provider. However, nurse navigator is often spread thin.
- **Many barriers to communication for Medicaid patients exist,** including high illiteracy rates and skepticism or misinformation about healthcare.

Solutions (in progress)

- Patients are **signing up for the patient portal** but not necessarily using it. Access instructions are given with the discharge summary. Signing up is tracked, but usage is not.
- **Social workers at the hospital** can be available if high level of social work services are needed.

Solutions (implemented)

- **Every patient meets with a disease-specific nurse navigator after diagnosis** (this is a tracked measure, at 100% for the year 2015). Navigator team receives all positive pathology reports daily and assigns them by tumor site; goal is for the navigator to try to reach out to patients before their first appointment.
- **Lung navigator will meet with a patient when he/she meets with the pulmonologist to receive a cancer diagnosis following a scope.**
- Patients are **navigated from the time of positive pathology through survivorship or end-of-life.** Navigators continue to be a resource for the patient for follow-up or questions even after patients leave the cancer center.
- Navigators are **a single point of contact** for patients. Patients are given navigator's business card, which includes a photo of the navigator, at the time of biopsy or diagnosis and can reach any of their treatment team members through their navigator's number, which is forwarded to her cell after hours.
- Non-clinical staff run a **call center** that handles all calls coming to the cancer center's main line; phone never rings more than 3 times before patient is connected to a person. Call center staff is trained to convince patients to come in when call to cancel appointments because of inability to make copays.



- Highly centralized navigation staff. Navigators are the **central “hub.”** Morning full-team huddles are held in the navigator office, which is centrally located in the facility. Huddles are attended by nearly all team members: radiation and infusion nurses, palliative care, navigators, research nurses, resource counselors etc. Physicians and managers do not attend to allow for greater communication among the rest of the team. Information about the patients is recorded in their chart and also shared verbally with the navigator to communicate with the rest of the team.
- **Front-end staff are trained to be patient-focused**, to listen for barriers to care when speaking with patients, and to communicate barriers to the navigator.

“[Nurse navigators] were placed strategically right in the middle of everything. Everybody can come to us and we can go to them. That has worked very well.”

“It’s not really navigation. It’s care coordination and care management, and that is the sort of beginning and ending of everything here for everybody.” (Patient Care Panel)



6. Treatment Team Integration

Challenges

- Physicians **bill separately** for services.
- PCPs generally do not attend tumor boards.

Solutions (implemented)

- **Strong culture of communication among all treatment team physicians.** This is done both verbally (phone calls) and electronically, through integrated EMR (Epic).
- **The cancer center has a culture of “continuous virtual multidisciplinary clinic.”** This culture was developed with strong support from the medical oncology Medical Director who actively recruited physicians with a focus on a whole-team approach. Physicians have times left open for same-day appointments and communication with other physicians. Medical oncologists and palliative physicians sometimes schedule appointments together and physicians call each other several times throughout the day.
- **Interdisciplinary huddles** every morning are attended by radiation, medical oncology, pharmacy, navigators, infusion nurses, palliative care, resource counselors, and research nurses; physicians and managers are not invited to attend. These huddles have been used to identify systemic issues.
- Navigator continues with patients from inpatient to outpatient setting and several nurses have worked on both units, creating an **easy transition when patients move between units.**
- All staff, from physicians to call center employees, are **recruited for and trained to have a patient-centered care philosophy.** The cancer center went through staff turnover until they had a team focused on meeting the patients’ medical and psychosocial needs. Staff provide care that fits the patients’ needs even if that means working late or adjusting their schedule.
- **Nurses have a private room in the hospital with massage chairs, a fountain, and adjustable lighting** where they can go to re-energize.

“We’ve got people there that are discussing the gamut of what’s going on with those patients so we’re all on the same page when the patient comes in. The patient sees a seamless process.”

(Psychosocial Care Panel)

“Our physicians are excellent about picking up the phone and calling other caregivers, whether it’s a new consult or referral piece or whatever. They fully believe that electronic should not replace verbal communication about a patient because many things can be lost or misinterpreted, so they still do a lot of phone calls.”

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

Challenges

- Lack of consistency in how PCPs communicate can cause some information to slip through the cracks. Some referring physicians that are on Epic send information electronically but **do not follow-up** with a phone call to ensure it was received.
- Lack of free patient education materials. The cancer center has to pay for materials to give to patients or create their own.

Solutions (in progress)

- Data available through Epic can be used for quality improvement initiatives, for example, working on tracking the time from incidental findings in the ED to seeing a thoracic surgeon or pulmonologist to the cancer center.
- **Developing information sheets** for patients. Working to have sheets throughout the building so patients can get information and suggested questions to ask while waiting for appointments.

Solutions (implemented)

- All providers within the Genesis Healthcare System, as well as the FQHCs, are on the same, **integrated EMR system** (Epic), so information and referrals are easily shared.
- **Oncology-dedicated IT consultant** updates Epic system yearly and continuously implements new tools for additional measures or triggers that the treatment team requests.
- Treatment plans following evidence-based guidelines are pre-built into the EMR system.
- **Auto-triggers are built into the EMR** in distress screening, toxicity assessment, etc.
- EMR “inbox” has tasking mechanism, which staff can assign to themselves or others to follow-up with a patient.

“Probably the frustrating part, I think is you’ve got different practices. Some practices want to just send referrals electronic and you’ve got to make sure that things don’t drop in the black box and get lost, so you know, these are concerns as the system was built you have to monitor, and then we have others that will send it electronic and also make a phone call which is, personally, our preference, and that’s what we do just to ensure.”

8. Survivorship Care

Challenges

- Most lung patients go to **end-of-life care rather than survivorship due to late-stage diagnosis**.
- Survivorship care plan is generic, not lung specific.
- Lung patients are **not attending support groups** due to transportation challenges, comorbidities, and advanced-stage disease.

Solutions (in progress)

- Treatment summary recently implemented into Epic with more specificity to the tumor site. Summary can be sent to the patient portal, but has not been implemented yet. Currently, **patients receive printed copy** that is also **sent to their PCP electronically**.
- Discussing adding **call-in support groups** for patients to get information and support without transportation barriers, since lung cancer patients are not participating in support groups. **Online support groups** are also available.

Solutions (implemented)

- Most PCPs are on Epic EMR allowing seamless communication of the survivorship care plan and allowing all providers to see scheduled follow-ups. Some PCPs quiz patients about their treatment to check for understanding.
- **Palliative physicians follow patients** to survivorship care and work with their PCP.
- Nurse navigators at the cancer center continue to be an available resource to patients during survivorship care. Patients can call at any time with questions.
- All patients and caregivers are given **ASCO survivorship plan** along with treatment summary.
- Audit trail tracks when treatment summary was given, who it was given to, and that it was sent to PCP.
- Some patients continue to go to the cancer center for **supportive care** after treatment as symptoms subside.
- **Patient pocket calendars** have contact info for the cancer center and comprehensive symptom management information. These are given to patients at the first meeting with the navigator, and patients can bring them to appointments for the navigator to update. Confirmed through patient interviews that these are used by most throughout treatment; many use it as a treatment journal.



- Clinical pharmacy used both inpatient and outpatient for treatment planning, QI tracking, patient education, discharge planning, etc. **Pharmacist provides face-to-face patient education** after initial diagnosis, before treatment, and during treatment on side effects and drug interactions. Education is provided verbally and with written materials. Education is tailored to patient needs and they are given pillboxes, calendars, or blister packs as needed.

“Even though they’ve hit the survivorship care plan, that navigator is still coordinating care for them. . . We would follow them until they pass away.” (Psychosocial Care Panel)



9. Supportive Care

Challenges

- Symptom management **medication is not always covered** by Medicaid so Palliative Care providers need to be creative with what they prescribe.
- Patients and caregivers with low literacy may **mix up similar medications** – e.g., a long-acting and a short-acting morphine, and end up taking the wrong medication at the wrong time.
- **Palliative Care** currently manages a lot of anxiety and depression, but there is a need for a full-time counselor or psychiatrist to handle psychiatric illness and substance abuse. There are no inpatient addiction treatment centers in the 6-county area.
- Lung cancer patients are diagnosed at **more advanced stages** and thus come to hospice later than other diseases.
- Many nursing homes require payment up front which causes **delays for patients who are Medicaid-pending**.
- Hospice nurses have to travel up to 1 hour and 15 minutes for home visits. They cannot serve a larger geographic area because response times would be too long.
- **Cancer Center does not have an outpatient social worker or nutritionist on staff.**

Solutions (in progress)

- Working to develop a **home palliative folder** with steps to take before calling palliative nurse or going to ED; shortness of breath has been developed, planning to expand.
- Robust inpatient **nutritional support services**, but outpatient services are lacking. Telemedicine consults used to supplement nutrition services for outpatients. Patients can order free meals when they are at the cancer center for appointments, and Ensure and other dietary supplements are covered by Medicaid.

Solutions (implemented)

- **Strong, engaged Palliative Care team.** Palliative Care is embedded in the oncology program and comprised of a team of both physicians and nurses who attend morning huddles and coordinate appointments with treatment team.
- **All stage IV lung cancer patients and any patient with symptom management automatically receives palliative care consult** at the time of diagnosis.



- Palliative physicians are dedicated to follow-up, following **patients through to hospice, assisted living, or survivorship care**. Team provides regular updates to referring PCP. Hospice inpatient notifies palliative physician of admissions within two hours.
- **Home-based palliative care program with 24/7 call availability** and NP who goes into the home at least once a month to prevent hospital admissions. Community resources help provide paid caregivers and hospice nurses assist palliative NPs with visits.
- To address lack of Medicaid coverage for supportive medications, **providers will recommend older or generic meds that patients can afford** or something they can be on long-term if they will be moving to hospice.
- **Education is provided to physicians and staff about the difference between palliative care and hospice**. Work closely together so hospice is seen as an “extension” of palliative care.
- **Symptom management information sheets** are hanging in Palliative Care office for patients to read.
- **Palliative team will meet with patients during infusion, more casual, easier to talk to family**.
- **Freestanding Genesis inpatient hospice facility** for symptom management.
- Increase in palliative care support and receiving palliative care earlier has **increased number of days in hospice**.
- **Passport**, an Ohio Medicaid program, provides custodial care in the home to help relieve caregivers assisting patients. Patients are referred to the program if they can be cared for in the home but do not have a caregiver available 24/7.
- **Distress screening given at every visit**, administered by the nurse during review of symptoms (ROS) using tool within Epic EMR, which can then be viewed by all members of the treatment team. Built-in triggers in Epic auto-refer or prompt nurse to contact navigator, physician, palliative care, or spiritual care as appropriate.

“We shaped what palliative meant for Genesis and we beat that drum hard. Palliative was care for patients with serious illness, it was expert management of symptoms and support for their families. It was not end of life care... It’s ‘this is a very normal part of your treatment and we’re going to treat it as such, you should too.’ Everyone on our team has this same consistent message. Our senior leadership, our administrators have the same consistent message.”

“It’s a very seamless program I guess, a seamless operation is what I want to say...from the Cancer Center and having the acute aggressive treatment to moving in to a more comfort-driven but very aggressive in a comfort-driven area.”

10. Tobacco Cessation

Challenges

- More **community smoking cessation resources are needed**, especially funding to cover nicotine replacement. Only part of what is needed is covered and patients must attend sessions first.
- Access to tobacco cessation education and resources is limited by the **lack of access to PCPs**.

Solutions (in progress)

- FQHC hired a new social worker to teach smoking cessation classes or refer patients to **community Quit Now program**.

Solutions (implemented)

- **Prompts for tobacco cessation** are built into Epic EHR system.



II. Clinical Trials

Challenges

- Many patients are **distrustful of clinical trials** and do not want to participate in research.
- **High illiteracy rate** makes it difficult to obtain informed consent among Medicaid patients.
- **Lack of availability of trials** for the lung cancer patient population or for cancer centers located in rural areas.

Solutions (implemented)

- **Full-time research nurse coordinator** sits down with patients and their caregivers to explain clinical trials and review informed consent. Patients are given written materials about clinical trials as well.
- **All patients are screened** for eligibility, regardless of ability to pay, and research coordinator discusses with physicians before approaching the patient.
- **The state of Ohio covers clinical trials for Medicaid patients** as long as there is a standard of care portion, it is a qualified clinical trial, and it is part of a cooperative group. Typically, costs outside the standard of care are also covered by Medicaid.

“A big barrier for us is that there’s a lot of groups that are doing clinical trials that don’t want to talk to centers like ours. We are a very busy lung cancer center but we are in the middle of nowhere. We don’t have access to the exciting things.”



12. Physician Engagement

Challenges

- Medicaid patients are often using FQHCs for primary care, which have higher patient volumes and therefore cannot maintain the same level of communication **with the cancer center** as PCPs in the Genesis Healthcare network.

Solutions (in progress)

- Cancer center is using data available through Epic EMR system to track the time from findings in the ED to seeing a thoracic surgeon or pulmonologist, and then to the cancer center, in order **to identify and reduce delays to biopsy.**
- Working on a **more comprehensive nodule program** with algorithms and access points to standardize the clinical pathway for diagnosis, focusing on incidental findings in radiology. Also working on getting additional equipment such as a radio ultrasound and updating their super-dimension software.

Solutions (implemented)

- All cancer center physicians are employees of the health system.
- Primary care physicians affiliated with the Genesis Healthcare system are on the same EMR system as the cancer center (**Epic**), which **allows for greater communication among referring PCPs and the cancer center team.** Providers have access to all notes, labs, referrals, and follow-ups.
- Health system leadership recognized the shift to **value-based care** early on and supported cancer center leadership in its restructuring of the program to accommodate this shift.
- Culture of **physician collaboration and willingness to get involved early in the process** means all physicians are communicating before the time of diagnosis. For example, pathologists are in the room when biopsies are done to ensure they have enough tissue before the patient leaves the appointment. Medical oncologists communicate with PCPs before there is a diagnosis to help them find the correct referral path and expedite the process.
- **ED regularly calls medical oncologists** to come over and meet with a newly-diagnosed patient so that he/she has a plan for follow-up before leaving.



- **Hired two new radiation oncologists who support the culture of patient-centered care.** They regularly accommodate same-day appointments and, as employees of the health system, are actively engaged in the creation and implementation of new processes.
- **Pulmonologists and surgeons will come in early and stay late to see these patients same-day** because they don't want to lose them.
- **Physicians were recruited to the cancer center who were open to a model of patient-focused care** after staff turnover at the center. The cancer center Medical Director and the Genesis Hospital CEO see the value of patient-centered care and support efforts by the cancer center administration and employees to focus on patient psychosocial needs, which are often not reimbursed. For example, they supported adding additional palliative care providers, which were then shown to be cost saving for the hospital.



13. Quality Measures and Improvement

Solutions (in progress)

- Currently looking to fill an opening for a **Clinical Operations Manager position** to focus on quality improvement, value-based care, and reducing costs.

Solutions (implemented)

- All treatment plans follow **evidence-based guidelines** and go through an **internal peer review**.
- Recently hired a Transformation Officer for the hospital to look at population health, etc.
- Data in Epic EMR enables greater tracking of quality measures, such as time to biopsy or time to initiation of treatment. Oncology-dedicated IT consultant can add additional tracking measures to EMR or change tools to make tracking quality measures easier for providers.
- Cancer program administrator and Medical Oncology medical director regularly report to hospital leadership on the status of cancer center quality projects.
- Ongoing **CoC studies** based on current needs. Recent quality initiative in palliative care led to the **addition of 1.6 additional physicians and 2 NPs** after showing the benefits of the palliative program.
- **Scorecard** with several measures including number of patients navigated, time for messages to be returned, time to contact palliative care after inpatient hospice admission, etc. The scorecard is accessible by managers within the Cancer Center and results are shared at departmental meetings and posted in the employee break room for access by staff at any time.



APPENDIX A

Site Interview Participants

Panel	Participants
Program Overview	Sharon Parker, Cancer Center Administrator
Flow of Patient Care	Carrie Lee, Nurse Navigator Kristi Smith, IT Senior Business Consultant
Medicaid Patients with Lung Cancer	3 patients, with their caregivers
Patient Care	Scott Wegner, MD, Medical Director Elizabeth Lear, Pharmacist/Chemo Educator Stephanie Bailey, Inpatient Clinical Nurse Manager Carrie Lee, Nurse Navigator Mary Hague, Radiation Oncology Nurse
Supportive Care	Erin Remster, MD, Palliative Care Physician Ann Grimm, Hospice Nurse Barb Marling, Outpatient Pharmacy Maggie Brydon, Clinic/infusion room Nurse Pebbles Kieber, Office Nurse
Psychosocial Care	Sister Bernadette, Spiritual Provider Gena Dunn, Financial Advocate Karen Wickham, Clinical Research Nurse Kimberly Tilton, Nurse Practitioner Chad Stoltz, Outpatient Nurse Manger Courtne Smith, Office Manager
Care Coordination and Communication	Scott Wegner, MD, Medical Oncology Shyamal Bastola, MD, Medical Oncology Philip Boniorno, MD, Thoracic Oncology Eugene Hong, MD, Radiation Oncology Neelima Gorantla, MD, Interventional Radiology Carrie Lee, Nurse Navigator Ilya Goldenberg, MD, Hospitalist James Adamo, MD, Pulmonologist and



	Intensivist John Zimmerman, MD, ED Physician Erin Remster, MD, Palliative Care
Referring Facilities	Primecare of Southeast Ohio - PCP Brian Luft, MD Muskingum Valley Health Center - FQHC Beth Fineran, CRNP





Association of Community Cancer Centers

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OPTIMAL CARE COORDINATION MODEL

For Lung Cancer Patients on Medicaid



Bristol-Myers Squibb Foundation

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