CANCER PROGRAM SNAPSHOT:

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

Sidney Kimmel Cancer Center at Methodist Hospital

Philadelphia, Pennsylvania

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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 **Sidney Kimmel Cancer Center at Methodist Hospital (SKCC-MH)** is a community-based facility that is **affiliated with the Thomas Jefferson University Hospital** system in the Philadelphia region. SKCC-MH collaborates closely with the Sidney Kimmel Cancer Center at Jefferson, located in Center City, which contains a multidisciplinary lung clinic. The Center City and South Philadelphia locations share specialists and resources. SKCC-MH is the only oncology practice in South Philadelphia, serving a small primary service area of an estimated 170,000 people, with 25 referring practices.

Pennsylvania Medicaid Overview

Pennsylvania began participating in the Medicaid expansion as of January 1, 2015, and uses a managed care model to provide services. Pennsylvania refers to Medicaid as Medical Assistance, or MA. Now, with Pennsylvania's Medicaid expansion, more individuals are covered. Current inclusion criteria are as follows: anyone age 19 and older, with a monthly household income less than 138% of the federal poverty level, and meeting a citizenship requirement (be lawfully present in the United States and have this status for at least 5 years). Undocumented individuals do not qualify for MA services in Pennsylvania under the managed care model, but may qualify for the state-facilitated Medicaid model. However, this model is rarely utilized now with expanded MA services.

Another type of MA access patients in Pennsylvania may qualify for is Medical Assistance for Workers with Disabilities (MAWD). Patients who are deemed temporarily disabled for at least 12 months or are declared permanently disabled may be eligible for MAWD. An individual does need to meet age, citizenship, and asset requirements and be working; however, this can be any type of employment, including informal working arrangements. The income requirements are increased to 250% of the federal poverty level. MAWD recipients pay 5% of their income monthly as a premium, and then are able to receive complete MA coverage.

Within the managed care MA program for Pennsylvania, there are 9 managed care plans. The state is divided into 5 geographical regions; each region has at least 3 managed care plans that MA recipients can choose from. The Sidney Kimmel Cancer Center at Methodist Hospital (SKCC-MH) in Philadelphia is located in the Southeast region. This region has 4 managed care plans available: Keystone First, Health Partners, UnitedHealthcare, and Aetna. Keystone First is the most used plan in the Southeast region (50% of MA managed care participants are enrolled in this plan). This is the only MA plan that SKCC-MH accepts. (For patients

who may live elsewhere in the state but receive care at SKCC-MH, the cancer center will accept 2 other MA managed care plans that are not available in the Southeast region. However, this is not a common occurrence.)

An issue somewhat unique to SKCC-MH is that patients may have originally received insurance coverage via MA when living in Pennsylvania, but have subsequently moved to nearby New Jersey. SKCC-MH will work with New Jersey's Medicaid managed care plan in obtaining a non-participating authorization so that these established patients may continue to receive their care at SKCC-MH. Financial counselors at SKCC-MH report that obtaining a non-participating authorization is usually easy to accomplish.

At SKCC-MH, 2 full-time financial coordinators (FCs) help in all matters related to insurance, especially regarding MA. This staff assists in enrolling patient into the Keystone First managed care MA plan, and estimate that in 2016 they enrolled 80 patients. The hospital typically contracts with an external group to help complete MA enrollment for patients; however, the cancer center's FCs have found that if they complete the MA enrollment forms themselves, their patients are much more likely to have an application approved initially. The FCs will also facilitate switching a patient's MA insurance plan to Keystone First if necessary, but they estimate that this only occurs about twice a month, since most patients are already enrolled with Keystone First.

As of January 1, 2016, Keystone First does not require that a participant be registered with a primary care provider (PCP) to receive care from a specialty provider. Referrals are not needed. Keystone First encourages patients to have a PCP, but many patients at SKCC-MH do not have a PCP.

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. The IV chemotherapy authorizations are handled by a 4-person chemotherapy pre-certification team. Oral chemotherapy and other prescription authorizations are obtained by the nursing staff at SKCC-MH. Copays for oral medications, once authorized, are very reasonable; Keystone First MA participants are responsible for a $1 copay for generic prescription drugs and a $3 copay for brand prescription drugs, including chemotherapy medications.

Radiation services are also covered very well by Keystone First. At SKCC-MH, there is a dedicated authorization team for radiation services, but the FCs also assist with any issues the radiation authorization team may experience.

PET/CT scans are typically covered by Keystone First. The FCs state that an initial insurance denial for these scans is not unusual, but many times approval can be obtained following an appeal process via a peer-to-peer decision.

All MA participants are eligible for transportation services via their individual insurer. This service is a very important aspect of patient care, especially in an urban setting such as Philadelphia. Transportation services include both para-transit services (LogistiCare is the contracted transportation provider for the state of Pennsylvania and all MA providers), as well as mass-transit services, such as city buses. In one fiscal year quarter alone, over 1.1 million trips were covered by MA transportation benefits in the city of Philadelphia. This statistic is inclusive of all medical care transportation needs for all MA beneficiaries, not exclusive to cancer care and those receiving care at SKCC-MH.

Drugs used in an investigational or experimental way are not a covered benefit by Keystone First, so clinical trial participation for Medicaid patients may be difficult. Standard of care drugs that are a part of a clinical trial are typically covered, however. A major issue that SKCC-MH has encountered involves coverage of lab work associated with clinical trials. Keystone First is contracted with LabCorp for all patient lab work. If a clinical trial requires lab work to be completed at a laboratory other than a LabCorp location, Keystone First will not cover any of the costs, including lab work that would routinely be considered standard of care. When this occurs, SKCC and Methodist Hospital will write-off these expenses as a loss.

Hospice services are covered by Keystone First. However, the state-facilitated MA program does not cover hospice services. While this does not affect a large portion of MA participants, this excluded service can make end-of-life care very difficult. Home health services, such as physical therapy, occupational therapy, and skilled nursing services are all routinely covered services of Keystone First. Supplemental nutrition, such as Ensure, is also covered by Keystone First.

There are a few major challenges that the FCs at SKCC-MH note. Lack of communication between the patient and insurance team is the biggest challenge, as patients are not always (or may not know to be) forthcoming about any changes to their MA coverage. When changes occur to a patient's MA coverage with limited time notification to the pre-certification team, the FCs have a difficult time attempting to obtain free or replacement medications that the patient could receive from the drug manufacturer until the MA coverage issue has been resolved. In addition, there are limited resources available for certain cancer diagnoses (i.e., colorectal cancer), creating additional challenges to providing assistance to these patients.

Site Demographics

Methodist Hospital's patient population is located within a small subsection of inner city of Philadelphia. In terms of race/ethnicity, the patient population has a higher percentage of minorities compared to the state of Pennsylvania overall: 66.6% white and 26.3% African American (compared to 81.9% white and 10.8% African American statewide), with a slightly higher percentage of Hispanics (1.2% vs. 0.2% statewide). Overall, the state of Pennsylvania has a higher rate of adult smokers (22.4%) as compared to the national median of 21% (Centers for Disease Control, 2011).

Lung/Medicaid Demographics

In 2015 lung cancer represented 47 out of 325 (or 14%) total new analytic cancer cases at the cancer center. Among new analytic lung cancer cases in 2015, 9% of patients (n=4) were on Medicaid (most, 40%, were dual-eligible for Medicare and Medicaid). 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 Methodist was comparable at 14%.
- SKCC-MH financial counselor program offers dedicated assistance to patients in filling out and following up on applications for Medicaid enrollments, and has created a Free Drug program to assist patients with cost/coverage of necessary chemotherapeutics regardless of insurance coverage or income.
- SKCC-MH has a dedicated social work program that provides patients and their families with support resources and programs, including transportation support and a Buddy Program in which trained survivors of cancer provide support and encouragement to patients who are newly diagnosed.

1. Patient Access to Care

Challenges

- Many Medicaid patients are entering care during later stages of the disease (stage III or IV) due to **delayed care seeking**.
- Most Medicaid patients with lung cancer first **enter the system through the ED/hospital**.
- Some Medicaid plans require PCP referral for specialty care, the default PCP option for Medicaid patients is referral to Community Health Centers, federally and state funded neighborhood clinics, which have **long wait times**. Private PCPs are preferred, but put caps on Medicaid patients.
- **Screening services are not covered by Medicaid**. The $300 fee for screening and consultation may be prohibitive to low-income patients.
- Need for greater **community outreach about services** (e.g., financial counselor, drug replacement representatives) for low-income patients.
- Difficulty with **reaching/communicating with Medicaid** patients (e.g., disconnected numbers, no cell phone, lack of internet, etc.) to get record releases so that cancer center can access records to initiate care.
- Need for improved coordination/navigation of Medicaid patients when admitted into ER; no urgency demonstrated by ED staff to get these patients scheduled for screening/biopsy/staging.

Solutions (in progress)

- Have set a goal to see all patients discharged from the hospital with a cancer diagnosis within 5 days.

Solutions (implemented)

- **Lung cancer screening program** using low-dose CT scans is available at Jefferson (Center City location). Positive screens forwarded to PCP and sent to pulmonologist who then expedites patients into evaluation.
- **"Meet and Greets" with PCPs** in community designed to foster greater integrations with referring physicians and PCPs.
- **App available to referring physicians** so they can search/ "find a physician" and start discussions about patients. In addition, the cancer center created a fact sheet, which includes a QR code for the app, for referring physicians with contact information for cancer center physicians.

2. Prospective Multidisciplinary Case Planning

Challenges

- Many Medicaid patients are entering care during later stages of the disease (stage 3 or 4) due to **delayed care seeking**.
- Medicaid **non-coverage of PET scans** impacts planning for radiation and can delay treatment.
- Referral to the MDC is on a "case-by-case" basis.
- Improvements are needed in **engagement of PCPs and incorporation of PCPs in treatment through follow-up care**. Some physicians at the cancer center maintain that communication with PCPs is often a "one-way street," while PCPs say it is sometimes difficult to reach specialists.
- Medicaid patients often have low caregiver involvement (difficulty getting caregivers to come consistently to appointments).

Solutions (in progress)

- **Treatment plans** will soon be shared with patients through Epic (currently patients provided with education sheet with information about chemo care/drugs).
- In process of implementing an **initiative** to get patients seen sooner, ideally within first 24 hours. However, access to medical records is major barrier to timely scheduling. Epic will improve the **patient portal** for secure transfer of patient records which will help to alleviate this issue.
- Working to develop **standardized patient education** materials (currently NPs provide patients with information on drugs and side effects and overview of cancer center resources).
- Nurses are re-developing a "welcome binder" with patient education materials that are disease-specific.
- Working to build a "welcome center" that will be staffed by a health educator at the Center City location and provide curated educational materials in a variety of formats (print, electronic) and languages. Welcome center staff will visit the Methodist location weekly to provide patient education.

Solutions (implemented)

- A dedicated **pulmonary nodule clinic** is available at the Center City location.
- **Multidisciplinary Clinic (MDC) for lung cancer** located at Jefferson (Center City) location. MDC helps to improve communication among

clinicians and streamline/coordinate appointments so that patients can see multiple providers in one setting.

- **Regional Cancer Care (RCC)** team of physicians/specialists is shared among all locations. This model makes it possible for patients to access cancer treatment and care in their own neighborhood.
- **Treatment algorithms are the same** regardless of insurance type.
- **Central scheduling line** (1-800-JEFF NOW) is staffed by nurses and operates 24/7.
- Recently the practice manager at the cancer center began **calls every two weeks for PCPs and physicians/specialists at cancer center to discuss patients** they are collaborating on and to improve follow-up and continuity of care.

"The time of initial evaluation until they enter a cancer program is an area where there's substantial room for improvement…Somebody who is seen in the ER with an abnormality is told, 'You need to see a lung doctor.' The community health center will just basically make the referral but there is no coordination to expedite."

3. Financial, Transportation, and Housing

Challenges

- Medicaid patients have very limited resources available within the broader community – financial assistance through cancer center can only go so far.
- Getting uninsured patients enrolled in Medicaid can cause major **delays in treatment**.
- Patients with **pending medical assistance do not receive coverage for medications,** including chemo drugs, (cancer center relies on community partners to cover costs for patients).
- **Medicaid–subsidized transportation** (LogistiCare van shares or public transportation vouchers) is unreliable and/or burdensome to patients.
- Many Medicaid patients are difficult to reach due to **unreliable access to phone and internet.**
- **Medicaid partnership with LabCorp** means that Medicaid patients cannot access lab services available on-site and have to travel several blocks away for lab work. This leads to delayed access to results causing delayed/cancelled infusion appointments.
- **Access to symptom management** medications (anti-nausea and opioids) and durable medical equipment (oxygen tanks) is "next to impossible" due to Medicaid restrictions.

Solutions (in progress)

- **Implementing telehealth visits** available to all patients, with financial support available to low-income patients to cover $49 copay. These visits will be used for side effect management in order to reduce hospital admissions. Currently only accessible to Jefferson employees.

Solutions (implemented)

- Dedicated **financial counseling program on-site** that provides assistance in accessing financial assistance programs for medications, transportation, and copays. Financial counselor with deep institutional knowledge works to enroll patients in Medicaid, going above and beyond to move the application process along, including initiating the process prior to the first visit. **Patients with pending applications are scanned, diagnosed, and treated during that period**.
- SKCC-MH helps to enroll patients in the Medicaid plan that is accepted by Jefferson and **initiates treatment for pending patients in order to avoid delays**. Hospital obtains letter of medical necessity to initiate treatment.

- Hospital doesn't take all four Medicaid plans but helps switch patients over to the plan that the hospital does take.
- Hospital billing office contacts financial counselor when care plan comes in and a Medicaid application is needed.
- Financial counselors pull a weekly report to determine which of the patients scheduled to be seen in the next 7 days have coverage gaps. Financial counselors then reach out to any flagged patients to offer assistance with obtaining coverage.
- Financial assistance programs provided to patients through Jefferson Hospital Charity Care program to ensure care regardless of insurance coverage/ability to pay.
- SKCC financial counselors created Free Drug program to assist patients with cost/coverage of necessary chemotherapeutics while medical assistance is pending.
- Dedicated American Cancer Society (ACS) navigator on staff who works to connect Medicaid patients with resources (both inpatient and outpatient).
- Social workers have established innovative ways of addressing top barriers to care: transportation and communication. Cancer center has set up **Lyft and Uber accounts** to assist with meeting transportation needs of patients at the cancer center.
- **Prepaid GoPhones** are provided to patients with telecommunication needs. Meanwhile, the cancer center is working to create a more formalized system to provide patients with access to phones.
- **Social workers have discretionary funding available to help with public transportation and taxi service.**

"She actually starts the process before they even get here to the appointment so that by the time they get to the appointment, she's already been in touch with them. Sometimes they even bring what they need to bring with them so that we can start. Once the application is made, Jefferson will let us do the biopsy. They'll even authorize the chemotherapy. Once it's MA pending, we're good to go." (Flow of Patient Care Panel)

"Once somebody has applied for medical assistance we will treat them. Even if there's a chance we won't get paid, we eat a lot of the cost." (Psychosocial Care Panel)

4. Management of Comorbid Conditions

Solutions (in progress)

- The head of the social work team is working with the cancer center leadership to establish a program for patients to meet with psychiatric experts free of charge.

Solutions (implemented)

- **Depression screening** at intake using patient health questionnaire-2 (PHQ-2).
- **Ongoing communication with PCPs.** Practice manager at the cancer center initiated bi-weekly calls for PCPs and physicians/specialists at cancer center to discuss patients they are collaborating on.
- **Same-day outpatient clinic** at Cancer Center staffed by NP and (sometimes) physicians where patients can be seen in the infusion center that day and treated in order to drive down ER visits and unnecessary admissions.

5. Care Coordination

Challenges

- **No formalized system of care coordination.** Patients lack a centrally-organized touchstone to help navigate them through different treatment modalities, from initial contact through survivorship.
- Navigator role is currently filled in piecemeal by NP and social workers who are already overburdened.
- **Social workers are overstretched.** Social workers work across locations and are often spread thin and the facility lacks any inpatient social workers. Many times, consults are done over the phone.
- **Facility does not have guest services**/welcoming service for patients. Upon entering the facility, it is not immediately clear that it is a cancer center.

Solutions (implemented)

- Nonclinical coordinators work on scheduling and access, particularly for MDCs.
- NP is very engaged with patients and caregivers; she takes extra time to hear their issues and discuss their needs. This helps her connect them to all possible healthcare system and community resources.
- **Strong social work program** (outpatient social workers assigned to doctor and disease) works to connect patients with community resources and support systems as well as helping to improve patient compliance/overcome barriers to care such as providing transportation and telecommunications assistance.

> *"What do we need from the nursing perspective? What do we need from the social worker? What are the palliative care issues? What are the radiation oncology issues? What are the pharmacy issues? That type of coordination of care for a Medicaid patient and someone that can then follow that into their home would ultimately be how you care for them better and keep them out of the hospital…. some kind of community case manager that could see them in the home and not just make phone calls."* (Supportive Care Panel)

6. Treatment Team Integration

Challenges

- Physicians **bill separately** for services.
- Several services and specialties are not offered on site at SKCC-MH. Patients in need of these services can consult with specialist at Center City location by telephone or they have to travel to or transfer their care to Center City.
- SKCC-MH site **does not provide radiation services**. Patients are given the choice of traveling to Center City for radiation (shuttle provided) or transferring all treatment to Center City (which, for many, poses a transportation barrier).
- **Rehabilitation services are only offered inpatient** at SKCC-MH. Patients in need of rehab services are either referred to PT/OT facilities in the community or to PM&R in Center City location.
- **Home care coverage is** not available for Medicaid patients.
- There is **no outpatient dietitian** at the SKCC-MH location. Patients have access to telephone consults with the dietitian at the Center City location but little opportunity for face-to-face time.

Solutions (implemented)

- On initial encounter form, first question is about PCP – "Do you need one?" If the answer is yes, team will assign internally.
- Morning **care team huddles** with physician, nurse practitioner, RN, medical assistant to discuss patients.
- **Tasking mechanism in EMR** utilized during morning huddles in order to task providers (physicians, dietitians, social workers) with follow-up for a specific patient.
- Tumor boards are open to PCPs.
- Pulmonologist has an office on Wednesday at the Navy Yard location – parking is free and shuttle service is also provided.
- Physicians within Jefferson system are shared across locations. Pulmonologist is located at Jefferson (Center City site).
- Patient **education is tailored to patient needs** – looking at "whole person and their environment." Medicaid patients often receive verbal instructions/counseling instead of written materials.
- **Inpatient nutrition** services are provided based on list of triggers and malnutrition screening.
- All patients are given an "**ED Card,"** small pocket card with information about what to do/who to contact with certain symptoms and the oncologist's contact information. The aim is to improve symptom management and reduce ER admissions for symptom management.

"If we notice an increased blood pressure over a period of time, we're referring back to the PCP to view the document…the doctor will pick up the phone or send a separate note than the usual, 'it's a pleasure to see mister so and so today,'an actual note."

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

Challenges

- Currently **various EMR systems are in place** throughout the cancer care system, which do not communicate with one another: OnCare is utilized for infusion patients; IDX is utilized for scheduling; and AllScripts is utilized for physician visits.
- Medicaid patients face many **barriers to access of their medical records** (e.g., lack of PCP, lack of internet and computer availability). Many say they don't want to read additional information/be given additional paperwork.

Solutions (in progress)

- Beginning fall 2016, there will be **one EMR (Epic) in place for the entire Jefferson system,** which will enable greater communication and patient follow-up.
- SKCC is working on a more **patient-friendly portal** where patients will have access to the vast majority of their medical records including scans, office notes, vitals, and prescriptions, as well a communication with their care team.
- Hospitalist copies and pastes patient record, including test results into document he provides to patients at discharge who he knows will be receiving follow-up care at the Community Health Center.

> *"It's hard to toggle between so many EMRs that we look at. Just having one space to see the full picture…that way we know exactly what has happened, therefore there's not X, Y, and Z people saying the same things maybe a little differently. That's where the confusion starts."* (Supportive Care Panel)

8. Survivorship Care

Challenges

- **Greater education** is needed among Medicaid patients around availability of support services in order to improve access to and participation in survivorship programs.
- **Patients are reluctant to follow up with a PCP.** Many Medicaid patients have a mindset that the oncologist is their primary doctor.
- Medicaid patients may be more likely to have **inconsistent caregivers** or lack of sources of support.

Solutions (in progress)

- **Working with CareVive** – nurse-owned company that tracks information for survivorship – **to develop improved survivorship care plan**. CareVive will receive data from the cancer center's registry (via Epic) and auto-populate the survivorship plan. The plan will include algorithm-driven recommendations for surveillance and follow-up. The plan will also contain hyperlinks that will push to the patient portal and be available in several different languages.
- Nurse practitioner is working to develop **Survivorship Clinic for lung patients** whereby all patients would come for a follow-up visit or receive a phone call 3-6 months after active treatment.

Solutions (implemented)

- At the end of treatment, patients meet with the NP to walk through the survivorship care plan.
- Currently, patients receive printed treatment summary and survivorship care plan.
- Care plan is shared (either electronically or by mail) with referring physicians.
- Cancer center conducts several survivorship conferences/celebration of life events; survivors are asked to volunteer to staff these events.

> *"It's algorithm-driven, so if [you] had this cancer, you need these tests. You need this surveillance. You need that follow-up. You should talk to a genetics counselor. You should talk to a nutritionist. This drug affects your lipids."* (Psychosocial Care Panel)

9. Supportive Care

Challenges

- Patients with lung cancer are **not automatically referred** to palliative care. Referrals for palliative care consults are mainly dependent on the oncologist as well as the patient.
- **Lack of consistency** in consultations for palliative care services – sometimes only done before patient enters hospice.
- Lack of understanding among physicians around the **distinction between palliative care and hospice**. Many physicians aren't comfortable having conversations about palliative care.
- Materials developed by the palliative care team are not routinely distributed/referred to by providers and patients.
- Many **Medicaid patients require residential hospice** facilities as they do not have consistent housing or caretaker availability. Getting placement in a residential facility, however, is challenging and many patients end up staying in the on-site inpatient hospice unit for several months.
- Panelists report that Medicaid patients are less likely to have **power of attorney** to make end-of-life decisions or are unable to have timely conversations about hospice due to family/caregiver inconsistency and unavailability.
- Panelists say that many Medicaid patients end up in hospice (vs. survivorship) because of **failure to navigate the healthcare system** – managing appointments and compliance with treatment.

Solutions (in progress)

- Rollout of monthly distress screening is in process – currently only screening patients in GI, palliative care, and geriatric oncology but will be rolled out to lung soon. Using **CareVive distress e-screening questionnaire** which is a customizable, iPad-based tool that incorporates NCCN and ESAS guidelines, distress thermometer, educational checklist (e.g., Do you have questions about care? Do you need more information?), and questions around resources and barriers to care.

Solutions (implemented)

- Palliative care team is multidisciplinary – comprised of physician, nurse, and social worker. ED/hospitalist has interest in palliative care.
- **Guidelines for palliative care** circulated to physicians and nurses, including how to classify early intervention and when to request

consults. Educational materials also available to patients in various areas of the cancer center.

- Requests for consults can come from physicians, physician assistants, and nurse practitioners (nurse can only suggest a consult).
- **Inpatient beds for hospice available on-site**. Inpatient unit is for symptom management (not a residential facility).
- Cancer center has **a robust Buddy program** where patients are paired with a buddy that has the same diagnosis (prognosis) and stage of treatment (e.g., in chemotherapy or just finished chemotherapy). Program also includes caregiver buddies. Patients in the buddy program receive access to a variety of support programs – pastoral, mindfulness, etc. The cancer center also has a "Buddy on the Spot" program where patients who are physically on the premises will visit with a patient to help relieve anxiety.

"Most often what opens that door for the initial outpatient palliative care is a symptom management issue…Something goes wrong and that's when we're there." (Supportive Care Panel)

"We've had patients live on our inpatient unit because we could not get them placed for months. We're not supposed to do that because Medicaid would say that's wrong, because they don't have symptoms…But there's nowhere for them to go. You can't discharge a patient to the street." (Supportive Care Panel)

10. Tobacco Cessation

Challenges

- Current program (QuitNow) is **out-of-pocket cost.** For Medicaid patients, therefore, smoking cessation efforts generally involve **referral to 800-QUIT-NOW** and getting them on nicotine replacement system. Methodist can provide funds for patients to enter the QuitNow program through their Quality of Life Grant, but patients are often not willing to travel to City Center for the program. There is a **need for smoking cessation programs within the community**.

Solutions (in progress)

- Looking into training staff within the cancer center to deliver smoking cessation to patients **while they are there for treatment/in the waiting room**.

Solutions (implemented)

- **Integrative smoking cessation (QuitNow) program** offered through Jefferson at the Center City location.

11. Clinical Trials

Challenges

- Because many Medicaid **patients are entering the system at more advanced stages of disease,** they are pushed into a treatment and therefore participation in clinical trials lower.
- Many Medicaid patients are distrustful of clinical trials and **more education is needed among Medicaid patients around the benefits (as well as potential risks)** of participation.
- Requirements for additional **CT and PET scans** for participation in trials may add additional burden/frustrate patients and limit participation.

Solutions (implemented)

- SKCC-MH patients have access to clinical trials through Jefferson Health System. Patient charts are screened by a full-time clinical trials coordinator prior to their visit. Providers also screen each patient at each patient visit (if warranted by disease progression, need for therapy change, new patient status, etc.) for clinical trial eligibility.

"Participation with clinical trials with a patient on medical assistance is less… Unfortunately there's that delay in entering the system in being at a more advanced stage that kind of forces your hand into moving with treatment….that results in reduced clinical trial enrollment."

12. Physician Engagement

Challenges

- Lack of a **clinical pathway for diagnosis of lung** patients. Most lung patients are sent to pulmonologist as first line for diagnosis and staging. However, sometimes patients are referred directly to the surgeon. Medicaid patients in particular may be referred directly to oncologist after CT-guided biopsy is ordered in ER/ED.

Solutions (implemented)

- The **cancer center works to keep patients within the Jefferson health system**, directing incoming patients to internal and family medicine in order to ensure continuity of care.
- The hospitalist is attuned to the special needs of this patient population and will order bone scan and full body CT while patient is in the hospital to maximize that time and expedite staging and start of treatment. He **reaches out directly to the ancer center with results and to start transition of care**.
- Pulmonologist has made a point to inform medical oncologists and PCPs in the system that they should **call his office directly** to expedite biopsy and staging for this high-risk patient population.
- Pulmonologist **provides personal cell** on all consult letters, open to receiving/answering all questions.

"A CT-guided needle biopsy gets done [in ED]. Great, now we have cancer, and then they are coming into the system completely un-staged…people are making referrals to the oncologist without the correct evaluation being done, so they are seeing them, but then there is a delay in institution of care because the appropriate evaluation and staging needs to be completed before they can get started."

13. Quality Measurement and Improvement

Solutions (implemented)

- **Dedicated quality officer** for the entire cancer center with large, multi-disciplinary "Quality Committee" comprised of inpatient and outpatient clinicians and nurses, social workers, pharmacists, as well as patient advocate who is both a cancer survivor and a nurse. Works on documentation improvement and quality infrastructure at the hospital. Recent initiatives include:
  - Patient-centered medical home and patient-centered specialty practice
  - Establishing a safety culture to improve error reporting and decrease medication errors in the infusion center
  - Examining re-admissions using CMS data to improve identification of patients at-risk for re-admission
  - Standardization of triage process so that there are standard algorithms to help the nurses improve triage
  - Transition of care project to improve placement of patients (many patients staying longer because of lack of places that will take cancer patients or because of disagreement between patients and their families).
- **Unbillable charge codes** are used creatively to monitor and improve care delivery. For example, these are being used to track implementation of pain assessments as part of Oncology Care Model to improve early and consistent identification of pain management needs.
- **Patient Advisory Council** helps to identify QI priorities from the patient perspective.
- **PCP who refers a high volume of patients to the cancer center hired a QI expert to help the practice with clinical optimization and population health issues.**

> *"The Oncology Care Model is looking at whether you are asking about pain every time. We give a pain assessment and on the bottom of our paper encounter form we create unbillable pseudo-codes. When a doctor discusses pain, they circle it. We do an unbillable charge capture.*

APPENDIX A

Site Interview Participants

Panel	Participants
Program Overview	Grace Parmisciano, Practice Manager Janene Palidora, Assistant Director of Operations
Flow of Patient Care	Janice Carsello, Nurse Practitioner Avnish Bhatia, MD, Medical Oncology
Medicaid Patients with Lung Cancer	4 patients, with their caregivers
Patient Care	Janice Carsello, CRNP, Nurse Practitioner Jodi Sandos, Social Worker Angie Santiago, Reimbursement Specialist Roseanne Iacono, Director of Cancer Program, Clinical Operations Mike Attanazio, MD, Referring PCP
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Psychosocial Care	Greg Garber, Social Worker Angie Santiago, Reimbursement Specialist
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OPTIMAL CARE COORDINATION MODEL

For Lung Cancer Patients on Medicaid

Bristol-Myers Squibb Foundation

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