CANCER PROGRAM

SNAPSHOT:

SUCCESSES & CHALLENGES

IN PROVIDING CARE TO LUNG CANCER PATIENTS ON MEDICAID

Harold Alfond Center for Cancer Care

Augusta, Maine

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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 (s*ee 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 **Harold Alfond Center for Cancer Care** is part of MaineGeneral Health, a collaborative of healthcare facilities throughout Maine, and is also part of the Kennebec Region Health Alliance. The cancer center is partnered with MaineGeneral Medical Center, the central hub of the collaborative. Medical oncologists are based out of the Cancer Center but also hold satellite clinics at two, smaller community hospitals. Harold Alfond serves a primary service area in Kennebec County, Maine, of an estimated 200,000 people, and receives referrals from 34 primary care practices (of which 11 are part of MaineGeneral).

Maine Medicaid Overview

The state of Maine has not opted to participate in expanded Medicaid. Maine still follows a traditional Medicaid model that is completely state-run, as opposed to a managed care model. The Medicaid program in Maine, known as "MaineCare," is only available for those individuals under age 21 or over age 65 deemed disabled by Social Security. In addition, financial information plays a role in determining eligibility for Medicaid. However, patients who do not meet the eligibility requirements for traditional MaineCare, may qualify for another program, MaineCare Disability. In this scenario, a medical review team with MaineCare reviews all pertinent medical information to determine if the patient could be considered disabled. If the patient is deemed disabled by the review team, the patient is placed in the MaineCare-eligible category and financial information is then taken into consideration. Patients that do not meet the financial criteria for MaineCare are not excluded from eventual coverage under MaineCare Disability. For these patients, a spend-down amount will be calculated and then, once the patients meet their out-of-pocket cost of healthcare, they will be covered at 100%. A patient does not necessarily need to be deemed as 100% disabled to be granted MaineCare Disability status.

The Harold Alfond Center for Cancer Care has an entire financial team that works on all aspects of services, including benefit initiation, insurance verification and re-verification, as well as an authorization team. There are several staff who work to ensure a patient's insurance is still active, re-verifying all patients' insurance at every visit. The cancer center has a staff member, with previous experience working for MaineCare and extensive familiarity with the program, who helps enroll patients into MaineCare. She estimates that she has about a 75% success rate in enrolling patients into MaineCare or MaineCare Disability. One problem that may cause a patient to be initially denied MaineCare Disability coverage is a short duration of time from diagnosis of cancer to application for insurance coverage, as extent of illness helps to determine coverage for MaineCare Disability. However, there is an appeal process that can be utilized that enables

submission of additional documentation. The staff will submit appeals as often as necessary until a patient is approved for MaineCare Disability.

With very few exceptions, MaineCare participants are required to be registered with a primary care provider (PCP). While patients are encouraged to select the PCP of their choice, one may be assigned. Most specialists will not see a patient with MaineCare unless the patient has a referral from the PCP.

Once a patient qualifies for MaineCare, 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. Narcotics and anti-emetics infrequently require a prior-authorization and are easily obtained from an insurance standpoint, especially if the prescription is noted with a cancer diagnosis. For oral and IV chemotherapy, a prior-authorization may be required, but this is easily obtained with proof of medical necessity from the physician. The cancer center has one dedicated staff member who obtains authorization for all of the above medications. Staff in the financial department at Harold Alfond Center for Cancer Care state that patients are not always required to pay the copay for prescription drugs, but are always encouraged to do so. Table 1 below illustrates typical copay costs for prescriptions. Once patients exceed 5% of their monthly income to cover the cost of copays, copays are no longer assessed for that month. Harold Alfond Center for Cancer Care also routinely waives copay costs for MaineCare patients.

Table 1. Typical Copay Costs for Prescriptions for Medicaid Patients in Maine

$10.00 or less	$0.50 copay
$10.01 - $25.00	$1.00 copay
$25.01 - $50.00	$2.00 copay
Over $50.00	$3.00 copay

Radiation services for MaineCare patients are well covered, with very few denials. MaineCare covers these services at 100%. Harold Alfond Center for Cancer Care has a dedicated authorization specialist for radiation services.

Low-dose CT (LDCT) scans used for screening patients for lung cancer are typically covered for all patients with MaineCare. PET/CT scans are also routinely covered by MaineCare. The cancer center staff sees very few denials for these scans.

Supplemental nutrition (e.g., Ensure, Boost, etc.) is covered by MaineCare at 100% after a prior-authorization is completed. The cancer center has a nutritionist on staff who sends the prescription for the supplement to the pharmacy and works

with a member of the financial team to obtain the authorization. Should coverage be denied, the cancer center has created a nutritional voucher program through a significant donation by the cancer center's namesake, Harold Alfond. Patients who are 175% below the federal poverty level will qualify for vouchers.

MaineCare provides coverage for emergent and non-emergent transportation for patients to attend appointments at the cancer center. The plan covers the costs for community vans that provide direct transportation to/from medical appointments. The cancer center also has transportation vouchers and gas cards available through the previously-mentioned voucher program established with the help of Mr. Alfond.

Drugs used in an investigational or experimental way are not a covered benefit by MaineCare. However, drugs that are part of a clinical trial but are already standard of care will be approved by MaineCare, allowing patients to participate in some available clinical trials.

Hospice services are covered at 100% for all MaineCare patients; no prior-authorization is needed. Home services, such as physical therapy, occupational therapy, skilled nursing services, and oxygen therapy, are also covered with prior authorization approval.

One special allowance by MaineCare is the coverage of services obtained outside of the state of Maine. Patients may be referred to larger cancer centers such as Dana-Farber Cancer Institute in Boston, Massachusetts, if the patient's oncologist deems it medically necessary. A special prior authorization is required to obtain services other than those provided in Maine (and in New Hampshire within 15 miles of the Maine/New Hampshire border), but MaineCare is very generous in granting these authorizations to allow patients to receive the best care possible.

Site Demographics

Harold Alfond's patient population is predominantly located within rural areas around Augusta (82% rural, 18% urban clusters). In terms of race/ethnicity, the patient population is almost entirely white (99.6%), comparable to the state of Maine overall (95.2% white). It is also almost entirely comprised of English-speakers (99.1%). The rate of smoking among adults in Kennebec County in 2016 was 21%, above the statewide average of 19% (countyhealthrankings.org).

Lung/Medicaid Demographics

Overall, 6.3% of the patient population at Harold Alfond is on Medicaid. In 2015, lung cancer represented 174 out of 995 (or 17%) total new analytic cancer cases at the cancer center. Among new analytic lung cancer cases in 2015, 22.6% of patients were on Medicaid or Medicaid/Medicare. Demographics of lung cancer patients as well as lung cancer patients with Medicaid did not differ greatly from the patient population overall.

Highlights

- According to the American Cancer Society 14% of all new cancers diagnosed are lung cancer – the rate for new cases in 2015 at Harold Alfond was slightly higher at 17%.
- The site has invested in making the cancer center a "comforting space complete with fireplaces, soft lighting and soaring windows that provide natural light and frame views of nature."
- All lung cancer patients in the catchment area are referred to Harold Alfond, regardless of payer source. No patient is denied treatment based on payer source or inability to pay.
- Oncologists hold clinic hours at Franklin Memorial Hospital in Farmington and Redington Fairview Hospital in Skowhegan in order to better serve patients traveling from rural areas.
- Prevention Center navigators assist in getting patients to lung screenings.
- The cancer center includes the state of Maine's first stationary PET/CT.

1. Patient Access to Care

Challenges

- Panelists reported **"tremendous" access issues in primary care**. Many practices are not accepting new patients and wait times are lengthy. The MaineGeneral Prevention Center hub refers patients to MaineGeneral primary care providers (PCPs) but is having a hard time getting them connected (wait time is often 3-6 months). Not many patients are coming through FQHCs, which are overrun and tend to be a last resort.
- Many Medicaid patients are **entering through the ER**/using the ER as primary care, where they are then referred to a PCP and back to the cancer center.
- There is a **lack of auto-triggers/tracking** within EMRs of PCPs for high-risk patients that need CT screening. Referral sites stated this would be beneficial.
- Medicaid patients face financial, physical, and educational barriers to healthcare seeking: transportation, lack of family support, lack of primary care providers, and prevailing **"Mainer" attitude** of "I'm going to die from something" leading to reluctance to seek care.
- Medicaid patients often have fewer resources and sources of support, which combined with "Mainer" attitude/reluctance to seek treatment, leads to **challenges in getting patients to show up for appointments.**
- PCPs need greater education around the benefits of low-dose CT scans – many are concerned about false positives or non-coverage for Medicaid patients.
- **Pushback from some PCPs on offering LDCT**; claim that there is a high false-positive rate and dissuading patients from participating.
- Cancer center physicians say PCP is "required component" to get patients into CT scan: *"We want them to order the test, but we'll watch the results. We act on that faster."* However, **PCPs often send abnormal images** (e.g., abnormal chest x-ray) **without pathology** so that patients have to be re-scanned, biopsied, and diagnosed within the Cancer Center.

Solutions (in progress)

- MaineGeneral's Prevention Center and Primary Care teams have created a **workflow to capture patients that are high risk and meet the criteria for lung cancer screening**. Under the workflow, every low dose CT lung screening will be read with a Lung-RADS™ category that includes the recommended management of the patients. This will go to the ordering provider and PCP, and positive findings will be tracked by the Lung Navigator at the cancer center. All patients, positive or negative, are entered into the ACR Lung Cancer Screening Registry™ by the Cancer Registry team and tracked for follow-up care. The tumor board will verify best practices in treatment. Next steps are to finalize the workflow and build the Low Dose CT Lung Screening order into the EMR. This work also has the possibility of

being further supported by grant funds from a grant that is currently in progress to support community outreach for smoking cessation and lung screenings.

- MaineGeneral Medical Center recently received a grant from the Maine Cancer Foundation that would enable MaineGeneral **patients who do not have insurance** and meet certain criteria to receive their first lung cancer screening at no cost (screening is covered by Medicaid). The screening includes a low-dose CT scan, interpretation by a radiologist, and smoking cessation counseling if appropriate.
- MaineGeneral Prevention Center (which works throughout the collaborative) has a **5-year plan to reduce lung cancer deaths**. The center is conducting PCP training in-network to ensure compliance around pre-screening protocol (including correct ordering of lung screens) and then will be expanding to out-of-network PCPs, as well as ensure that data is collected through EMR. Currently focused on Medicare compliance but may affect Medicaid as well.
- Medicaid (MaineCare) **contractual requirements for evidence-based measures including tobacco screening** have encouraged greater focus and review of screening data. PCPs receive prevention reports that roll up with the balanced scorecard. The cancer center is working to institute a review process to help notify and work with practices with low screening rates of high-risk patients.

Solutions (implemented)

- MaineGeneral uses **a Crimson Population Risk Management tool (an Advisory Board product) to capture claims.** Patients are then assigned a Milliman Advance Risk Adjusters (MARA) score to determine high-cost/high-risk oncology patients and assign them to a community care team and complex care management program. Care Managers within the cancer center are automatically notified of when high-risk patients present inpatient.
- **Point-of-Entry Navigation** begins at the time of abnormal result. Navigators will assess patient support needs at that time (transportation issues, etc.) as well as link patients to Care Managers who can begin the process for insurance enrollment.
- Physician-led **screening program** begun last year has been very successful – 250 patients screened over 13 months with 4 successful resections. Medicaid (MaineCare) covers cost of screening and follow-up.
- Thoracic surgeons and point-of-entry Navigators have started to engage in **"Block Parties" –** discussions around screening with MaineGeneral PCPs that include insurance coverage.
- Community-based education sessions around lung cancer screening are underway by MaineGeneral's **community health worker program**, with funding from a Bristol-Myers Squibb grant. "Popumap" is being used to identify and target geographic areas with high tobacco use rates as well as areas with high concentrations of radon. High-risk patients are identified and directed toward PCPs for screening. Community health workers follow up

with patients, help to get them enrolled in insurance, and also work to link high-risk patients to resources (e.g., heating fuel, food, and transportation).

- **The Oncology Site Manager at the Cancer Center receives a monthly report of PCPs who are accepting new patients.**
- **The local FQHC offers early and late hours to see as many patients as possible.**

2. Prospective Multidisciplinary Case Planning

Challenges

- **Schedule coordination** between medical oncology and radiation oncology can be challenging due to separate scheduling systems between the two departments, leading to communication issues.
- Medicaid patients face **lack of rehabilitation and support options** in the home, complicating surgery recovery and leading to lengthier hospital stays.

Solutions (implemented)

- **Conduct a weekly Multidisciplinary Clinic (MDC) for thoracic patients;** patient slots for the MDC are determined by the medical oncologist scheduled to present cases that week.
- **Patients with suspicious nodules are often referred to the MDC** to avoid delays in care**.** All malignant cases are then reviewed by the tumor board.
- **Pulmonologist shares suspicious nodules with MDC team via email** so the team can engage prior to the next scheduled tumor board.
- **All treatment plans are signed by the medical oncologist, navigator, and oncology pharmacist.**
- **Crimson Care Management tool** enables all providers across specialties that are part of a patient's care plan (within the cancer center) to access and share care plan information. Not yet determined how tool will interact with MaineGeneral hospital.
- **Physicians do not factor insurance type into treatment planning.** Adjustments to treatment plans are made based on individual circumstances such as mobility and transportation.
- **Chemo "class"/education (including oral chemo)** provided to all patients prior to initiation of treatment. Patients have mandatory hour-long, one-on-one sit down with nurse where they discuss what to expect, side effects, etc., and are given a packet of information on support resources. Family/caregivers are also invited to attend. Provides opportunity for patients and family to ask questions.

3. Financial, Transportation, and Housing

Challenges

- **Medicaid office is overburdened** and difficult to communicate with. Patient enrollment can take up to 45 days.
- **Need for financial counseling of patients** before treatment is initiated to help sort through out-of-pocket costs.
- **Restrictions on use of Alfond Fund**; money left over each year.
- **PCPs unclear about costs of LDCT**, would like to have additional education about this from cancer center so they can provide it to patients.
- **Transportation is a major barrier** for Medicaid (MaineCare) patients, with many coming from remote/rural areas of the county. The cost of gas can be prohibitive and it is difficult for patients to find someone to drive them. Winter poses particular challenges and can lead to delays/interruptions in treatment.
- While transportation services are offered through a number of programs, panelists say that these are sometimes **unreliable**.
- Transportation services are not permitted to assist patients with stairs, walkers, etc., which can be a barrier for this patient population.
- Many patients **lack internet access** due to rural location.
- Telecommunications can be particularly challenging with Medicaid (MaineCare) patients as many have **phones that are disconnected** or use track mobile phones that get turned off due to non-payment.
- **Housing is also a challenge** for some Medicaid (MaineCare) patients. Many are "couch surfing" or even in homeless shelters, which poses particular risks to immunocompromised patients. Getting patients to qualify for emergency housing through Maine Housing Authority is also challenging.
- **Patients aren't always forthcoming about their needs/challenges**.
- **Section 8 housing** is not an option for patients using medical marijuana because this housing is federally funded.
- **CT scan** not offered at cancer center (provided at MaineGeneral Medical Center, which is on same campus).

Solutions (in progress)

- Cancer Center just **hired a financial counselor** who will work with care managers to help get patients enrolled on Medicaid (MaineCare).

Solutions (implemented)

- **Care Managers assist patients with financial needs,** including foundation applications, prior authorizations, and initiation of enrollment into Medicaid (MaineCare), and coordinate with ACS Navigator to link patients to resources for transportation, etc.

- Care Managers work with **MaineGeneral Medical Center Patient Financial Counselors** who assist with financial planning and applications for Medicaid (MaineCare).
- **Alfond Foundation** provides supplemental funding for gas cards, prescriptions (up to $500) and overnight stays as well as nutritional assistance. It is a good resource for covering costs of Medicaid-pending patients.
- Cancer center refers patients to **Bread of Life**, which provides financial assistance ($700) to eligible patients who need assistance with practical bills (e.g., rent, mortgage, insurance, electric/heating).
- Oncologists hold clinic hours at Franklin Memorial Hospital in Farmington and Redington Fairview Hospital in Skowhegan in order to better serve patients traveling from very rural areas.
- **Transportation needs are assessed and coordinated at the time of initial diagnosis** when Care Managers give intake assessments. Some patients are also mailed the intake form in advance, although the one-on-one interview format is preferred. Medicaid patients qualify for non-emergency medical transportation through MaineCare, which is either through contracted or volunteer drivers that are reimbursed at the state rate – also works to provide gas vouchers to patients through Alfond Fund and provide taxi vouchers through partnership with local taxi companies.
- ACS coordinator helps to arrange transportation through **Road to Recovery program** with volunteer drivers for patients that cannot afford to pay or are not yet enrolled in Medicaid—also helps arrange for overnight stays for patients traveling long distances and provide vouchers for gas.
- **Tele-health service for genetic testing/counseling** from Portland site. Navigator communicates with genetics counselor and helps patients with educational resources and setting up lab work and follow-ups. Counselor talks to patients over TV monitor. Allows greater access for outpatient population at cancer center.
- **MaineHealth Community Care Team conducts home health visits.** Team is comprised of nurses, social workers, and pharmacist. PCPs refer patients who need additional support (for example, with multiple medications or dual diagnosis). Nurses are cross-trained in home care and hospice to ensure continuity of care.
- **MaineCare covers nutritional supplements** (e.g., Ensure) but only for patients with swallowing problems – foundation funds are used to cover additional expenses.

"If you can find resources, sometimes you have to put a string across several of them, but somehow you pull it off. You've got to be creative sometimes." (Psychosocial Care Panel)

4. Management of Comorbid Conditions

Challenges

- Perception that Medicaid patients tend to have greater number of **co-morbidities**, including high number with undiagnosed mental health issues, which can delay/lead to gaps in treatment when these issues flare up, particularly since many patients do not have regular care from PCP.
- Very private patient population; can be **very difficult to assess behavioral health needs before a crisis occurs**.
- More seamless communication is needed around **transition of care** (co-morbidities, medications, etc). PCPs and the cancer center need to be able to see/access each other's charts. This is particularly needed for PCPs not within the MaineGeneral network (e.g., VA providers).
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Solutions (in progress)

- MaineGeneral is working to implement the **Crimson Care Management platform** that would enable all EMRs within the MaineGeneral system to communicate with each other. **This would allow the cancer center to communicate with PCPs who are managing comorbid conditions, directly through the EMR.**

5. Care Coordination

Challenges

- Point-of-entry navigators can't see every incoming patient – too overwhelming for a **small staff given the degree of time/attention required to navigate each patien**t. Currently this service is only being offered to lung, GI, and head and neck cancer patients.
- **Patients receiving chemotherapy and radiation are referred to two different clinical navigators** (one for each department), depending on their appointment schedule.
- **PCPs need additional care managers** to manage follow-up for all moderate- and high-risk patients.

Solutions (implemented)

- **Comprehensive navigation program**, from community health workers who assist in getting patient to lung screenings to clinical navigators who see patients through follow-up care.
- Initial **Point-of-Entry (POE) Navigation** begins after suspicious lung nodule. Navigators monitor patients with ACR Lung Imaging Reporting and Data System (Lung-RADS™) 3s, 4As and 4Bs to make sure that what was recommended on the report is followed up on with PCP (however, they also monitor all 2s to ensure follow-up screening is repeated and patients aren't lost to follow-up). Navigators have contact with all patients before they come to their first appointment, serve as first point of contact, and physically navigate new patients to their first appointment in the cancer center. Navigators determine patient needs/barriers, including arranging transportation and helping initiate applications for Medicare (MaineCare), and work to get patients to appropriate consults (including physical navigation).
- POE Navigators officially hand patients over to **clinical navigators** who are dedicated to radiation oncology, medical oncology, or thoracic surgery. Clinical navigators work with patients from treatment through to survivorship, palliative care, home care, and/or hospice.
- **Care Managers**, team of two social workers, work to assist patients specifically with psychosocial and financial needs (e.g., transportation, financial assistance, enrollment in Medicaid). One Care Manager is focused on financial and the other on psychosocial support. The program is in the process of adding behavioral health needs to their scope. Patients are referred to Care Manager through point-of-entry navigator, front desk staff, cancer center staff, or patients themselves.
- **MaineGeneral PCPs have, or are working to bring on, Care Managers** (nurses) to help with behavioral health and coordination needs/follow-up for high-risk patients to help avoid ED admissions.
- Navigators use **OncoNav** communications tool.
- **ACS navigator** on-site (salary is split between cancer center and ACS). Navigator meets with patients to provide educational materials and links

patients to resources. ACS provides two on-site programs: Road to Recovery and Look Good, Feel Better program.

- **Waiting room coordinators**, comprised of volunteers who are carefully selected and include many cancer survivors or caregivers, are a vital service for patients and staff. They spend one-on-one time with patients, putting patients at ease and helping with communication around schedule/wait time and physical navigation around the cancer center.

6. Treatment Team Integration

Challenges

- **Radiology Department is a private entity** – radiologists work with the cancer center on a contractual basis. Contract physicians' hours are more inconsistent and difficult to schedule.
- Physicians bill separately.
- **No mechanism currently in place for ED staff and hospitalists to notify medical oncologist** when a cancer center patient is seen in the ED and/or admitted.

Solutions (implemented)

- **MaineGeneral's Tumor Board** meets twice weekly to evaluate and discuss multidisciplinary approaches for specific oncology patients. Tumor Board participants include surgery, medical and radiation oncology, radiology, pulmonology, pharmacy, pathology, as well as oncology nurses, cancer registrars, data managers, social workers, and physical therapists. PCPs are invited but rarely attend. Tumor board discussion is organized by where patients are currently in their treatment – covering patients from initial diagnosis to follow-up care.
- **Thoracic Multidisciplinary Clinic (MDC)** was recently initiated. The multidisciplinary team includes thoracic surgeon, radiation, and medical oncology. Following tumor board, the team sees patients together. Surgical candidates are often referred to the MDC so that they can see surgery, radiation, and medical oncology as well as nutrition, social work, palliative care, (and anything else discovered during screening by point-of-entry navigator), all in the same day – with back-to-back appointments in one room. Physicians have time blocked off in their schedules specifically for the MDC.
- **Open Access Clinic available –** patients can come in for symptom management (dehydration, nausea, etc.) without an appointment; same hours of operation as the cancer center.
- **Oncology rehabilitation services**, physical therapy, speech therapy and occupational therapy program. Therapists have gone through oncology online program and are familiar with issues related to oncology patients. They see patients on-site at the cancer center.
- **Dedicated dietitian for outpatient oncology lung cancer patients.** Cost of services is covered by the cancer center as part of provision of quality care (not covered by insurance).
- **Onsite pharmacists** work inpatient and outpatient and are involved in the treatment plan for every patient.

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

Challenges

- There are **three different EMRs** within the cancer center making communication among departments a challenge. Radiation oncology is using Aria (PCPs and specialty clinics use Allscripts), but the medical oncology unit is still using SCM for charting (paper charts).
- Across MaineGeneral primary practices there are **11 different EMRs** and some are still using paper charts, complicating communication and hand-offs between PCPs and the cancer center.
- **Low education and literacy** levels among Medicaid population makes patient education challenging. Patients have difficulty understanding instructions, which can lead to forgetting and mixing up medications.

Solutions (in progress)

- MaineGeneral is working to implement the **Crimson Care Management platform** that would enable all EMRs within the MaineGeneral system to communicate with each other.
- MaineGeneral PCPs are looking at **capturing pack years for all patients** so they can trigger LDCT for all greater than 30 years.
- Working on a DVD/video that patients can take home with them to provide more **education around chemotherapy**.

Solutions (implemented)

- Cancer center staff **work to empower patients** to take charge of their own care. Patients are given color-coded folders to store paperwork (e.g., test and lab results) that include instructions for accessing services (e.g., transportation) and a deadline calendar of things to follow up on.
- Physicians **tailor conversation** to patient's education level.

8. Survivorship Care

Challenges

- Nurse practitioner formerly "owned" (i.e., was responsible for) survivorship treatment plan (*Journey Forward*) and was responsible for seeing patients in long-term follow-up. However, **the clinic was not maintained after her departure from the cancer center**.
- **Survivorship plan is "piecemeal"** and follow-up care plan is informal. Survivorship treatment summaries, in the ASCO template with NCCN guidelines that are disease specific, are filled out by the cancer registry and patients are given a copy. The summary is also forward to advance practice providers. However, the survivorship plan is not forwarded to PCP.
- **Support groups are poorly attended** by Medicaid (MaineCare) patients, mainly due to transportation barriers.
- The cancer center does not have a formal **buddy system** for patients, which panelists acknowledge would be helpful.

Solutions (in progress)

- The cancer center is working to implement a **survivorship standard** with engaged advance practitioners as a package deal from treatment through survivorship.

Solutions (implemented)

- **MaineGeneral Prevention Center** offers programs to patients through PCP referrals (from PCPs in MaineGeneral network and through Kennebec Regional Health Alliance) as well as through patient self-referrals. Programs include smoking cessation, physical activity, cooking, and WIC, as well as courses in chronic disease self-management, diabetes self-management, and chronic pain. Programs are funded through MaineGeneral's endowment, and self-management and tobacco cessation programs are offered for free.
- **Healthy Living Resources** program is beneficiary-funded program through which a variety of low-cost or free health promotion classes are offered to the community. Included are classes on hypnosis for smoking cessation, low-cost cooking class, etc. However, transportation is sometimes a barrier to participation.
- **Wellness coordinator** runs integrative programs, support groups, and many survivorship-specific initiatives offered for free to patients. Courses include mindfulness, yoga, healthy eating during and after treatment, and managing side effects.
- The cancer center also refers patients to free **YMCA LIVESTRONG** program, both during and after treatment, for courses on nutrition and support

groups (also includes sessions for caregivers). However, not many attend due to transportation issues.

> *"When you get them, you get them. How can you do as much as possible when they're here because they don't tend to come back for special classes."* (Flow of Patient Care Panel)

9. Supportive Care

Challenges

- Cancer center is looking to find a more **systematic way to refer patients into the palliative care program.** No auto-trigger for palliative care consults within EMR. Previously there was an algorithm for stage 4 patients but that "did not work out."
- **Pain management medications (e.g., oxycontin) are difficult to procure** due to dispensing restrictions (restrictions on quantity). Staff has to be creative in circumventing these restrictions (e.g., writing "terminally ill hospice patient" on scripts for morphine-equivalents) or submitting prior-authorizations which can cause delays.
- **Greater education around palliative care is needed among both patients and physicians.** Palliative care and hospice care are often seen as interchangeable leading to resistance to refer patients. Palliative care team also stressed the need to make a distinction that sedative care is not supportive care but rather a form of primary/specialty care.
- Inpatient hospice is available, but there are not dedicated beds due to "single beds" design. Typically, inpatient hospice is hosted in the Oncology wing of MaineGeneral Medical Center.
- **Respiratory therapy** is only available inpatient. Home care needs only available to hospice patients.
- Chaplain position eliminated; outpatient **spiritual services** provided by volunteer pastor who is on site 1-2 days per week and is reportedly underutilized by staff.

Solutions (in progress)

- **Distress tool is going to be added into EMR** with discussions to follow around who will be responsible for completing it and when (timing). The aim is to include distress screening as part of ongoing check-ins, akin to use of a pain scale.

Solutions (implemented)

- **Care Managers (social workers) as well as Navigators are using distress thermometer.** Care Managers conduct distress screening at chemo teaching, radiation teaching, and the end of treatment. Care Managers review distress score together with chart notes to determine patient needs and direct patients to appropriate resources.
- Palliative care is provided using a **team-based approach** where patients are evaluated by the entire palliative care team at the initial consult (although may consult with patients individually afterwards).

- **Palliative Care team conducts inpatient consults and sees outpatients upon referral** from physicians. MaineGeneral PCPs can also refer patients directly to palliative care.
- **Outpatient palliative care clinic** established, and they see 6-10 patients per week.
- Palliative Care team provides an additional source of **psychosocial support to patients as well as educating patients to advocate for themselves** (e.g., requesting referrals to palliative care from their doctors).
- Palliative Care team will **visit patients in their homes**.
- Full-time **hospice liaison**, based at MaineGeneral Medical Center, is point person for staff. Hospice referrals are made and vetted through the hospice nurse and then passed along to the medical director. This helps to provide a clear distinction between the palliative care and hospice teams.
- Palliative Care is **integrated with home health** so that care is continued into outpatient hospice services. A nurse practitioner was brought on board to see patients at home and conduct follow-up. They are looking to ideally ramp up the program to be able to provide 24/7 support.
- The cancer center has set specific goals and **made progress to decrease the number of hospice referrals in the last 7 days of life** as well as making sure that patients aren't on active treatment within the last 2 weeks of life.
- **Pet Therapy program** provides therapy pets as well as passes for non-therapy family dogs to visit patients in the hospital.
- **Healthy Living series of programs** available for patients and caregivers; topics range from hypnosis to healthy cooking (have a teaching kitchen). The program is grant funded so scholarships are available and class fees can be waived.

> **"***Because of the relationship they end up having with these patients they hear things, whether it's about transportation or other issues…They are our extended eyes and ears… They've been instrumental for us connecting some dots for people."*
> (Psychosocial Care Panel)

10. Tobacco Cessation

Challenges

- **Patients do not often seek out or adhere to smoking cessation classes**.
- Many patients are especially reluctant to consider smoking cessation right after they receive their diagnosis because of their **increased stress**.

Solutions (implemented)

- **Smoking cessation** offered through MaineGeneral Prevention Center, includes telephone consults as well as medications, which are covered under Medicare (MaineCare). Physician assistant at cancer center is trained in smoking cessation. Physicians can refer to her; however, there is a high no-show rate.
- MaineGeneral Medical Center **lung cancer screenings include smoking cessation counseling** if appropriate.
- **Grant from the Maine Cancer Foundation would enable MaineGeneral patients who do not have insurance** and meet certain criteria to receive their first lung cancer screening at no cost (screening is covered by Medicaid). This would include smoking cessation counseling.

11. Clinical Trials

Challenges

- Continued **misperceptions among providers** that Medicaid (MaineCare) does not cover clinical trials, due to misinformation originally gathered from the Medicaid office, poses potential barrier to enrollment.
- Medicaid patients will sometimes enroll in clinical trials with **perception that cost of medications will be fully subsidized**.
- **Informed consent language causes confusion** for patients/often not at the appropriate literacy level.
- **Transportation issues** pose major barrier to trial participation/adherence.

Solutions (implemented)

- **All new consults are screened to determine clinical trial eligibility**. Trials are offered as a treatment option to all eligible patients, regardless of insurance type.
- **Research coordinator attends tumor boards** and monthly provider meetings to introduce new trials and discuss potential patients.
- Research nurses spend time with patients to **review and clarify clinical trial procedures.**

> *"We do not look at insurance before we offer it [clinical trial]. We do tell the patient that your insurance may or may not pay for some of the testing, and that's all insurances in fact."*
> (Care Coordination and Communication Panel)

12. Physician Engagement

Challenges

- **Physician engagement within the cancer center is a struggle**, especially as it relates to non-clinical discussions (e.g., operations, external communication/relationship building).
- **Radiation Oncology is comprised of contract physicians** (staff are MaineGeneral employees; same with radiology). All other staff is part of the MaineGeneral system except for Radiation Oncology and Radiology Departments. As a result, there are separate medical directors: one for medical oncology and one for radiation oncology. The two departments are "a little siloed," which requires greater coordination.

Solutions (in progress)

- Once **Crimson risk-assessment tool** is up and running, it will enable greater communication among care managers. Currently, physicians rely on phone calls.
- **Recruiting for two additional medical oncologists**; goal is to bring them on in summer 2017.

Solutions (implemented)

- MaineGeneral **PCPs are copied on all notes and patient results** (which can be accessed via Crimson or HealthInfoNet). Referring out-of-network physicians are sent notes via mail.
- **Tumor Board discussions include discussion of nodules**. Physicians in pathology, radiology, pulmonology, and thoracic surgery discuss quickest means of getting patient into the system (imagery, biopsy, etc.).

13. Quality Measurement and Improvement

Solutions (in progress)

- MaineGeneral is in the process of implementing a **new data analytics platform (Crimson Risk Manager) along** with the new care management platform (Crimson Care Management). The system will receive claims data from Medicaid which will improve data on and tracking of referral patterns.

Solutions (implemented)

- Cancer Center participates in statewide **health needs assessment** to identify health areas of concern that will be used to inform annual strategic goals.
- **Cancer Committee** works on several different QI initiatives, for example:
- Efforts to decrease the number of hospice referrals in the last 7 days of life (making sure patients aren't on active treatment within the last 2 weeks).
- **Rapid response survey to determine patient spiritual care needs.**
- **Patient and Family Council** comprised of Cancer Center staff, patients and caregiver volunteers work on initiatives to improve the look and feel of patient areas at the Cancer Center. For example, bringing in artwork and more comfortable furniture to the waiting rooms.
- Cancer Center conducted a **study on pre-treatment staging guidelines** looking at retrospective lung cancer cases from 2005-2009 in the cancer registry, stratified according to insurance. Results showed that the majority of lung patients are stage IV, regardless of insurance type. Based on this data the Cancer Center is continuing its smoking cessation programs as well as actively promoting LDCT screening to bend the curve toward earlier diagnosis.
- Cancer Center participates in QOPI, ACR, CoC, RQRS and ACR Lung Cancer Screening Registry for collections of data on quality measures.
- **Collecting patient-reported measures** of care through CG-CAHPS.

APPENDIX A

Site Interview Participants

Panel	Participants
Program Overview	Deb Bowden, RN, MSN, Administrative Director Arlene McLean, Site manager Jennifer Yurges, Manager Radiation Oncology and Cancer Registry Rebecca Kingsbury,Director Data Planning and Analytics Erika Rodrigue, Cancer Registry
Flow of Patient Care	Andrea Martelle, RN, Nurse Navigator Juanita Begin, RN, Nurse navigator Kerri Medeiros, RN, Point-of-Entry Nurse Navigator Kim Smith, RN, Medical Oncology Nurse Manager Barb Wiggin, Manager Nuclear Medicine Anne Chase, Patient Care Coordinator Jennifer Yurges, Manager Radiation Oncology and Cancer Registry Erika Rodrigue, Cancer Registry Nicole Brown, Point-of-Entry Navigator Deb Bowden, RN, MSN, Administrative Director
Medicaid Patients with Lung Cancer	4 patients
Patient Care	Carol Maxwell, LCSW, Case Manager Kim Smith, RN, Medical Oncology Nurse Manger Kyle Robblee, Care Management Associate Deb Bowden, RN, MSN, Administrative Director Jennifer Yurges, Manager Radiation Oncology and Cancer Registry Erika Rodrigue, Cancer Registry
Supportive Care	Donna Walsh, MS, RD, LD, coordinator nutrition and wellness Marietta Dyer, LCSW, ACHP-SW, Palliative Care coordinator Robert Dohner, MD, Medical Director Palliative Care Steve Townsend, PharmD, BCOP Audra Miville, Supervisor, Respiratory Care Erika Rodrigue, Cancer Registry Deb Bowden, RN, MSN, Administrative Director Jennifer Yurges, Manager Radiation Oncology and Cancer Registry Nicole Brown, Point-of-Entry Navigator
Psychosocial Care	Bob and Anne McCarthy, Patient Family Council–survivor and caregiver, volunteers Dan Bahr, ACS Navigator *(continued)*

	Carol Maxwell, LCSW, Care Manager Kyle Robblee, Care Management Associate Trisha Ware and Victoria Condon, Prevention Center, CHWs Deb Bowden, RN, MSN, Administrative Director Jennifer Yurges, Manager Radiation Oncology and Cancer Registry
Care Coordination and Communication	Dr. Seth Blank, MD, Thoracic Surgeon Dr. Glenn Healey, MD, Radiation Oncologist Kathy Malatesta, RN, Clinical Research Kerri Medeiros, RN, Point-of-Entry nurse navigator Jennifer Yurges, Manager Radiation Oncology and Cancer Registry Nicole Brown, Point-of-Entry Navigator Deb Bowden, RN, MSN, Administrative Director
Referring Facilities	**Augusta Family Medicine,** Thomas Beard, RN, Clinical Manager **Winthrop Family Medicine,** Denise Breer, RN, BSN, and Josie Poulin, RN, Clinical Nurse Manager

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OPTIMAL CARE COORDINATION MODEL

For Lung Cancer Patients on Medicaid

Bristol-Myers Squibb Foundation

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