



NCI Community Cancer Centers Program Pilot Work Plan and Deliverables Summary

Additional Program Components Including Quality of Care and Survivorship

This Work Plan includes components that have not been captured in the work plans specific for the four focus areas (Disparities, Clinical Trials, IT, Biospecimens) and includes work related to the following components: Quality of Care, Survivorship, and Other.

INTRODUCTION: The NCI Community Cancer Centers Program (NCCCP) pilot research initiative will explore the development of a national network of community-based cancer centers. The focus of the pilot will be to research how best to accomplish the following:

- increase accruals to NCI-sponsored clinical trials, especially for underrepresented and disadvantaged populations;
- develop new or expanded programs to increase outreach to the uninsured, underrepresented, and disadvantaged populations for prevention, screening, treatment, follow-up care, palliative care, survivorship plans, and end-of-life care;
- increase knowledge of infrastructure requirements, necessary interfaces, and applicability of specific components of caBIG™ for community hospital settings, and increase implementation of electronic medical records and exploration of the application of electronic medical records in the provision of cancer care;
- increase knowledge of infrastructure requirements, policies and procedures, costs, and other issues (e.g. collaborations or contracts necessary for biospecimen collection, annotation and storage) required for implementation of NCI Best Practices for Biospecimen Resources, thus enabling community hospitals to participate in biospecimen initiatives that will advance the NCI's research agenda.

The NCCCP pilot will incorporate key NCI initiatives into the examination of a model for hospital-based community cancer care to include the four focus areas listed above. In addition, there is interest in exploring the following special areas of interest that could serve to enhance the model:

- Models for effective linkages with NCI-designated cancer centers or academic medical research institutions that would support the program goals;
- Effective linkages with state-sponsored cancer initiatives;
- The potential benefit of participation in healthcare information technology initiatives such as a RHIO (Regional Health Information Organization) or similar initiative;
- Working with providers to examine the potential for the development of new reimbursement models for cancer prevention, screening and treatment;
- Models for survivorship plans that would support the overall goals of the program;
- Exploration of the benefit of linkages with the NCI-sponsored Cancer Expert Corps, a program under development, to bring cancer expertise to locations where there is a gap in a needed service;
- The value of a knowledge exchange network for community hospital-based cancer providers;
- Models for co-investment with the NCI to broaden the effective reach of the NCI research programs;
- Models of multidisciplinary cancer care that incorporate the continuum of services including early detection, prevention, therapy, survivorship follow-up and end-of-life support programs;
- Working with providers that have developed successful approaches for accrual of patients into NCI-sponsored clinical trials. NCCCP pilot sites are not expected to encompass all areas of special interest;
- Programs in locations where the population has significant hardships affecting access to healthcare; and
- Whether selecting a site that is part of a national health system might speed the replication of a successful model.

QUALITY OF CARE WORKSCOPE: The organization will participate in routine conference calls with the NCI and SAIC-Frederick staff, to include representatives from the entire pilot group. The NCCCP pilot plans to assess quality-of-care through review of pilot site enhanced infrastructure for quality improvement, the increased utilization of evidence-based guidelines, and review of selected quality indicators as reported to the American College of Surgeons' Commission on Cancer (CoC), the capability and results of multi-disciplinary coordination of care, and patient satisfaction results compared over the pilot, and consideration of an optional study involving pilot site physician participation in the ASCO Quality Oncology Practice Initiative (QOPI).

In general, the workscope will be focused on the following principles:

(These activities and requirements are contingent upon NCI reaching agreements with the American College of Surgeons' Commission on Cancer and the American Society of Clinical Oncology to participate in the NCCCP pilot program.)

- Assess sites needs for *internal* program quality improvement
 - Complement external program focus of disparities workgroup
 - Complement whenever possible NCCCP quality-related initiatives in clinical trials and survivorship
 - Focus on select opportunities linked to national or NCI initiatives to include the Commission of Cancer reporting for breast cancer and colorectal cancer diagnosis and treatment quality measures, and as an optional project, participation in ASCO's QOPI initiative for improvement on select office-based oncology practice quality measures.
- Enhance infrastructure for sustained and ongoing quality improvement to support clinical and patient-centered performance
 - Quality Improvement Initiatives to Improve Evidence-based Care and Patients' Satisfaction and Experience – Sites select opportunities and improvement goals within broad NCI framework
 - Enhanced multi-disciplinary QI teams with tracking on pilot-selected hospital-based and oncology practice based quality indicators to track improvement in care
 - Enhanced patient support programs based on patient perspective of needs
 - Measurement, intervention, feedback on select initiatives
 - Results of patient experience survey as compared to baseline
- Baseline and Follow-up Assessments of both Process and Outcome improvement
 - Compare when possible to pilot baseline, NCCCP program experience, and similar national programs/national trends

During the pilot period, specific research questions will include the following:

- Have the multi-disciplinary QI teams enhanced performance on systems-based measures?
 - Referral for adjuvant therapy
 - Provision of treatment summaries to patients
 - Appropriate pathological examination of lymph nodes for colon cancer
 - Select measures from the ASCO QOPI initiative
- Have the quality improvement initiatives increased adherence to evidence-based practice?
 - Is there consistent improvement across sites?
 - How have NCCCP pilots improved overall?
 - How does their improvement in clinical care compare to similar national providers or programs?
- Are tailored patient education/support programs associated with improved patient experience and quality of life?
 - Are patients more knowledgeable of programs and resources available at sites? If so, do they find them helpful?
 - Has there been an improvement in the overall patient experience and quality of care?
 - Has there been an overall improvement in patient-reported needs for support services?

QUALITY OF CARE DELIVERABLES: The organization will provide reports consistent with the CoC and ASCO reporting protocols, and a final report to include methods and strategies employed (and resources required) to achieve the metrics outlined below. It is expected that increased use of evidence-based guidelines, standards and protocols (e.g., NCCN, ASCO, USPSTF, ACoS) will be accomplished, and that documentation of the use of guidelines and reports or improved compliance with guidelines will be provided. Reports should monitor sites progress in building infrastructure, developing intervention programs, and organizational support towards achieving year 1-3 activities and should discuss plans for improving performance when achievement of activities is delayed – problems and potential solutions should be highlighted.

QUALITY OF CARE TIMELINE – MAJOR ACTIVITIES AND SAMPLE METRICS:

(These activities and requirements are contingent upon NCI reaching agreements with the American College of Surgeons’ Commission on Cancer and the American Society of Clinical Oncology to participate in the NCCCP pilot program.)

YEAR 1
Provide assistance to site multi-disciplinary teams on CoC and optional ASCO quality improvement projects and opportunities: Pilots establish multi-disciplinary practice improvement teams and begin to build site capacity and culture for quality improvement
Assist multi-disciplinary teams with baseline needs assessment of capacity to identify/track patients based on site priorities: Identify gaps; prioritize and select improvement activities
Assist sites with baseline assessment of patient, family and caregiver education and support resources: Assess gaps in patient information and resource support based on base line responses
NCI, ASCO, and ACoS work with site multi-disciplinary teams to seek agreement to participate in QI initiatives: Core hospital based breast and colorectal cancer measures will emphasize system integration; Optional oncology office-based measures will emphasize breast and colorectal cancer domain modules with other domain sets up to the sites
Each pilot’s multi-disciplinary teams decide whether to participate in ASCO QOPI project. Agreements executed with ASCO and ACoS for NCCCP participation in quality improvement studies
Hospitals Report Baseline performance metrics: NCI and ASCO establish broad criteria for pilot sites selection of hospital-based performance metrics. Pilot multi-disciplinary teams select improvement measures and improvement targets; Pilot Sites report to Commission on Cancer; Commission transmits quality profiles back to hospitals
Complete baseline patient HRQOL and QOC survey questionnaire
Create an NCCCP quality of care committee to support quality improvement activities: Include representation from all pilot sites, NCI, ASCO and ACoS
YEAR 2
NCI and CoC assist hospital-based pilot sites multi-disciplinary teams with design and implementation of intervention programs to improve quality of care measures: Colorectal Cancer Diagnosis and Treatment; Breast Cancer Diagnosis and Treatment

Pilot sites and ASCO complete baseline measurement for NCCCP QOPI oncology practices: Sites select improvement measures and targets within broad framework established by NCI and ASCO
NCI provides baseline patient survey report to pilot sites
NCI assist sites with program enhancements to support diversity and survivorship implementation plans: Implement oncology treatment summaries; Provide resources for other site initiatives as necessary, e.g., Indian Health Service palliative care treatment guide
YEAR 3
Assess site success in creating organizational infrastructure to support and sustain a quality improvement program: Improved data tracking and monitoring; Success of multi-disciplinary QI collaborative
Assess sites success in improving: selected breast cancer and colorectal cancer treatment indicators for hospital-based services; Selected office-based oncology QOPI measures
NCI will benchmark site performance against their own baseline, NCCCP pilot program overall; national comparisons for hospital-based QI activities
Field follow-up patient HRQOL and QOC survey to assess changes in patient perspectives: Assess improvement in global measures of health-related quality of life and patient satisfaction; Assess improvements in program awareness, access to needed services; Assess improvement in patient experience with care

Sample Metrics (Final metrics for each pilot organization will depend on the capabilities of each site and will be formalized in Year 1, as the work plan is developed in conjunction with the NCI Program Advisory Committee's Quality of Care subcommittee.)

AREA	YEAR 1	YEAR 2	YEAR 3
Clinical Improvement Infrastructure	Orient/organize Site multi-disciplinary care committees on QI project opportunities	Site QI committees are actively involved with clinicians in QI improvement projects	Demonstrate increased pilot site commitment and infrastructure support for QI projects
Clinical QI indicator Tracking	Implement data assessment and collection to assess improvement opportunities	Track performance during intervention period with feedback on progress to sites	Demonstrate increased adherence to evidence-based practice guidelines
Activating Clinical QI Interventions	Assess, prioritize and select EQIP & QOPI intervention projects	Implement methods to change clinical practice in hospitals and in oncology practice	Demonstrate change in clinical processes
Coordination	Establish NCI/ACoS/ASCO Quality Committee	Continued calls with sites to assist with intervention or data issues	Committee continues to provide assistance as needed by sites
Patient Centered Infrastructure	Baseline inventory of site patient aides and support programs and potential gaps	Sites patient program staff actively involved to select/support intervention activities	Demonstrate increased pilot site commitment and infrastructure support for QI projects
Patient Needs and Outcomes indicator Tracking	Develop and implement survey instrumentation and collect base line data	Provide sites reports from baseline patient survey	Follow-up survey to assess program impact on patients
Activating Interventions	Assess, prioritize and select patient-focused intervention projects	Implement new patient interventions to fill gaps in patient information and support programs	Demonstrate change in patient awareness and use of these new services
Communication	NCI liaison group to assist sites with needs assessment and gap analysis	Continued calls with sites to assist with access to & uses of intervention material	NCI Liaison group continues to provide assistance as needed

SURVIVORSHIP WORKSCOPE: The organization will participate in routine conference calls with the NCI and SAIC-Frederick staff, to include representatives from the entire pilot group. Ideally, to deliver quality cancer care and effectively address cancer healthcare disparities across the full continuum of cancer care, including risk assessment, prevention, screening, treatment, follow-up care, palliative care, and appropriate end-of-life care, it is recognized that a coordinated and broad-based community approach is required. A detailed workscope is available for the Disparities focus area of the pilot. Activities dedicated to Survivorship are included here.

Research questions include:

- For those with no/limited Psychosocial or Pain & Palliative Care Service: What is the feasibility of establishing one?
- What information resources and supportive services have been added in response to needs identified by patients in year 1? Have these resources shown benefit?
- Has training with providers resulted in increased referral to psychosocial and supportive services?
- Has capacity to develop and deliver (to patients and their identified primary care providers) treatment summary and follow-up care plans for patients completing cancer therapy increased?

SURVIVORSHIP DELIVERABLES: The organization will provide quarterly reports and a final report to include methods and strategies employed (and resources required) to achieve the following:

- Increased referrals to hospice, as evidenced by increased number of referrals based on volume and increase from baseline of patients receiving hospice program benefits (with an increased Length of Stay) in primary hospice receiving program referrals.
- Expansion of psychosocial and palliative care initiatives into the cancer program – A full description of the palliative care plan, program, and staffing will be required at the end of the pilot period.
- Incorporation or expansion of *survivorship plans* into a model-of-care to ensure that a treatment summary is developed for patients and along with a post-treatment care plan to ensure appropriate follow-up and monitoring for cancer patients – A full description of the program integrating survivorship plans and a report on the status of implementation will be required at the end of the pilot period.

Quarterly reports should monitor progress towards achieving year 1-3 activities and should discuss plans for improving performance when achievement of activities is delayed – problems and potential solutions should be highlighted. Performance will be measured by assessing how many activities are achieved per year and in what timeframe.

SURVIVORSHIP TIMELINE – MAJOR ACTIVITIES AND SAMPLE METRICS:

YEAR 1
Obtain baseline metrics – complete a baseline assessment survey
Develop the more detailed survivorship work plan, in conjunction with the NCI Advisory Committee’s Survivorship subcommittee
Identify currently available psychosocial & behavioral programs/resources (structural and materials assessment) and means to assess use of these
Describe current pain and palliative care services available to the center’s patients and any center policies that enhance their delivery (i.e., monitoring pain as a vital sign)
Through the patient satisfaction survey, utilize patients/survivors & caregiver feedback with respect to current information & service needs, & barriers to use of these – identify one or two programs to develop to fill gap

<p>needs and tools to assess the impact of the following:</p> <ul style="list-style-type: none"> ○ consider use of navigator programs; ○ emphasize use of off-the-shelf materials (e.g., Facing Forward series, NCCS Tool Box); ○ encourage partnerships with community programs (e.g., ACS, TWC, Gilda’s Club, Cancer Care)
Describe and document current and new training/educational opportunities for staff with respect to survivorship issues and palliative care
Document how/whether physicians provide and patients receive a summary of their cancer treatment at the end of active therapy (ASCO or other template)
Consider the feedback from the patient needs evaluation, and as available patient focus groups and other sources of feedback, to establish a process for eliciting ongoing stakeholder (e.g., healthcare team members, service organizers, patients, family members) input and oversight
YEAR 2
<p>Design and implement new or enhance existing programs to deliver psychosocial palliative care/support</p> <ul style="list-style-type: none"> ○ Navigator program ○ Educational seminars ○ Transition to post-treatment intervention ○ Distress screening and triage system ○ Targeted symptom management (e.g., sexual dysfunction, fatigue)
Ensure access to and use of psychosocial/behavioral and palliative care services and resources; monitor use of these
Develop or improve communications in-house (e.g., types of and referral to psychosocial and supportive resources and palliative care/hospice, document implementation of this activity)
Deliver/increase training to staff on palliative care and survivorship care (e.g., City of Hope survivorship program, APOS online modules, ELNEC, EPEC-O training)
YEAR 3
<p>Demonstrate increase in:</p> <ul style="list-style-type: none"> ○ Use of psychosocial & palliative care resources by cancer patients/survivors/families ○ Links to community resources providing psychosocial/supportive services to cancer patients/survivors and their families ○ Number of physicians and staff who develop and patients who receive treatment summaries/care plans ○ Number of staff who have taken palliative care training and survivorship workshops or courses; referral rates to services
Review results of second patient satisfaction survey – and compare to baseline; Utilize findings of other processes to elicit patient/survivor/family feedback and use to plan next phase of program development
<p>IF targeted improvement program is developed: Assess patient/survivor HRQOL and QOC related to this; link to use of services/resources –expected outcome:</p> <ul style="list-style-type: none"> ○ Improve patients/survivors’ HRQOL and satisfaction with QOC ○ Improve patients/survivors’ knowledge about and likely use of supportive services (empowerment)
Develop an individual and a joint report with other sites that will be a collection of successful approaches for palliative care and survivorship

Sample Metrics (Final metrics for each pilot organization will depend on the capabilities of each site and will be formalized in Year 1, as the work plan is developed in conjunction with the NCI Program Advisory Committee's Survivorship subcommittee.)

Survivorship	YEAR 1	YEAR 2	YEAR 3
Community Input	Establish committee (including minority representatives and community partners) to provide input on psychosocial/palliative care/survivorship issues	Utilize input for program expansion modification on psychosocial and survivorship needs	Continue to elicit and utilize input
Psychosocial & Palliative Care Services	Conduct baseline PPCS assessment, i.e. types, topics, # using these	Expand to include other services or links to these	REPEAT baseline PPCS assessment & show increase # programs and appropriate use of these
Patient/Survivor/Family Needs	Through pilot patient satisfaction survey and other methods complete baseline assessment on knowledge about/satisfaction with (plus barriers to use of) PPCS services	Implement interventions (informed by needs survey) to improve awareness and access	Pilot patient satisfaction survey to be repeated. Other methods to continue to be utilized to drive program changes and to guide next phase of program development
Infrastructure	Assess infrastructure & staff dedicated to delivering PPCS care; education for new staff	Increase staff awareness about PS programs and how to refer to these; increase community connects	Demonstrate increased staffing committed and infrastructure support to PS care
Targeted Program or Intervention	Using services gap analysis & needs survey pick area to develop; plan intervention/program & outcomes assessment	Conduct program/intervention	Assess impact of program/intervention
Survivors' Follow Up Care	Determine if treatment summaries are being generated & delivered	Use standard template for development and delivery of treatment summaries (w/ care plan?)	Demonstrate uniform delivery of these to survivors and their healthcare providers (PCP)
Community Outreach	Assess connections with community partners, programs and services in PPCS area	Implement outreach and collaborative activities	Demonstrate improved ties with community to provide PS care
Communication	Assess methods to identify patients who need psychosocial or palliative care	Implement systems to better identify and refer those needing PPCS care	Demonstrate systems improvement in timely and appropriate referral

WORKSCOPE for ALL OTHER COMPONENTS:

Comprehensive Deliverable Summary (*includes Program Components not already captured in specific work plans for key focus areas of the pilot*)

Program Component	Deliverable
A physician program director with cancer expertise with the program under an administrative/medical structure.	A position description and CV of physician program director that demonstrates that the physician director has a broad scope of authority to oversee all aspects of the program and that the director shall dedicate most of his or her time to the cancer program (including patient care responsibilities). A description of his or her time commitment, and an organizational chart showing the reporting relationships and the span of authority.
Ongoing support and regular meetings for at least four multidisciplinary, organ-site specific, planning committees. A colorectal cancer multidisciplinary planning committee may be a priority if one does not exist, since this will be the focus of evaluation during the pilot.	Minutes of multi-disciplinary meetings, quarterly reports, and final report of process improvement/ accomplishments/issues resolved.
The development of a cancer center specific medical staff credentialing program to support the patient care, quality research, and community outreach goals of the cancer center.	A process for credentialing of medical staff for the cancer center shall be approved by the organization and its medical staff and implemented.
<p>Linkages with NCI-designated cancer centers or academic medical research institutions appropriate to meet the objectives for the NCCCP pilot.</p> <p>Exploration of the resources and assistance of the developing Cancer Expert Corps program and/or linkages with expertise at NCI-designated centers for more specialized training or access to more specialized services with a special focus on reducing healthcare disparities.</p>	<p>All relevant relationships will be noted and described including how these relationships assist the NCCCP pilot in the achievement of pilot goals.</p> <p>New or expanded relationships established during the pilot will be included in quarterly progress reports, including participation with state-funded programs.</p>
Genetic and molecular testing on site or through a formal specimen referral to approved labs.	A description of the in-house program with the credentials of the staff person or a copy of an affiliation agreement or contract with a description of the service.
NCCCP Network recommendations for incorporation into the future program.	Participation in the network development activities over the course of the pilot.
For Health Systems	<p>For developmental locations, each location will have achieved all baseline and subcontract deliverables, such as distinct location.</p> <p>Provision of a “tool kit” for effective strategies and methods for successful knowledge transfer of cancer program key components. If applicable, transfer of</p>

Program Component	Deliverable
	knowledge to rural settings. Participation in the formal program evaluation.
<p>Consider utilizing the wide range of assistance available via the Director’s Consumer Liaison Group (DCLG) – Consumer Advocates in Research and Related Activities (CARRA).</p> <p>Assistance is available across all focus areas of the pilot.</p>	<p>No formal deliverable; however, pilot sites are encouraged to work with the CARRA members within the community to reach the goals of the pilot. The following are specific areas where CARRA members may be helpful:</p> <ul style="list-style-type: none"> - membership/participation on advisory boards - assist with patient navigation - assist with public education/communication, patient recruitment - participate on IRB, review protocols