WELCOME TO THE LUNG CANCER PATIENT SUPPORT ECHO
PLEASE ENTER YOUR NAME AND ORGANIZATION IN THE CHAT BOX
9:00 AM ET
MULTIDISCIPLINARY TEAMS AND CARE COORDINATION
IN LUNG CANCER PATIENT CARE

THOMAS ASFELDT, RN, BAN, MBA
PETER MAZZONE, MD, MPH, FCCP
WENDI WAUGH, R.T. (R)(T) CMD CTR BS
JOHN RUCKDESCHEL, MD (FACILITATOR)

JANUARY 31, 2019
9:00 AM ET
<table>
<thead>
<tr>
<th>Time</th>
<th>Presentation</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:10</td>
<td>Welcome, roll call, housekeeping</td>
<td>John Ruckdeschel</td>
</tr>
<tr>
<td>9:45-10:00</td>
<td>Q &amp; A/Discussion</td>
<td>John Ruckdeschel</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Program/Case Presentation: Southern Ohio Medical Center</td>
<td>Wendi Waugh</td>
</tr>
<tr>
<td>10:15-10:25</td>
<td>Q &amp; A/Discussion</td>
<td>John Ruckdeschel</td>
</tr>
<tr>
<td>10:25-10:30</td>
<td>Conclusion/Next session</td>
<td>John Ruckdeschel Dawn Wiatrek, Ph.D. Octavia Vogel, MPH</td>
</tr>
</tbody>
</table>
UNM CME policy, in compliance with the ACCME Standards of Commercial Support, requires that anyone who is in a position to control the content of an activity disclose all relevant financial relationships they have had within the last 12 months with a commercial interest related to the content of this activity.

The following planners and faculty disclose that they have no financial relationships with any commercial interest: (next slide)
FACILITATOR & PRESENTERS

Lead Facilitator:

Presenters:

Thomas Asfeldt, RN, BAN, MBA
Director, Outpatient Cancer Services & Radiation Oncology
Sanford Health
ACCC Advisory Board Member, Technical Expert Panel Chair and Consultant for the Optimal Care Coordination Model for Lung Cancer Patients on Medicaid

Peter Mazzone, MD, MPH, FCCP
Pulmonologist
Director, Lung Cancer Program
Respiratory Institute, Cleveland Clinic

Case Presentation:

Wendi Waugh
Administrative Director of Cancer Services/Community Health and Wellness
Southern Ohio Medical Center
Pilot site director for the Optimal Care Coordination Model for Lung Cancer Patients on Medicaid
LEARNING OBJECTIVES

This session will provide a discussion of key aspects of care coordination and multidisciplinary care in the setting of lung cancer.

Upon completion of this session participants will be able to:

1. Engage in a framework of cancer program self-assessment
2. Define several models of prospective multidisciplinary treatment planning
3. Recognize some of their care coordination program strengths
4. Recognize some of their care coordination program weaknesses
OPTIMAL CARE COORDINATION MODEL: A BETA TEST AND VALUABLE LESSONS LEARNED

THOMAS ASFELDT, RN, BAN, MBA
SANFORD HEALTH
OPTIMAL CARE COORDINATION AND THE PATIENT EXPERIENCE
OPTIMAL CARE COORDINATION AND THE CARE TEAM EXPERIENCE
IMPORTANT CONCEPTS AND TERMS

- Care Coordination:
- Multidisciplinary Care:
- Team Science:
  - And this one: Salas E. Team Science in Cancer Care: Questions, an Observation, and a Caution. *Journal of Oncology Practice* 2016 12:11, 972-974. DOI: 10.1200/JOP.2016.018226
KEY OBJECTIVE

- No matter your environment…

- or ....

- You can provide well coordinated high quality multidisciplinary lung cancer care for all your patients. Both extremes have their advantages and their disadvantages and learning to leverage the former and overcome the latter is essential to optimal care coordination.
**OPTIMAL CARE COORDINATION MODEL OBJECTIVE**

- **Bristol-Myers Squibb Foundation** had a desire to develop a multidisciplinary coordinated care model that will address the needs of the Medicaid population with lung cancer that would lead to improved care and increased survival.

- **Why?** Do a simple publication search on survival disparities by insurance status. Patients with Medicaid have more advanced disease at diagnosis, are less likely to get treatment, and have lower survival than other insurance groups.


- **Premise:** If you treat everyone the same, then everyone won’t have the same outcome, so you have to treat people differently. This may seem unjust at first pass, or unfair, but it is necessary to provide equity.
DEVELOPMENT OF THE OPTIMAL CARE COORDINATION MODEL (OCCM)

- OCCM is deeply rooted in the NCI Community Cancer Centers Program (NCCCP)

- NCCCP Launched June 2007, ended Sept 2014
  - National Cancer Institute-sponsored program
  - Brainchild of NCI Director Dr. Neiderhuber
  - Premise: 85% of patients with a cancer diagnosis get their care in the community.
    - Pilot to explore capacity of community hospitals to improve cancer patient care and contribute to NCI research mission.
NCCCP REPRESENTED 30 HOSPITALS IN 2010

- 53,000 new cancer cases
- 23 million population in 22 states
DEPTH AND BREADTH OF WORK

NCCCP

Enhance Access

Improve Quality of Care

Expand Research

Disparities 40% of Funding
Quality of Care
Survivorship and Palliative Care
Advocacy
Biospecimens
Clinical Trials
EHR and (IT)

Cancer Continuum
Prevention Screening Treatment Palliative Care Follow-up Survivor Support End-of-life Care
PILLARS OF WORK: QUALITY OF CARE

NCCCP Contract Deliverable:

*Establish at least four Multidisciplinary Care (MDC) Centers*

- Tumor site was not important
- Sites with early success helped others
- MDC Assessment tool was developed: *The Matrix!*
  - Site Self Assessment and Evaluation
  - Guide Program Development
# EARLY VERSION OF THE MDC MATRIX

## MDC Assessment Tool

<table>
<thead>
<tr>
<th>Assessment Area</th>
<th>Evolving MDC (1)</th>
<th>Developing MDC (2)</th>
<th>MDC (3)</th>
<th>Moving towards Excellence (4)</th>
<th>Achieving Excellence (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Planning</td>
<td>Care planning is asynchronous with patient presenting to multiple physician offices without a shared medical record. 100% cases reviewed retrospectively.</td>
<td>Care planning is asynchronous with patient presenting the multiple physician offices with a shared medical record.</td>
<td>Most care planning is asynchronous, but some patient’s care plans are discussed in multidisciplinary conferences which occur on a weekly basis.</td>
<td>All patients’ care planning is done through a multidisciplinary conference which occurs on at least a weekly basis. 100% of cases reviewed prospectively.</td>
<td>All patients’ care planning is done through a multidisciplinary conference which occurs while the patient encounters care. 100% of cases reviewed prospectively.</td>
</tr>
<tr>
<td>Physician Engagement</td>
<td>Diagnostic and treatment Physician belong to multiple independent groups, with little interaction, and a representative from some groups is engaged with the cancer center.</td>
<td>Diagnostic and treatment Physician belong to multiple independent groups, with little interaction, and at least one representative from each group is actively engaged with the cancer center.</td>
<td>The MDC has a physician agreement, participation, and physicians are actively engaged in developing treatment standards.</td>
<td>Same as prior with the addition of engagement in quality improvement initiatives and strategic standards.</td>
<td>Same as prior with the addition of physicians having operational and financial authority for the MDC.</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>Patient care is episodic. Patient has to present to multiple locations on multiple days for treatment and or diagnostic modalities. Information is stored in multiple locations, and difficult to reconcile. No nurse navigator.</td>
<td>Patient care is episodic, but some treatment and diagnostic modalities are coordinated. Information is stored and readily available to physicians and staff.</td>
<td>Some dedicated diagnostic and treatment abilities to meet patient's care needs. Information is readily available to physician and staff.</td>
<td>MDC is fully integrated with treatment and diagnostic modalities, and all information is available from a single source. Nurse navigator is available to coordinate.</td>
<td>Same as prior with the addition of ancillary services such as education, support groups and wellness programs for patients and families. Nurse navigator available to coordinate.</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Limited physical infrastructure with limited information system support, hospital, physician office model.</td>
<td>Limited physical infrastructure with integrated clinical and administrative systems used by all.</td>
<td>Some dedicated physical facilities which do not cover the full spectrum of care with integrated clinical and administrative information systems.</td>
<td>Some dedicated physical facilities which do not cover the full spectrum of care with integrated clinical and administrative information systems.</td>
<td>Dedicated center with ability to provide full service to patients with integrated information systems.</td>
</tr>
<tr>
<td>Financial</td>
<td>Billing is episodic based at encounter with facility or physician. No facility fee is applied.</td>
<td>NA</td>
<td>Physicians bill separately for MDC. Communication between MDC and physicians.</td>
<td>NA</td>
<td>Global bill for MDC billing inclusive of facility fee.</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Patient not reviewed for eligibility for clinical trials. No literature given to patient on clinical trials.</td>
<td>Some patients reviewed for eligibility. No formal process to make decisions for clinical trials. Clinical trial literature given to patient.</td>
<td>Participation in clinical trials. There is a formal accrual and recruitment plan.</td>
<td>4% of patients participating in clinical trials. There is a formal accrual and recruitment plan. Clinical trial literature given to all patients.</td>
<td>8% of patients participating in clinical trials. There is a formal accrual and recruitment plan. Clinical trial literature given to all patients.</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Paper chart plus some EMR with isolated pockets.</td>
<td>Mainly for documentation reasons only. Medical information not integrated. Little to no sharing. Mixture of paper and electronic.</td>
<td>Mixture of paper and EMR. Starting to share no fee lab, radiology, medical history, treatment plans and medications.</td>
<td>40% of hospital systems using physician offices is integrated electronically across the continuum.</td>
<td>Fully integrated electronic record across the continuum with access to information.</td>
</tr>
</tbody>
</table>

Total Score: 19
EVALUATING THE MDC MATRIX AND TESTING THE MODEL

- Publications

- Research
Goal: Modify MDC Assessment Tool to assess for Optimal Care Coordination from Presentation to Survivorship or End-of-Life for Lung Cancer Patients on Medicaid

**Contributors:**
- Technical Expert Panel
- OCCM Advisory Committee
- ACCC Staff and Consultants

**Inputs:**
- Practice
- Evidence
- Environmental Scan
- Developmental Sites
Key Attributes

- Patient Centered
  - Informed by where patients get their care
- Data and evidence
- Focus on high impact areas
- Usable

What it isn’t

- All inclusive
BETA TEST OF THE OCCM

- Grant funded - BMSF
- Competitively selected
- One year quality improvement projects
  - One or two projects per site
  - Testing an assessment area of the model
- Weekly or biweekly project calls
- Two onsite visits by ACCC staff and consultants
- Significant data collection, input and analysis
OCCM TESTING SITES
OPTIMAL CARE COORDINATION MODEL

7. Electronic Health Records (EHR) and Patient Access to Information: This assessment area addresses factors related to facilitating interdisciplinary communication along the continuum of care by accessing clinical information from physician practices, hospitals, outpatient clinics, and diagnostic centers. The EHR provides...

8. Survivorship Care: This assessment area addresses factors related to ongoing surveillance for recurrence of the original cancer, prevention, early detection of new health circumstances, and coordination of care.

9. Supportive Care: This assessment area addresses factors related to the evaluation of physical, emotional, mental, and spiritual symptoms and the cancer program infrastructure, resources, and established processes available to manage these symptoms throughout the continuum of care, including end of life care.

10. Tobacco Cessation: This assessment area addresses factors related to evaluation of tobacco use and provision of tobacco cessation activities. Tobacco cessation has a direct impact on reducing cancer and other associated outcomes. Tobacco use is 79% in the Medicaid population compared to 26% in the general population.

11. Clinical Trials: This assessment area addresses factors related to overcoming cultural, financial, and logistical barriers that patients face in accessing clinical trials, including cultural competence of cancer program staff related to medical research feasibility of protocols for this patient population, review of patients for eligibility, and time to complete training.

12. Physician Engagement: This assessment area addresses factors related to the physician’s current specific disease expertise, availability to the patient and the care team.

13. Quality Measurement and Improvement: This assessment area addresses factors related to quality metrics, stratified by key patient demographics to reveal disparities (such as coverage type, socioeconomic status, gender, race, and ethnicity) to ensure that there is minimal variation in care by patient type. A quality improvement program must be responsive to evidence-based guidelines, national directives on quality and payment, and program-specific challenges.

<table>
<thead>
<tr>
<th>Time to complete training</th>
<th>Commitment from leadership to ensure staff are trained</th>
<th>Used to incorporate the results of training into routine practice</th>
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<tbody>
<tr>
<td>Measure 1</td>
<td>Measure 2</td>
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<td>Measure 4</td>
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<td>Measure 31</td>
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<tr>
<td>Measure 34</td>
<td>Measure 35</td>
<td>Measure 36</td>
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</tbody>
</table>

CONFIDENTIAL—DO NOT DISTRIBUTE.
7 testing sites, spanning 6 States and 3,081 miles
12 OCCM Areas of Focus, some overlapping
252 Medicaid / Dual Eligible Participants
Variation in age, racial distribution, smoking status
Different approaches to similar challenges
LESSONS LEARNED

- **Self evaluation** using an external evaluation tool is extremely valuable
- **Organic change** as a result of participation was uniform across sites
- **Data driven** approach to improving care was foreign to most sites
  - Each site had common data elements, as well as, site specific elements for their project
- Prospective treatment planning can happen effectively in several forms
MULTIDISCIPLINARY PROSPECTIVE TREATMENT PLANNING

- **Formats**
  - Face-to-face conference
  - Web connected conference
  - Virtual tumor board
  - Huddle

- **Objectives are the same**
  - Prospective – Before treatment is initiated
  - Multidisciplinary – Key players have to be present AND participate
  - Dialogue – You know it when you see it
  - Collaborative – The higher the functioning the team, the better this works, regardless of the format
MDC Treatment planning gets a lot of attention, and rightfully so. But there is a great deal more to optimal coordinated care, especially for our most vulnerable patients.

Other key lessons learned…

• It is difficult to isolate the assessment areas, they are *interrelated*. This is the organic improvement the sites began to see as a result of their project and using the OCCM.

• Dedicated Lung Navigation is *imperative*.

• Data measurement is *essential*, you don’t know how well or how poorly you are doing unless you measure it.
KEY INGREDIENTS

- Physician champion
- Administrative champion
- Dedicated, committed, staff
- Data
WHAT’S NEXT IN THE VERY NEAR FUTURE

- Version 2.0 of the OCCM is in development
- Manuscript will be forthcoming
- ACCC will deploy the model and lessons learned
ACKNOWLEDGEMENTS

- **Our funder**: Bristol-Myers Squibb Foundation
- **Association of Community Cancer Centers**, and particularly Amanda Kramar, Chief Learning Officer
- **Testing Sites**: Advocate Lutheran, General Hospital, Park Ridge, IL; Ascension Wheaton Franciscan Cancer Center, Milwaukee, WI, Genesis Cancer Center, Zanesville, OH; Florida Hospital, Daytona, FL; Munson Healthcare-Cowell Family Cancer Center, Traverse City, MI; Northwest Medical Specialties, Tacoma WA; Southern Ohio Medical Center, Portsmouth, OH.
- **Advisory Committee Co-Chairs/Co-PIs**: Christopher Lathan, MD, MS, MPH, Faculty Director for Cancer Care Equity, Dana-Farber Cancer Institute, Boston, MA; Randy Oyer, MD, Medical Director, Oncology, Lancaster General Health, Ann B. Barshinger Cancer Institute, Lancaster, PA.
- **Lead Clinical Research Consultant**: Ray Osarogiagbon, MBBS, FACP, Director, Thoracic Oncology Group and Multidisciplinary Thoracic Oncology Program, Baptist Cancer Center, Memphis, TN
- **Subject Matter Expert Consultants**: Nick Faris, Mdiv, Data Coordinating Center, Baptist Cancer Center, Memphis, TN; Vikki Nolan, DSc, PhD, Meredith Ray, PhD, Matthew Smeltzer, PhD, Epidemiology & Biostatistics, University of Memphis; Christine Amorosi, RN, MHSA, Health Quality Solutions; Thomas Asfeldt, Sanford Health, Sioux Falls, SD.
- **Technical Expert Panel Members**: Nancy Johnson, MSM, Executive Director, Nancy N. and J.C. Lewis Cancer & Research Pavilion at St. Joseph’s/Candler, Savannah, GA; Dick Demming, MD, Medical Director, Mercy Cancer Center, Des Moines, IA; Karyl Blaseg, MSN, RN, OCN, Practice Manager, University of Arizona Cancer Center/Dignity Health, Phoenix, AZ; Thomas Asfeldt (Chair), Director, Oncology Services, Sanford Health, Sioux Falls, SD.
- **Advisory Committee Members**: Thomas Asfeldt, John Cox, Becky DeKay, Andrea Ferris, Lovell Jones, Matthew Loscalzo, James Mulshine, Kathleen Nolan, Shawn Regis, Maureen Rigney, Cardinale Smith, Mark Soberman.
THANK YOU!

You may email questions to:

Thomas.Asfeldt@SanfordHealth.org
MULTIDISCIPLINARY TEAMS AND CARE COORDINATION IN LUNG CANCER PATIENT CARE

PETER MAZZONE, MD, MPH, FCCP

CLEVELAND CLINIC
PATIENT ACCESS TO CARE

- **Screening Program:**
  - Order by referring provider – consult to screening program
  - Screening program phone line
  - On-line referral form

- **Nodule Program:**
  - Macro embedded in radiology report
  - Natural language processing tool

- **Lung cancer Program:**
  - Cancer-answer line
  - Dedicated schedulers in each discipline
  - New patient seen within 5-7 days
PROSPECTIVE MULTIDISCIPLINARY CASE PLANNING

- **Screening Program:**
  - All consults reviewed by program coordinator for eligibility and orders placed if eligible
  - Counseling and shared-decision making visit

- **Nodule Program:**
  - Program coordinator review with distribution based on algorithms

- **Lung cancer Program:**
  - Reviewed by receiving service providers
  - Coordination of care attempted, MDC
FINANCIAL, TRANSPORTATION, AND HOUSING

- **Screening Program:**
  - Scheduling is delayed for LDCT pre-authorization
  - 11 sites throughout the region

- **Nodule Program:**
  - Programs at several regional sites

- **Lung cancer Program:**
  - Financial counselor reviews
  - Social work assistance with transportation and lodging
MANAGEMENT OF COMORBID CONDITIONS

- **Screening Program:**
  - Incidental findings managed by screening program based on algorithms

- **Nodule Program:**
  - PCP

- **Lung cancer Program:**
  - Partnership with PCP
  - Specialists as needed
CARE COORDINATION

- **Screening Program:**
  - Visit on same day as LDCT
  - Results within 48 hours

- **Nodule Program:**
  - Visits planned locally
  - Communication with PCP

- **Lung cancer Program:**
  - Navigator introduction at time of diagnosis
  - Coordination of care attempted, MDC
  - MD Tumor board weekly
  - Huddle of navigator and program personnel weekly
TREATMENT TEAM INTEGRATION

- **Screening Program:**
  - Education sessions
  - Nodule tumor board

- **Nodule Program:**
  - Education sessions

- **Lung cancer Program:**
  - Navigator, nurses, APPs, physicians
  - Care pathways developed for nodule evaluation, screening, staging, preoperative evaluation, treatment of each stage, small cell
  - MD tumor board
  - Phone calls, e-mails, EMR messages
ELECTRONIC HEALTH RECORD AND PATIENT ACCESS TO INFORMATION

- **Screening Program:**
  - Notes, results template, available to all in EMR
  - Results communicated how preferred, MyChart

- **Nodule Program:**
  - As screening

- **Lung cancer Program:**
  - EMR available throughout health system
  - MyChart access
SURVIVORSHIP CARE

- **Screening Program:**
  - N/A

- **Nodule Program:**
  - N/A

- **Lung cancer Program:**
  - APP visits within Oncology and Thoracic Surgery
  - Documentation standards
  - Wellness services
SUPPORTIVE CARE

- **Screening Program:**
  - Counselling and SDM visit

- **Nodule Program:**
  - Communication and education plans

- **Lung cancer Program:**
  - Palliative care program
  - Support services available
  - Oncology specific psychologist
TOBACCO CESSATION

- **Screening Program:**
  - Providers trained

- **Nodule Program:**
  - Provider training

- **Lung cancer Program:**
  - Program within Cancer Center
  - Program organized for health system
CLINICAL TRIALS

- **Screening Program:**
  - Assessing biomarker trials

- **Nodule Program:**
  - Biomarker, radiomic trials

- **Lung cancer Program:**
  - Infrastructure in place with trials available for most stages
PHYSICIAN ENGAGEMENT

- **Screening Program:**
  - Leadership role
  - Regularly scheduled team meetings

- **Nodule Program:**
  - As screening

- **Lung cancer Program:**
  - Leadership from each discipline
  - Regularly scheduled meetings to address operational and quality issues
QUALITY MEASUREMENT AND IMPROVEMENT

- **Screening Program:**
  - Quality metrics tracked and assessed
  - Regionalization, nodule tumor board
- **Nodule Program:**
  - Plans to mirror screening
- **Lung cancer Program:**
  - Metrics assessed
  - TTT goals, LN stations
  - Compliance with care paths
## DISCIPLINES INVOLVED IN SCREENING PROGRAM

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Providers</td>
<td>Identify eligible patients and order screening</td>
</tr>
<tr>
<td>Radiologists</td>
<td>Imaging protocols, results reporting</td>
</tr>
<tr>
<td>Pulmonary/IP</td>
<td>SDM visit, nodule evaluation</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>Nodule evaluation, cancer care</td>
</tr>
<tr>
<td>Other subspecialists</td>
<td>Other findings, cancer care</td>
</tr>
<tr>
<td>Advanced practice provider</td>
<td>SDM visit, communication, tracking</td>
</tr>
<tr>
<td>Administrator</td>
<td>Infrastructure support</td>
</tr>
<tr>
<td>Marketing</td>
<td>Program awareness, education</td>
</tr>
<tr>
<td>Billing</td>
<td>Billing compliance, financial data</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Schedule coordination</td>
</tr>
<tr>
<td>EHR/IT specialist</td>
<td>Order sets, structured reports, and registries; assist with test follow-up, quality management, and data reporting</td>
</tr>
</tbody>
</table>
THANK YOU!

You may email questions to:

mazzonp@ccf.org
CASE PRESENTATION

WENDI WAUGH, CANCER SERVICES ADMINISTRATIVE DIRECTOR
SOUTHERN OHIO MEDICAL CENTER
• 234-bed non-profit health care organization serving rural Southern Ohio and Northern Kentucky
• Lung Cancer Screening Program since 2015
  • One of the highest smoking rates in the nation
  • 28 cancers identified in ~1800 screens
• Project Objective: Study timeliness of care and expose delays by insurance status
## Lung Cancer Statistics

*Rates per 100,000 population*

<table>
<thead>
<tr>
<th></th>
<th>Scioto(^1)</th>
<th>Ohio(^1)</th>
<th>National(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence</td>
<td>71.8</td>
<td>67.2</td>
<td>58</td>
</tr>
<tr>
<td>Mortality</td>
<td>63</td>
<td>48</td>
<td>41</td>
</tr>
</tbody>
</table>

PROJECT SUMMARY – RESULTS
N = 105

- Commercial: 23%
- Medicare: 40%
- Medicaid - Dual: 37%
CASE STUDY OVERALL TIMELINESS RESULTS

- No observed timeliness differences by insurance status.
- Decreased detection to treatment times from an average of 34.4 days (pre-study) to 28.8 days (post-study).
CASE STUDY: DIAGNOSIS TO TREATMENT BY NUMBER OF EVENTS DOES MATTER
DAYS (P=0.0012, TREND P<0.001)
SOMC CONCLUSIONS

- SOMC SERVES A SIGNIFICANT MEDICAID POPULATION
- TIMELINESS IS AN EASILY MEASURABLE GOAL FOR PROCESS IMPROVEMENT EFFORTS AND IS A SURROGATE FOR OVERALL QUALITY IN THE SYSTEM
- DESPITE A SIGNIFICANT PROPORTION OF THE SOMC LUNG CANCER POPULATION BEING AT RISK, INSURANCE STATUS DID NOT AFFECT TIMELINESS TO TREATMENT
- THE NUMBER OF EVENTS BEFORE TREATMENT INITIATION DID INCREASE DAYS TO TREATMENT START
- PROCESS MAPPING AND DATA MEASUREMENT DATA POINTS EXPOSE OPPORTUNITIES
- FORMATION OF A MULTIDISCIPLINARY LUNG HEALTH LEADERSHIP TEAM WAS A KEY SUCCESS FACTOR
- REAL-TIME NAVIGATION AND MONITORING OF ELAPSED DAYS IN THE TIMELY DELIVERY OF LUNG CANCER CARE IS MISSION-CRITICAL
To quote Thomas, ‘You can provide well coordinated high quality multidisciplinary lung cancer care for all your patients. Both extremes (academic vs community) have their advantages and their disadvantages and learning to leverage the former and overcome the latter is essential to optimal care coordination.”

Upon initial review of the OCCM Levels and the task, our small group was overwhelmed and skeptical.

The administrative team was unclear how these things might translate in our organization and drive improvement and even if we did learn, could we invest the resources to sustain?
Pre-OCCM, SOMC had a lung navigator who oversaw the lung screening program but unless the patient abnormality was discovered in the screening program there was no real oncology lung navigation.

In addition, there was no multidisciplinary Lung health Leadership Team (LHLT). The extent of measure discussion occurred only at the administrative level and/or at Cancer Committee.

The mere process of abstracting data created a mechanism through which we knew a patient had entered the vortex. Once in the vortex the natural tendency to assist developed.

Simultaneously, the LHLT formed and we were spinning!
At approximately study mid-point, significant data existed demonstrating if the team was allocated resources to provide oncology lung navigation we could increase patient loyalty, decrease patient anxiety, and expedite care. Not only would this benefit patients but decrease inefficiencies related to duplicate testing and cancelled or rescheduled appointments.

By the project end, we had implemented oncology lung navigation and acquired more data building the case to begin an incidental lung nodule program.
Today, the screening program continues to grow, the lung nodule program is gaining traction and is exploring platforms to assist in data management.

The LHLT meets monthly, reviews performance and continues to add indicators to measure success.

SOMC made the strategic decision to continue data abstraction and progress toward OCCM Level Goals.

Key members of the LHLT are presenting data in various forums and continuing to learn and network with others.

SOMC is using the model to expand into other tumor sites.
CASE RELATED QUESTIONS FOR GROUP DISCUSSION
JOIN US IN FEBRUARY FOR LUNG CANCER PATIENT SUPPORT ECHO SESSION 10
STIGMA AND OTHER PSYCHOSOCIAL ISSUES: UNDERSTANDING THE UNIQUE ISSUES FACING LUNG CANCER PATIENTS

FEBRUARY 28, 2019
9:00 AM ET

Presenters:

Jamie Studts, Ph.D.
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