

# *Bristol-Myers Squibb Foundation Grantee Summit 2018*

Charleston, South Carolina | April 9-11, 2018



# Panel II: Health Systems Strengthening/Innovative Models to Improve Access to Specialty Care For Vulnerable Populations

Moderator: Lauren Smith, FSG



# West Virginia Lung Cancer Project

## Patient Advocate Foundation

### Shonta Chambers, MSW



# The Lung Cancer Avengers

- WVU Cancer Institute- *Lead Partner*
- Aetna Better Health (*Medicaid Managed care provider*)
- American Cancer Society
- Mountains of Hope Cancer Coalition
- West Virginia Comprehensive Cancer Control Program
- West Virginia Hospital Association\*
- West Virginia Tobacco Use Prevention Program\*

\*decreased funding for WV Tobacco Use Prevention Funding resulting in the elimination of the two staff positions represented on the WV Lung Cancer Advisory Council



## Goals:

- Increased lung cancer screening among eligible Medicaid Managed Care beneficiaries
- Improved early diagnosis of lung cancer among low-income and limited resources individuals
- Increased access and adherence to lung cancer treatment
- Decreased lung cancer mortality

## Intervention:

- To navigate Medicaid Managed Care Beneficiaries to lung cancer screenings, and where appropriate, lung cancer diagnosis.
- To establish a case management platform designed to support providers and patients with lung cancer.
- Link Medicaid Managed Care Beneficiaries with a confirmed diagnosis of lung cancer to comprehensive case management support to assist with overcoming logistical and financial barriers to treatment.

## The Five P's

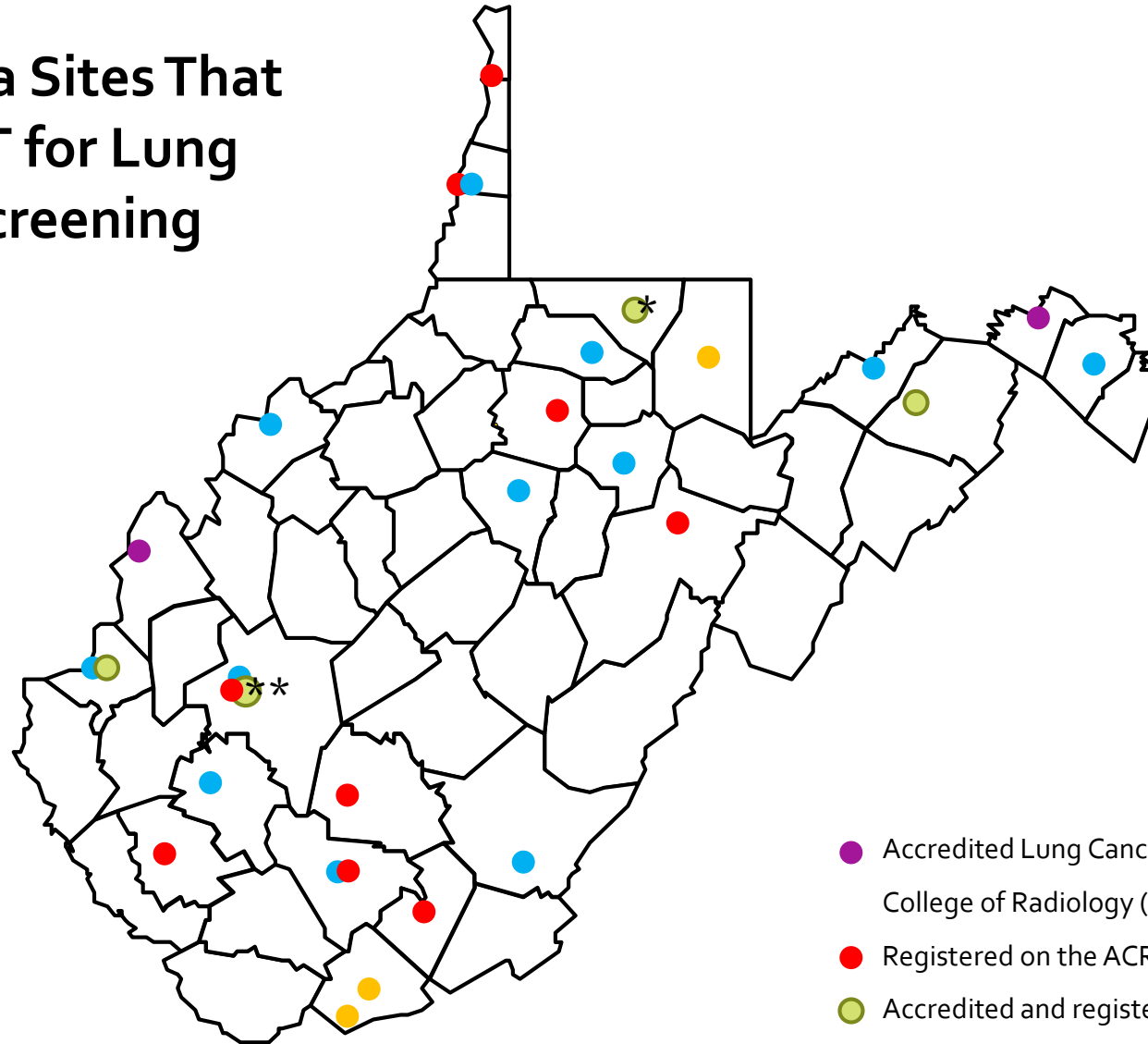
- Patients-Those at risk for lung cancer and those currently in treatment.
- Payers'-Medicaid Managed Care Organizations (Aetna Better Health, Unicare, The Health Plan)
- Providers-Primary Care and LDCT Scan Screening Facilities
- Policy-What infrastructure needs to be in place to support lung cancer early detection, tobacco cessation, etc.?
- Public-General awareness about lung cancer screening for those who meet the guidelines



# Innovation

- The West Virginia Lung Cancer Project was designed to serve as a model to highlight the importance of addressing non-clinical access to care barriers (i.e., transportation, cost of living expenses, time off work restrictions, etc.) and the need to address these barriers so that individuals at risk for lung cancer could take advantage of lung cancer screening and those diagnosed with lung cancer could fully adhere to lung cancer treatment.
- Secondly, the program identified the potential benefit of proactive engagement with eligible Medicaid Managed Care beneficiaries to get them into screening sooner with the overall goal of improving early detection.

# West Virginia Sites That Offer LDCT for Lung Cancer Screening



- Accredited Lung Cancer Screening Center by American College of Radiology (ACR)
- Registered on the ACR Lung Cancer Screening Registry
- Accredited and registered
- Site offers LDCT but is not accredited or registered
- Possible future site/under consideration

\* Three sites are located in Monongalia County, two under WVU Medicine and one under Mon General.

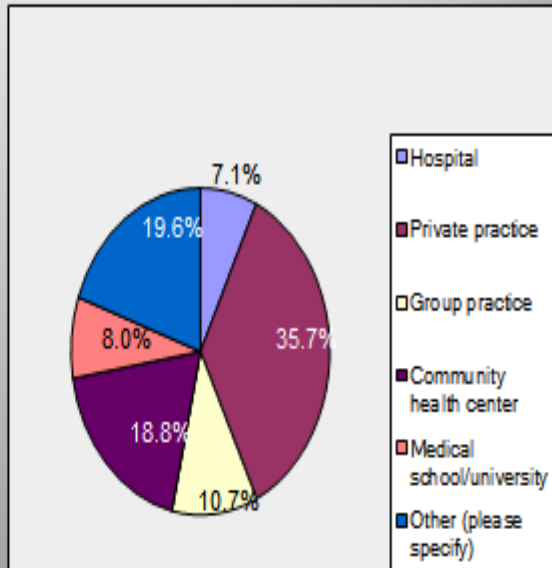
\*\* Eight sites are located in Kanawha County, three under Thomas Health, three under CAMC, one under Saint Francis Hospital, and one at Pulmonary Associates of Charleston.

# Challenges aka Disguised Opportunities

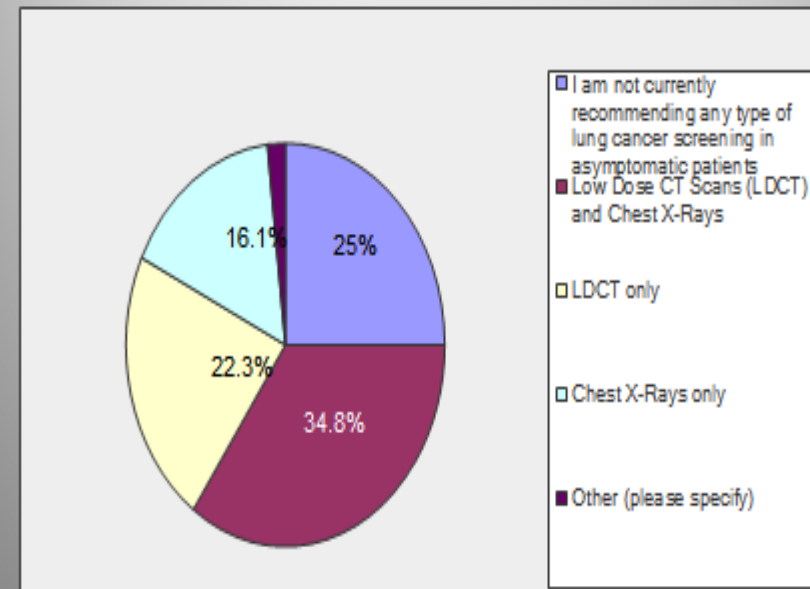
## Provider Survey Results



- 633 providers surveyed
- 114 returned
- 18% return rate



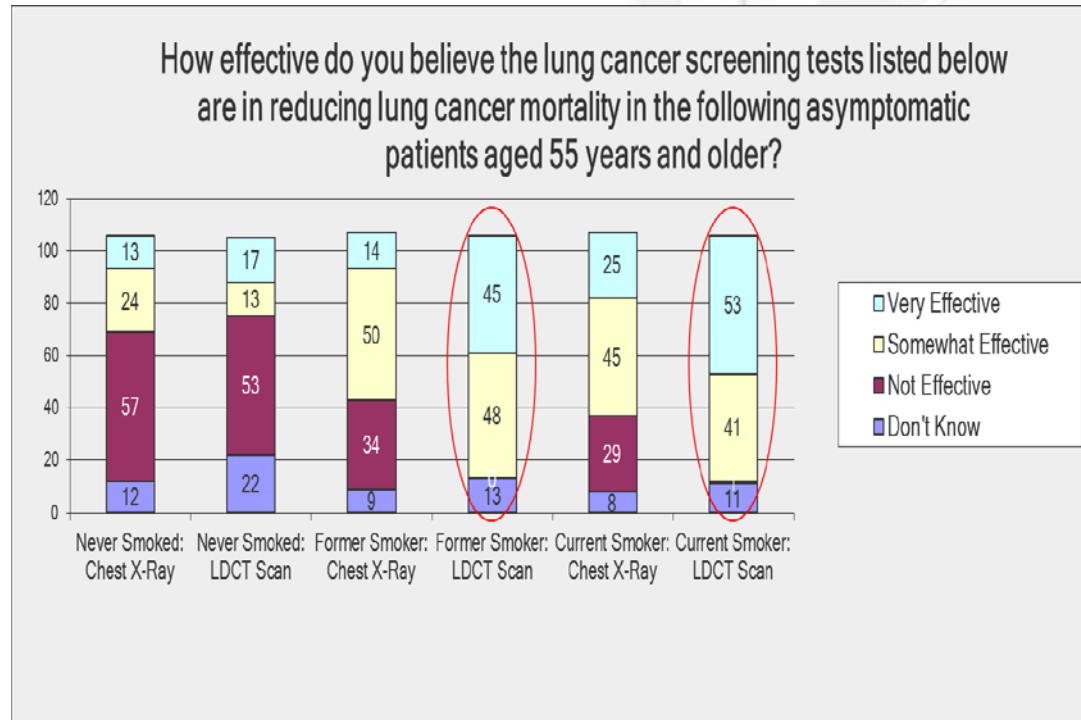
## Current Lung Cancer Screening Referrals



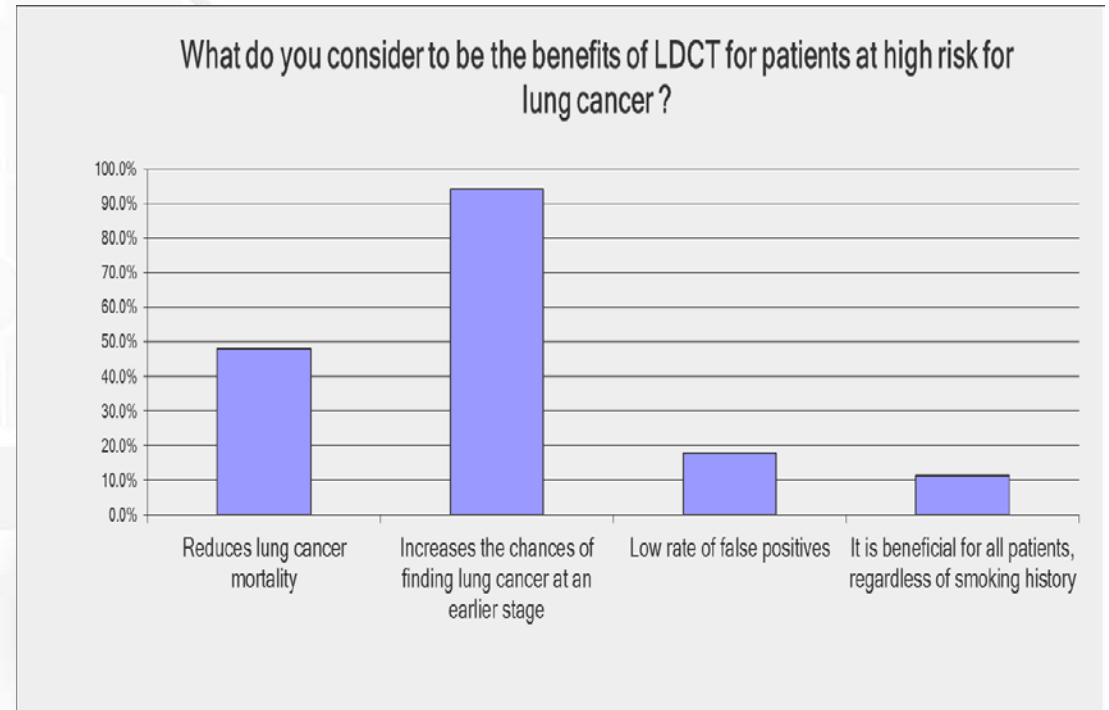


# Challenges aka Disguised Opportunities

## Perspective on Effectiveness



## Perspective on Benefits



# Results to date

<b>Number of members contacted</b>	<b>1,333</b>
<b>Members who scheduled appointment with provider</b>	111
<b>Members that kept their appointment</b>	43
<b>Members who completed LDCT</b>	14
<b>Outcome of LDCT</b>	9 negative 1 positive (just started treatment) 4 need additional testing

# Sustainability

- Lung Cancer identified as an area of focused in revised WV State Cancer Plan (released 2016)
- Partnership with Medicaid Managed Care Organizations
  - Incorporation of Pro-active Lung Cancer Pre-assessment incorporated into standard operating procedures for eligible beneficiaries
- Integration into Patient Advocate Foundation's Case Management Platform
- 2018 West Virginia Lung Cancer Summit

**SAVE the DATE**

*2018 Lung Cancer Conference:  
Catalyzing Change to Address  
Lung Cancer*

**NOVEMBER 1-2, 2018**

A two day event at the Erickson Alumni Center, Morgantown, WV including:

- Mountains of Hope Meeting
- Policy Summit
- 2nd Annual Lung Cancer Conference

More details will be provided soon.  
For questions please call 304-293-2370.



A COLLABORATIVE EVENT FROM THE FOLLOWING



## Public Awareness Messages

- Duke Jordan-[https://youtu.be/jCCwPVZU\\_9M](https://youtu.be/jCCwPVZU_9M)
- Overview of Lung Cancer Screening-[https://youtu.be/-q\\_vtyLlx5w](https://youtu.be/-q_vtyLlx5w)

# THANK YOU.....

*Bristol-Myers Squibb Foundation, this initial pilot has allowed us to initiate some very important conversations and activities across West Virginia to address lung cancer. These conversations are taking place in various entities and bringing groups together to identify tangible solutions. We have learned a lot through the process and found ways to turn our challenges into opportunities to improve access to low dose CT screening. Our partners remain steadfast in our pursuit to decrease lung cancer mortality across the state.*

# A System-wide Care Pathway for Atrial Fibrillation



Anil Gehi, MD  
Associate Professor of Medicine  
Cardiac Electrophysiology  
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THE UNIVERSITY  
*of* NORTH CAROLINA  
*at* CHAPEL HILL



# Typical Case

- 56 year-old man with hypertension, type II diabetes, hyperlipidemia, sleep apnea, obesity (BMI 34) developed shortness of breath
- Diagnosed with AF at work physical, called PCP and told to go to ED
- A-Fib, rate 108
- Was admitted from ED and started on anticoagulant
- Spontaneously converted to normal rhythm overnight
- Scheduled for follow-up with PCP in two weeks
- PCP continued anticoagulant, aspirin
- 4 weeks later, developed recurrent A-Fib with rapid rate and came back to ED



# Key gaps in AFib care

- **Plan for acute AF issues**
  - Triage, access, patient understanding
- Comorbidity management
  - Aggressive therapy, who does what?
- Quality improvement
  - Care should be evidence-based and consistent across patients, practices
- Patient engagement
  - Education, psychosocial support, patient activation



# AF costs of care

- Estimated annual costs of AF care in US > \$6 billion
- Nearly  $\frac{3}{4}$  of costs due to hospitalizations
- **Not every AF hospitalization may be necessary**
- Causes of ED presentations and hospitalizations for AF:
  - *Patient misconceptions*
    - e.g. patients think they are having a heart attack
  - *Provider misconceptions*
    - e.g. providers think aggressive rate or rhythm control are emergent
  - *Poor access to specialty care*
- ***Patients are uneducated on what to do for Afib episodes – need an action plan***

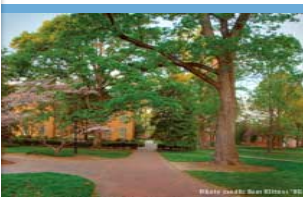


# AF: #9 cause of NC hospitalizations

State statistics - 2013 North Carolina - principal diagnosis only

## Rank order of ICD-9-CM principal diagnosis code by number of discharges

Rank	ICD-9-CM principal diagnosis code and name	Total number of discharges
1.	V30.00 Single Lb In-Hosp W/O Cs	75,745
2.	V30.01 Single Lb In-Hosp W Cs	32,472
3.	038.9 Septicemia Nos	32,310
4.	486 Pneumonia, Organism Nos	24,296
5.	584.9 Acute Renal Failure Nos	16,676
6.	715.36 Loc Osteoarth Nos-L/Leg	16,272
7.	491.21 Obs Chr Brnc W Act Exa (after Oct 1, 2003)	14,925
8.	410.71 Subendo Infarct, Initial	14,499
9.	427.31 Atrial Fibrillation	14,346
10.	654.21 Prev C-Delivery-Delivrd	13,230
11.	434.91 Crbl Art Ocl Nos W Infrc	12,779
12.	599.0 Urin Tract Infection Nos	11,839
13.	414.01 Crnry Athrscd Natve Vssl	11,315
14.	V57.89 Rehabilitation Proc Nec	10,569
15.	645.11 Post Term Preg-Del	9,530
16.	428.23 Ac On Chr Syst Hrt Fail	9,252
17.	664.11 Del W 2 Deg Lacerat-Del	8,832
18.	577.0 Acute Pancreatitis	8,595
19.	518.81 Acute Respiratry Failure (after Oct 1, 1998)	8,147
20.	428.33 Ac On Chr Diast Hrt Fail	7,858
21.	518.84 Acute & Chronc Resp Fail	7,830
22.	664.01 Del W 1 Deg Lacerat-Del	7,686
23.	715.35 Loc Osteoarth Nos-Pelvis	7,306
24.	648.91 Oth Curr Cond-Delivered	7,016
25.	786.59 Chest Pain Nec	6,859

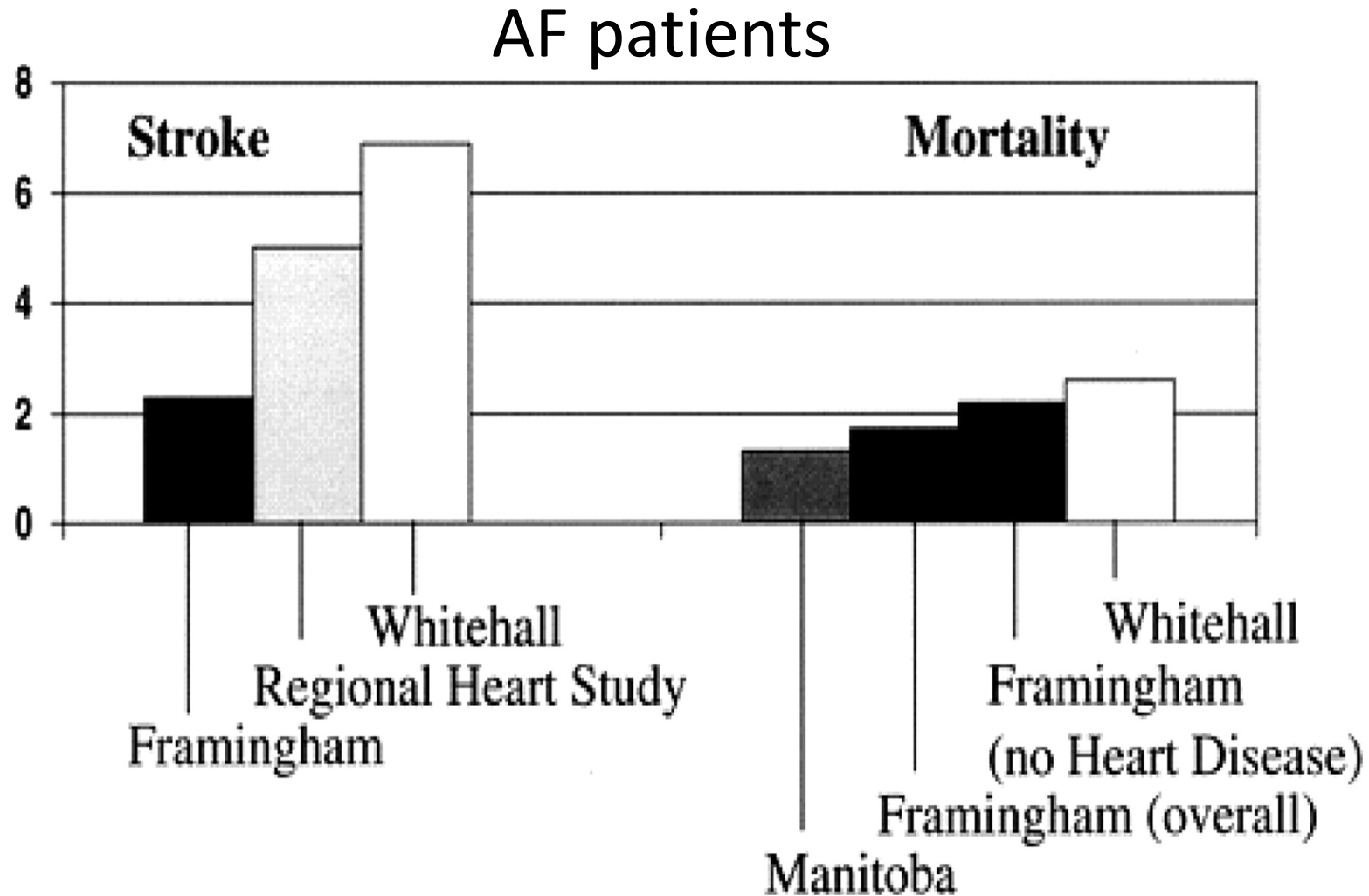


# Key gaps in AFib care

- Plan for acute AF issues
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# Increased risk for stroke/mortality in AF

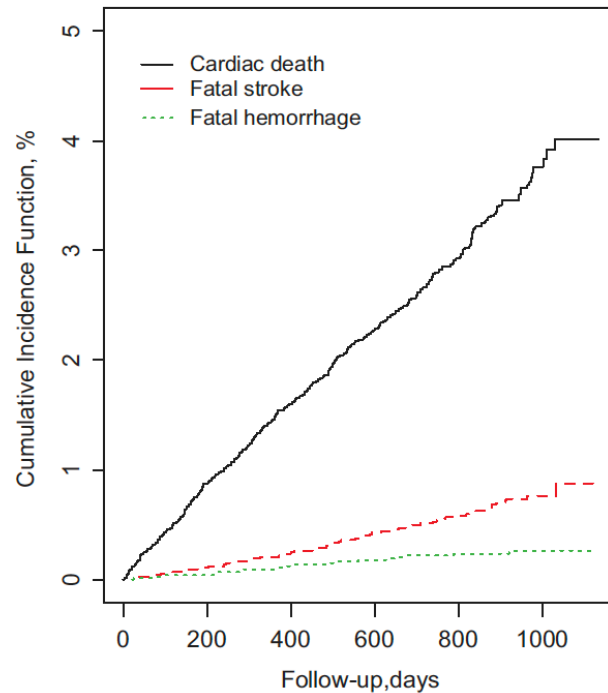




# Causes of Death and Influencing Factors in Patients With Atrial Fibrillation

## A Competing-Risk Analysis From the Randomized Evaluation of Long-Term Anticoagulant Therapy Study

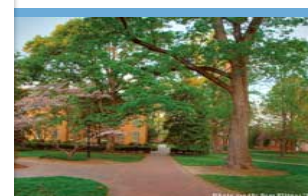
Eloi Marijon, MD, PhD; Jean-Yves Le Heuzey, MD; Stuart Connolly, MD; Sean Yang, MSc; Janice Pogue, PhD; Martina Brueckmann, MD; John Eikelboom, MD; Ellison Themeles, BA; Michael Ezekowitz, MB, ChB, DPhil; Lars Wallentin, MD, PhD; Salim Yusuf, FRCPC, DPhil;



**Table 4. Causes of Death in the RE-LY Trial**

Causes of Death in RE-LY	n	%
Total	1371	100.00
Cardiovascular death	842	61.41
Cardiac	512	37.35
Sudden cardiac death	305	22.25
Progressive heart failure	207	15.10
Vascular	139	10.14
Stroke/peripheral embolism	96	7.00
Hemorrhage	39	2.84
Pulmonary embolism	4	0.29
Other/unknown	191	13.93
Noncardiovascular death	491	35.81
Cancer	191	13.93
Respiratory failure	79	5.76
Trauma	12	0.88
Infection	61	4.45
Other	148	10.80
Undetermined death	38	2.77

RE-LY indicates Randomized Evaluation of Long-Term Anticoagulant Therapy.



# Multiple factors leading to A-Fib need to be addressed

## Non-modifiable factors

- Age
- Race/ethnicity
- Genetics (family history)
- Height

**10% have “lone” Afib – no obvious risk factors**

## Modifiable factors

- Other heart problems (valve disease, heart failure, heart surgery)
- High blood pressure
- Obesity
- Physical inactivity
- Sleep apnea
- Alcohol consumption
- Diabetes
- Individual triggers
- Thyroid problems
- Lung problems



# Key gaps in AFib care

- Plan for acute AF issues
  - Triage, access, patient understanding
- Comorbidity management
  - Aggressive therapy, who does what?
- **Quality improvement**
  - Care should be evidence-based and consistent across patients, practices
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# Patient education / support

CARDIOLOGY PATIENT PAGE

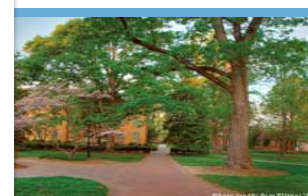


## A Patient's Guide to Living With Atrial Fibrillation

Julie B. Shea, MS, RNCS; Samuel F. Sears, PhD



The banner features the American Heart Association logo on the left, the "myAFibexperience" logo in the center, and the "StopAfib.org" logo on the right. Below the logos is an illustration of a diverse group of people with speech bubbles containing question marks and hearts with ECG lines. On the right side, there is a red "SIGN UP" button and the text "TO JOIN OUR ONLINE COMMUNITY FOR ATRIAL FIBRILLATION".

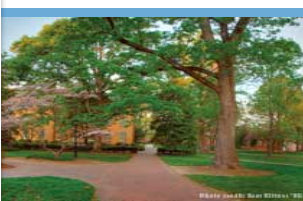
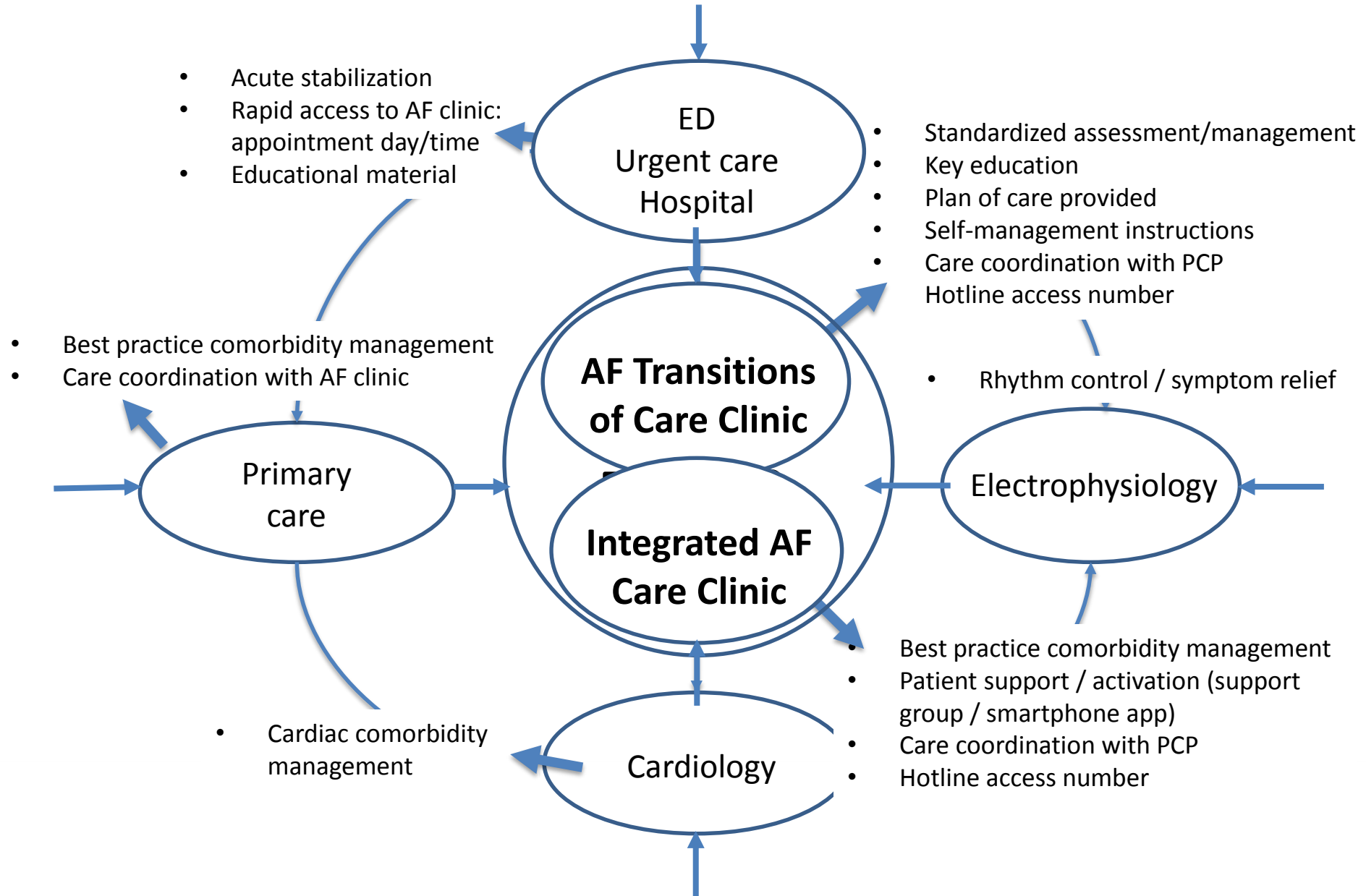


# Project innovation – Integrated Care Model: Key Features

- Optimal management requires input from different medical specialties
- Close cooperation between AF specialists and community general cardiologists, primary care providers, allied health professionals, patients, family
- Support shared decision-making
- Empower patients to own their care
- Provide support where needed
- Strategically deploy access sites where vulnerable patients reside



# AFib Care Network Model – Key Features

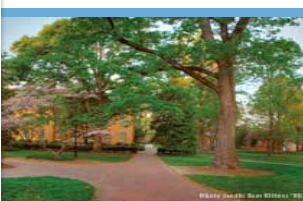




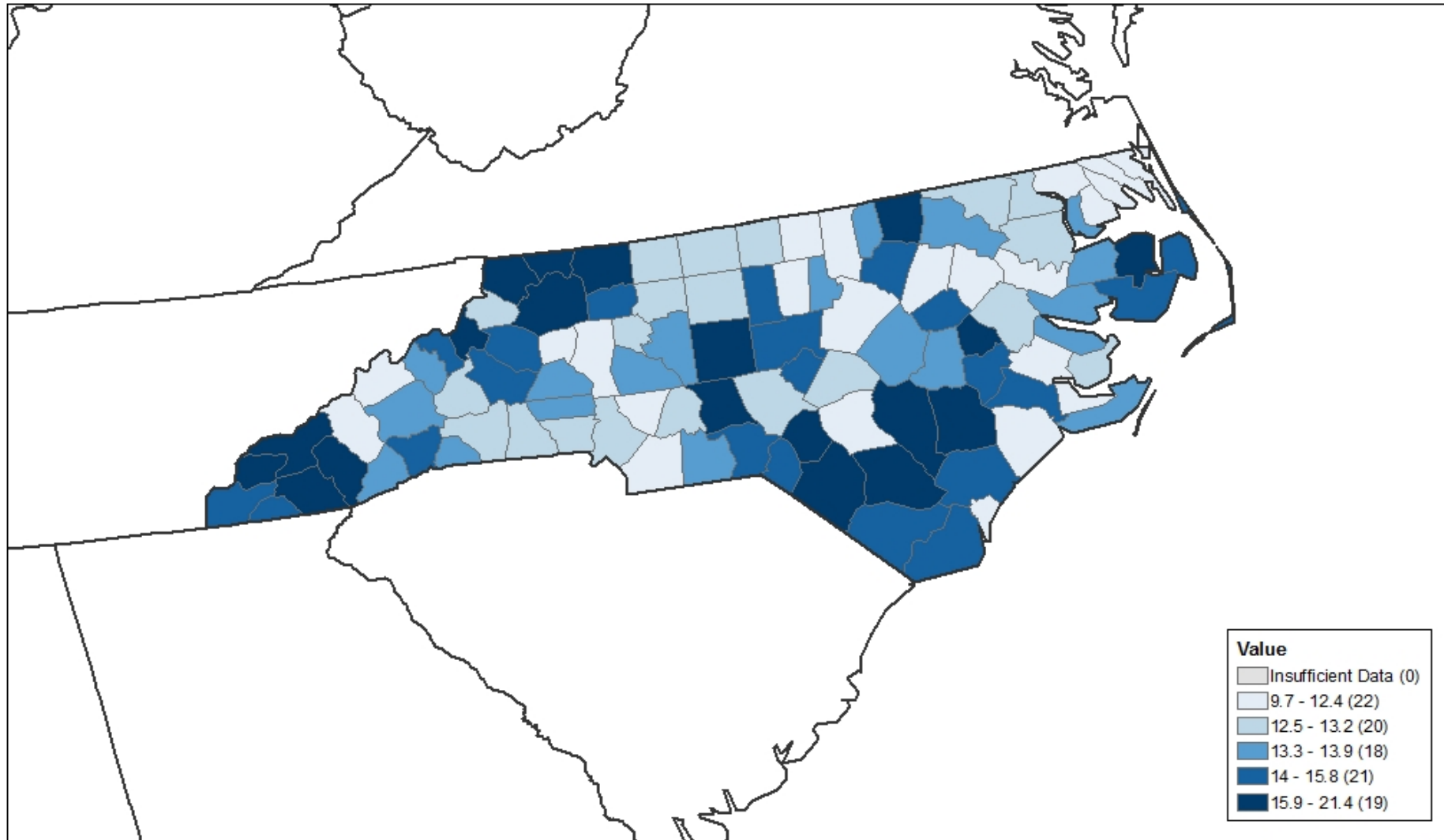
# A-Fib Care Network

- ED: Triage protocol, rapid access to specialty care
- AF Transitions-of-care clinic: standardized management, patient action plan, self management skills, establish with / coordinate with PCP, cardiology, EP
- AF Integrated care clinic: best practice comorbidity management, patient support / activation, coordinate with PCP, cardiology, EP
- PCP: care coordination, comorbidity management
- Cardiology: cardiac comorbidity management
- Electrophysiology: rhythm control when needed

**\*Strategic deployment of AF care clinics to ease access**



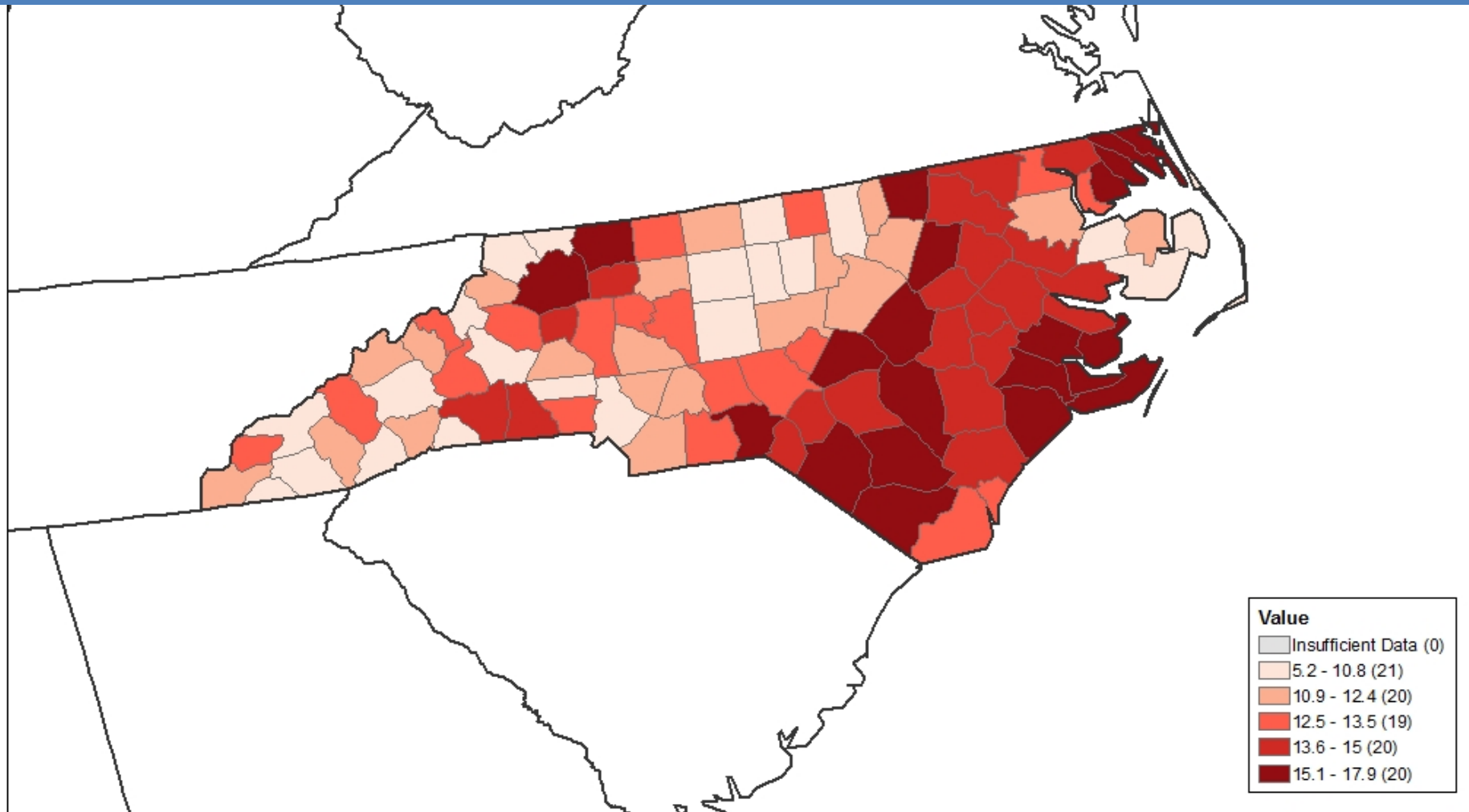
# Percentage without Health Insurance, Under Age 65, 2015



This map was created using the Interactive Atlas of Heart Disease and Stroke, a website developed by the Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention.  
<http://www.cdc.gov/dhdsp/maps/atlas>



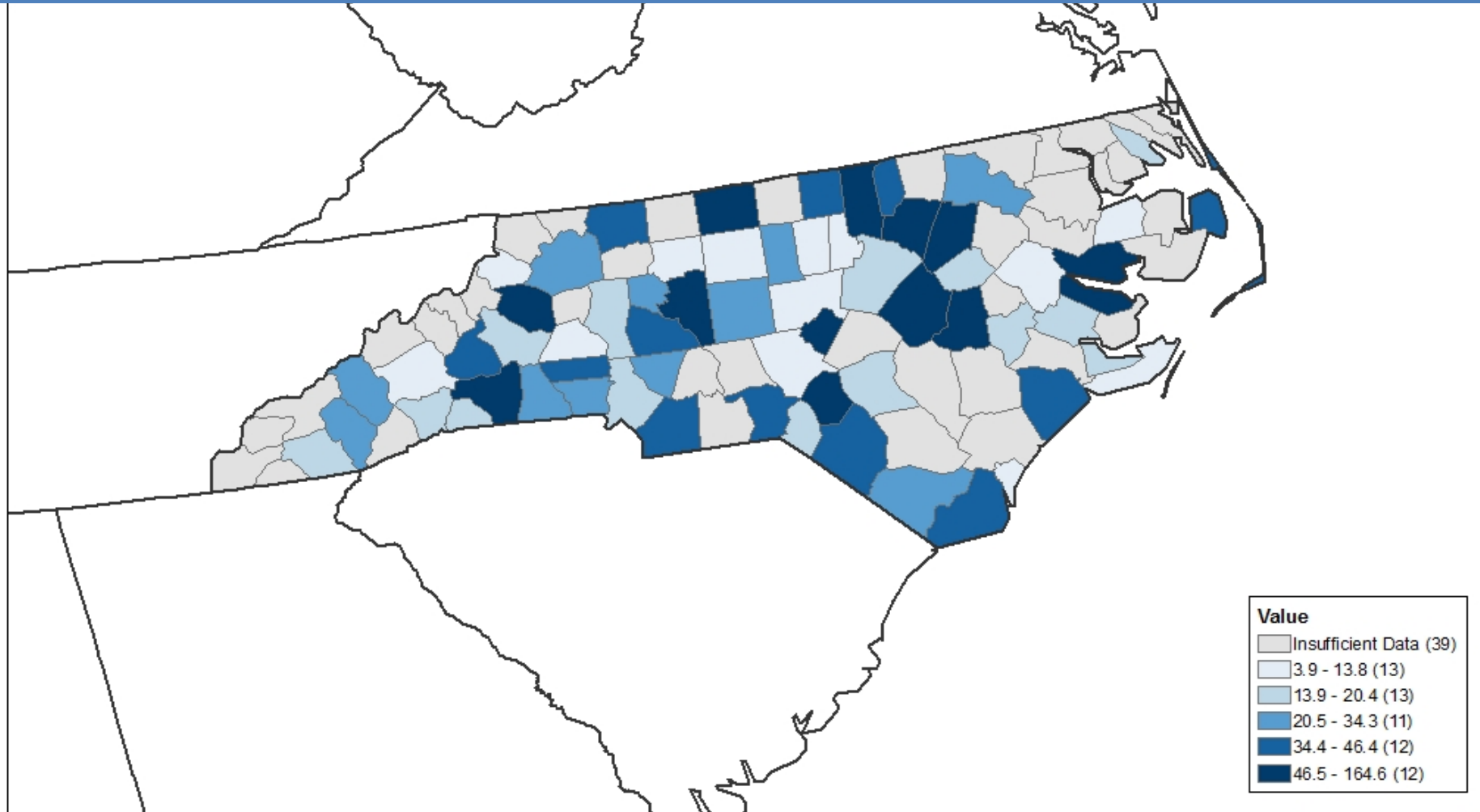
# Cardiac Dysrhythmia Hospitalization Rate/1,000 Medicare Beneficiaries, 2012-2014



This map was created using the Interactive Atlas of Heart Disease and Stroke, a website developed by the Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention.  
<http://www.cdc.gov/dhdsp/maps/atlas>



# Population per Cardiovascular Disease Physician (in thousands), 2014



This map was created using the Interactive Atlas of Heart Disease and Stroke, a website developed by the Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention.  
<http://www.cdc.gov/dhdsp/maps/atlas>



## PATIENT PRESENTS TO ED WITH AF

### LOW risk AF patient



- No other illness requiring hospitalization
- Conversion to sinus rhythm OR mild symptoms of AF (CCS – SAF  $\leq$  2)
- HR  $\leq$  110 and MAP  $\geq$  55 with/without rate control meds

#### DISPOSITION:

AF transitions network follow-up

### MODERATE risk AF patient



- No other illness requiring hospitalization
- Conversion to sinus rhythm OR moderate symptoms of AF (CCS – SAF  $\leq$  3)
- HR  $\leq$  130 and MAP  $\geq$  55 with/without rate control meds

#### DISPOSITION:

- AF transitions network follow-up
- OR
- ED/ Observation Unit cardioversion and AF transitions network follow-up

### HIGH risk AF patient



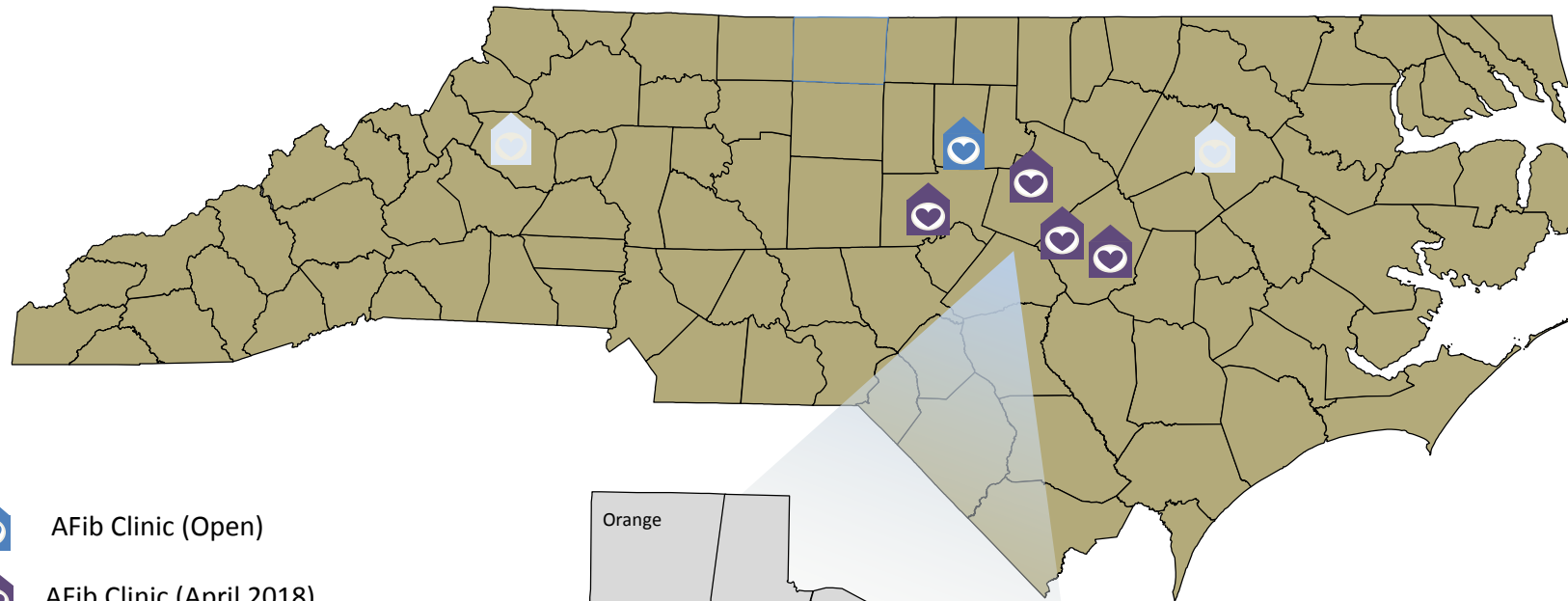
- Other illness requiring hospitalization
- Severe symptoms of AF (CCS – SAF = 4)
- Recent syncope
- HR  $>$  130 despite rate control meds or MAP  $<$  55
- Physician discretion





#### DISPOSITION:

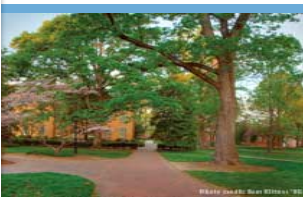
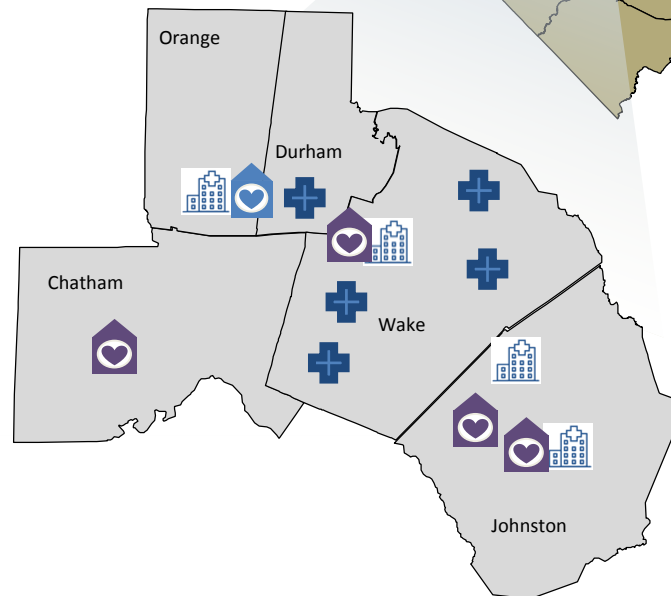
- ED / Observation Unit cardioversion and AF transitions network follow-up
- OR
- Admit



# AFib Clinics have been strategically positioned in order to be accessible to the UNCHC patient population



-  AFib Clinic (Open)
-  AFib Clinic (April 2018)
-  AFib Clinic (Timing TBD)
-  UNCHC Hospital
-  Freestanding Urgent Care





# Conclusions

- Key gaps in AF care can only be addressed by strengthening systems of care
- An integrated AF care model requires close cooperation between AF specialists and community general cardiologists, PCPs, allied health professionals, patients, family
- Successful innovations in AF care delivery will require provider and patient activation



# Creating an Optimal Care Coordination Model for Lung Cancer Patients on Medicaid

Association of Community Cancer Centers (ACCC)

Amanda Kramar, Chief Learning Officer

Amy Marbaugh, Senior Clinical Content Manager

Chandra Persaud, Program Officer



# Project Goal and Timeline

- **Goal**

- Create an Optimal Care Coordination Model (OCCM) that reduces disparities related to access to care for lung cancer patients on Medicaid

- **Timeline**



- **Why Develop the OCCM?**

- ✓ Provide practical guidance to cancer programs to achieve patient-centered, multidisciplinary, coordinated care for lung cancer patients on Medicaid
- ✓ Designed to be used by any cancer center, regardless of program size, location, and resource level

# Summary of Phase I and II Milestones

- **Phase I: Development Phase - January 2016-December 2016**
  - **Accomplishments**
    - ✓ Drafted Environmental Scan
    - ✓ Selected 5 ACCC Cancer Program Member Sites to serve as Development Sites
- **Phase II: Recruitment Phase - January 2017-September 2017**
  - **Accomplishments**
    - ✓ Completed draft OCCM and Measure Compendium
    - ✓ Selected 7 Testing Sites from Applicant Pool

# Developing the OCCM

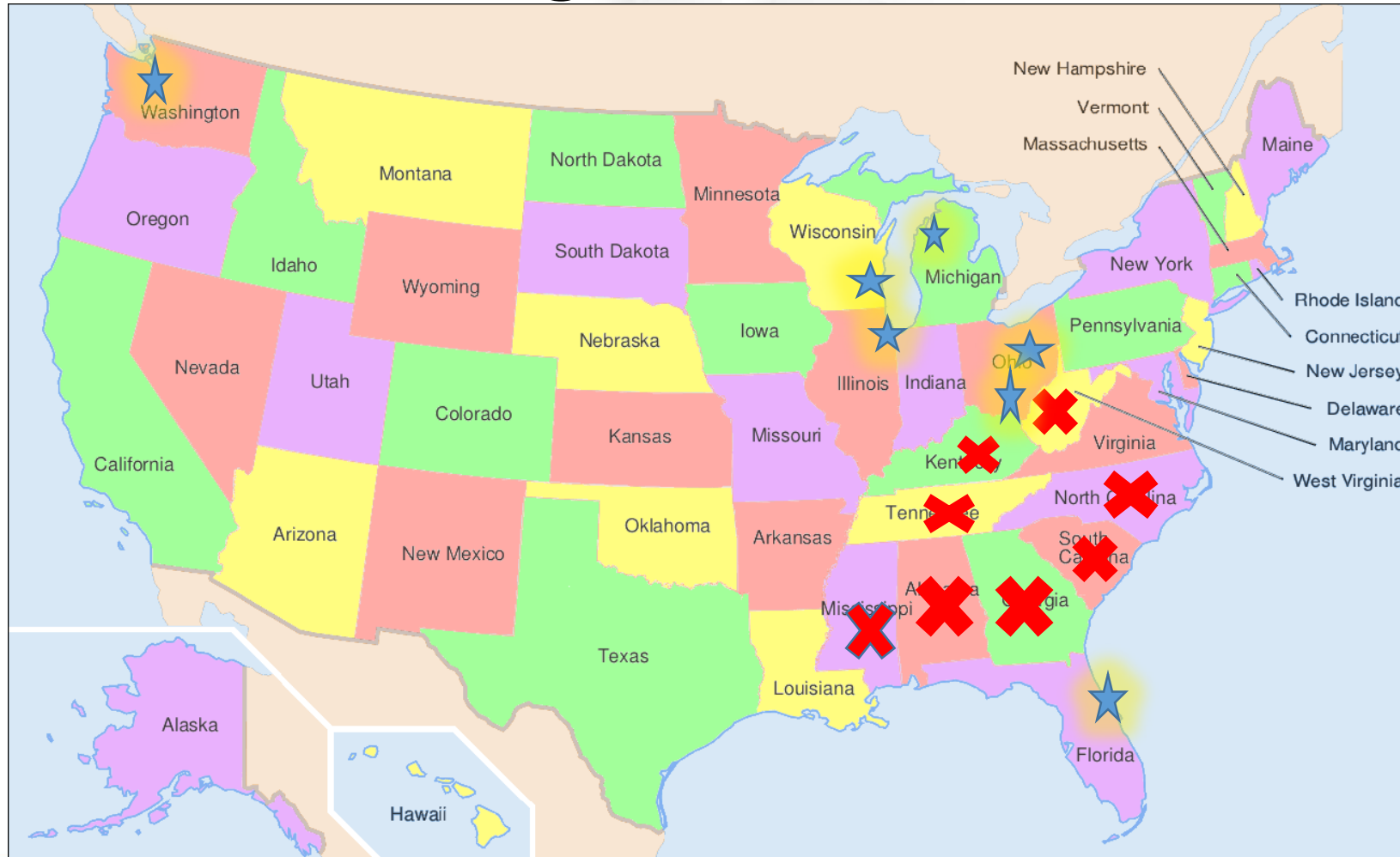
**Built directly upon the Multidisciplinary Care Assessment Tool created by the NCI Community Cancer Centers Program (NCCCP)**

## 13 Assessment Areas

1. Patient Access to Care\*\*
2. Prospective Multidisciplinary Case Planning\*\*
3. Financial, Transportation, and Housing\*\*
4. Management of Comorbid Conditions
5. Care Coordination\*\*
6. Treatment Team Integration\*\*
7. Electronic Health Records and Patient Access to Information\*\*
8. Survivorship Care
9. Supportive Care
9. Tobacco Cessation
11. Clinical Trials
12. Physician Engagement
13. Quality Measurement and Improvement

\*\* Designated as priority Assessment Areas by the Advisory Committee

# OCCM Selected Testing Sites and Assessment Areas





# Currently In Progress: Phase III

- Testing Phase

- October 2017-December 2018

- Accomplishments

- Selected Testing Sites Assessing Usability and Feasibility of OCCM by Implementing Their Proposed QI Projects

- In process of 12-month testing phase (**October 2017-September 2018**)

- Quarter 1 (October-December 2017) progress reports were completed by sites, reviewed by consultants and feedback provided to sites in January 2018

- Hosted a Policy Summit in November 2017

- Introduced OCCM to federal stakeholders, patient advocacy organizations, and oncology professional associations to gain their feedback on how the model could be implemented on a large scale

# Establishing a Multi-Location Quality Improvement Initiative

- Successes and Challenges
  - Selecting the Testing Sites
  - Launching the OCCM
  - Project Consultants
  - Testing Site Staffing
  - Progress Report Implementation

# Looking Ahead...SUSTAINABILITY

- Where can we go from here?
  - Expanding models into other cancer sites



- Publications, presentations, abstracts

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**IASLC**

International Association for  
the Study of Lung Cancer



Bristol-Myers Squibb Foundation  
Specialty Care for  
Vulnerable Populations  
Care Collaborations & Patient Support

Bristol-Myers Squibb Foundation  
Bridging Cancer Care<sup>™</sup>  
Community Awareness, Prevention and Care

# In Their Own Words...

- Imelda Unto, RN, MSN, OCN, Regional Administrator
  - ***Florida Hospital Memorial Medical Center***



- Wendi Waugh, RT (R)(T) CMD CTR BS, Administrative Director of Cancer Services and Community Health & Wellness
  - ***Southern Ohio Medical Center Cancer Center***



# Thank You!

# Mobile Outreach Retention & Engagement Doing MORE for HIV

## Whitman-Walker Health

Presenters: Krishna Kothary, Chris Kubaska & Malachi Stewart





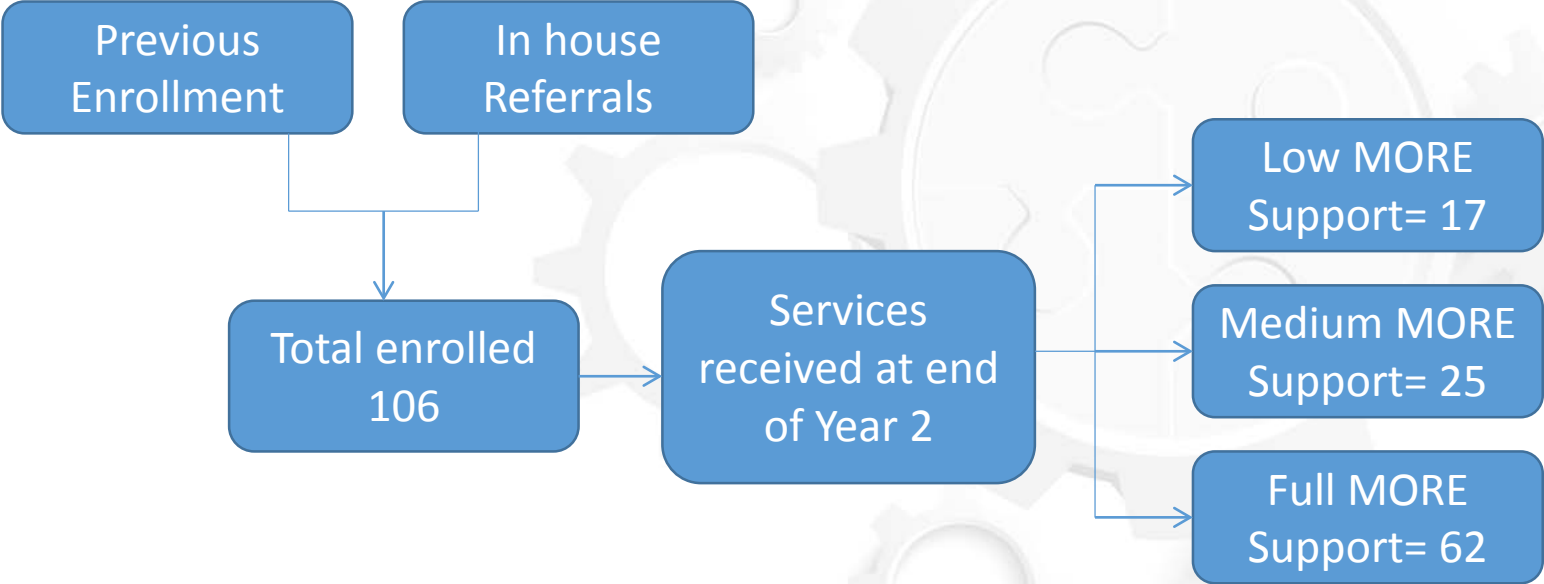
## Summary

*MORE takes care out of the four walls of a health center to, literally, wherever the patient is. By providing mobile support in addition to clinical care in a non-traditional setting, we increase access to health education, navigation, lab work, and medical service while we build relationships that allow for greater collaboration. When we get to know patients in their homes, we better identify resources and opportunities to work with them towards their best health.*

# Our secret: Meeting patients where they are

Barrier	Response
Transportation	-Help with transport through Uber/Lyft, Metro Access or MTM -Medical and Phlebotomy visits in home or other preferred site
Forgetting	-Care navigation support/reminder calls
Stigma	-Medical and Phlebotomy visits outside of the clinic
Feeling sick	-Medical and Phlebotomy visits in home
Scheduling	-Extended hours offered -Home visits -Care Navigation
Insufficient Health Insurance	-Care navigation to public benefits
Competing Priorities	-Medical and Phlebotomy home visits, extended hours
Housing	-Connection with Services
Mental Health/Substance Abuse	-Transportation to appointments -Facilitation of scheduling with in-house services

# Project Results: Recruitment Flow



- *Team Roles*
  - *Care Navigator*
  - *Medical Provider*
- *Service Flow*
  - *Intake and Referrals*
  - *Scheduling*
  - *Graduation*

# Key Challenges

- Socioeconomic barriers
- Complex medical co-morbidities
- Mental health and substance abuse
- Inevitable emotional involvement
- Varying levels of engagement
- Expectation management
- Funding

# Project Results

- 45% were between the ages of 35-54, followed by 20-34 (34%), and 55+ (21%).
- **84% live in DC**, with the highest percentages in Ward 5 (12%), Ward 7 (15%), and Ward 8 (16%).
- **82% identified as African American**, followed by white (11%).
- 7% identified as Hispanic or Latino.
- **46% identified their sexual orientation as LGBTQ**-gay, lesbian, homosexual; followed by heterosexual (31%); bisexual (7%); other (7%); or not reported (8%).
- **27% are in temporary (17%) or unstable (10%) housing situations.**
- Almost two-thirds receive **Medicaid (60%)**, followed by Medicare (18%).
- **60% have mental health diagnosis or substance abuse history**

**Program showed decreased VL and increased access to labs across all groups**

# Lessons Learned

Team based care

Availability  
Reliability

Relationship building



Immersive health care

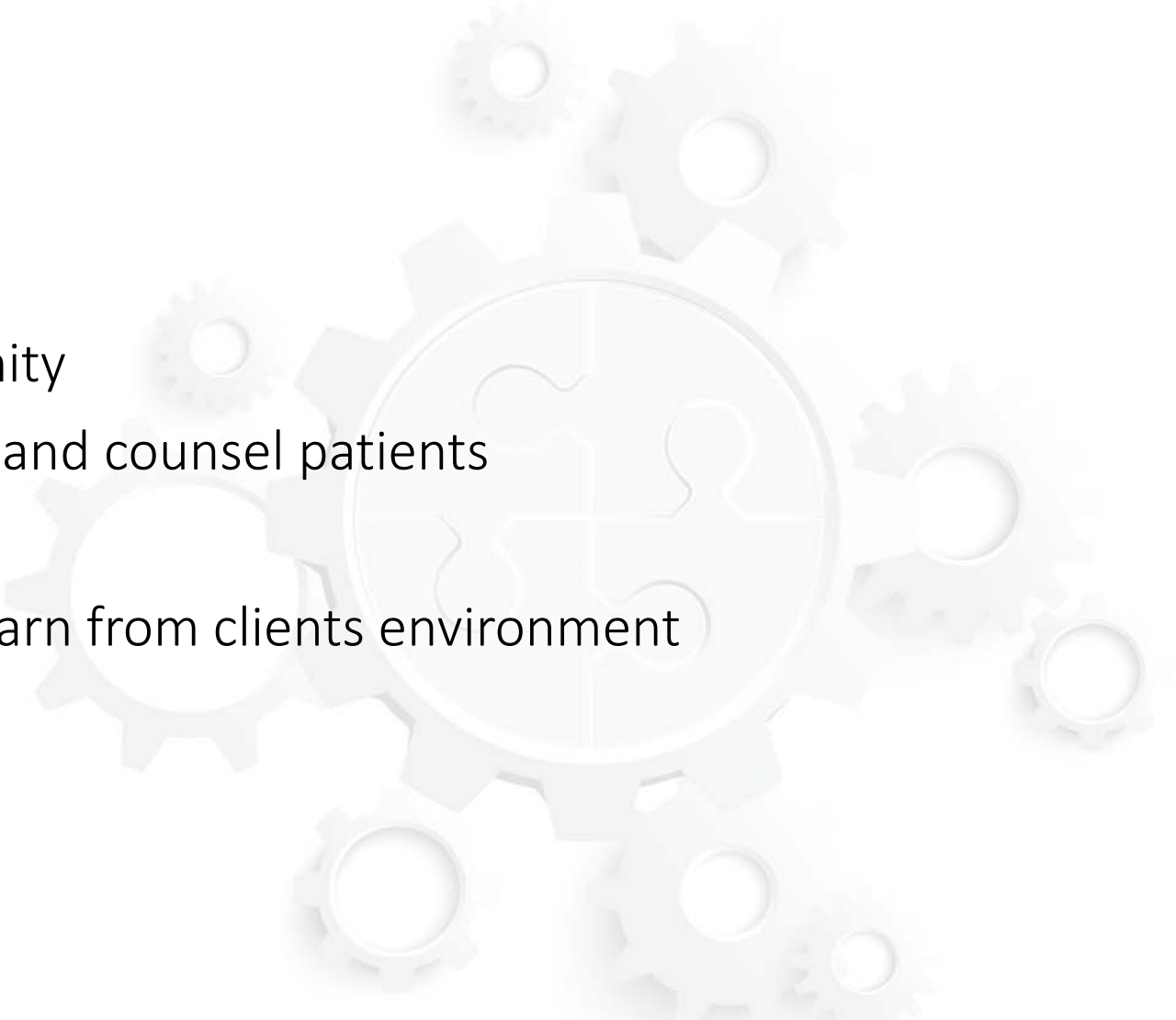
Counseling  
&  
Education

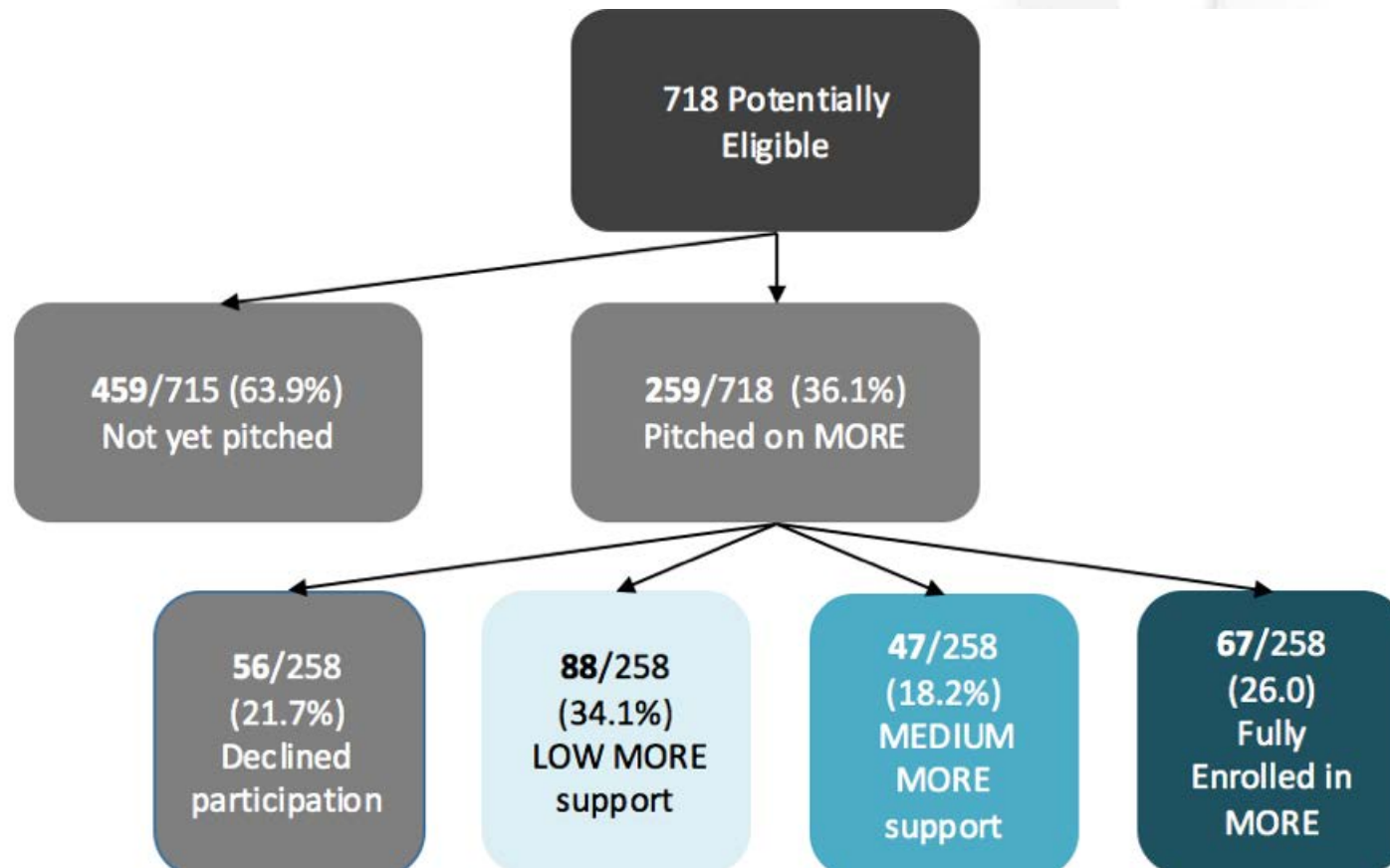
Care  
Coordination





Thank you for your time and attention

- 
- Trust building
  - Power of community
  - Ability to educate and counsel patients
  - Patient gratitude
  - Appreciation to learn from clients environment



Please take a moment to evaluate this session in your mobile meeting app.

Thank you!

