

The CaLM Model: Hardwiring Cancer Centers for Whole Person Care

Submitted by: Livestrong Cancer Institutes of the Dell Medical School, The University of Texas at Austin

Silver Winner

Category: Access to Palliative Care

Overview

At Dell Medical School, we are redesigning cancer care delivery around the needs of persons with cancer and their loved ones by flipping the usual delivery system design to develop a person-centered “front-door” for cancer care. Our CaLM (CancerLife Re-imagined) concept anchors the cancer treatment integrated practice unit in supporting patients across the entire cancer continuum, so that all cancer patients receive the benefit of whole-person assessment and access to sub-specialty palliative care from the point of diagnosis onward.

Impact

Health care in the U.S. has evolved to treat disease based on specialty and subspecialty care. Innovative approaches have emerged to fight cancer. New treatments like immunotherapies are available for many types of cancer to improve the trajectory of survival or slow disease progression for many patients. But, the health system is failing many people affected by cancer because without addressing the social, emotional, spiritual, and practical aspects of the human experience we aren't truly caring for whole people or ensuring that they live with vitality and resilience.

The mission of the LIVESTRONG Cancer Institute at the Dell Medical School - University of Texas is to radically improve people's cancer experience and quality of life; revolutionize how we treat cancer; and reinvent the way cancer patients are cared for. Central to our approach is the creation and operationalization of the CaLM Model of Whole-Person Cancer Care™— a comprehensive clinical and supportive ambulatory program with wraparound care for patients and their loved ones in all phases of the cancer continuum that hardwires access to subspecialty palliative care into the foundations of health care delivery.

In many traditional models of cancer care, providers prioritize delivery of medical services and disease treatment. The social, emotional, spiritual, cultural, practical, and financial aspects of care are considered ancillary. Access to subspecialty palliative care is effectively left to chance in many systems - some providers refer early, some not at all. Each specialty team brings varying perspectives to the patient's care based on their own goals; goals for care within each specialty may not necessarily align, which results in conflicting guidance or treatment for patients. Navigating a cancer diagnosis can be the equivalent of a full time job, and it often brings chaos to patients' daily lives, which makes working, social activity, and daily life difficult to manage.

As a result, the predominant model of cancer care is fragmented and leaves people trying to navigate a broken system: having a number of providers who don't communicate; receiving disjointed services in many locations that do not address all of their issues; and having to manage and coordinate their own care in order to meet their basic practical and emotional needs. For many cancer is becoming a chronic disease, and many patients will live with cancer for a long time. The common model of care delivery focuses on high-acuity medical decision-making, where patients often feel as though they "live from scan to scan," and rely heavily on medical oncologists to drive their care when medical oncologists are often not equipped to address emotional, social, and practical issues. This model does not optimize a person's ability to live a resilient life with and through cancer. We set out to build a model that treats the mind, body and heart as one entity; to deliver cutting-edge cancer therapies in coordination with psychosocial and palliative care, and to implement an interdisciplinary, team-based approach to care that prioritizes not just survival, but supports every person's capability, comfort and calm as they fight cancer.

Evidence-Base

The CaLM Model is anchored in several existing evidence-based models of care. Notably, the National Academies of Science, Engineering and Medicine's 2013 report "Delivering HighQuality Cancer Care: Charting a New Course for a System in Crisis" set forth a concept for a high quality cancer care delivery system that is grounded in six components: engaged patients; an adequately staffed, trained, and coordinated workforce; evidence-based cancer care; a learning health care IT system for cancer; translation of evidence into clinical practice, quality measurement and performance improvement; and accessible, affordable cancer care. The CaLM Model also builds on AHRQ and John Sprandio's Oncology Patient-Centered Medical Home model, the Collaborative Care Model, and the Robert Wood Johnson Foundation and Macoll Institute for Healthcare Innovation's Chronic Care Model. The process of designing the model launched with establishment of several cross-functional community work groups at the LIVESTRONG Cancer Institutes in 2017; one of which was solely focused on patient-centered support. We engaged administrators and clinicians from other cancer centers in the Austin area, leaders from local and national cancer support non-profits, researchers from the University of Texas, and patients and survivors from the Central Texas community and met quarterly for one year to identify the ideal components of patient-centered cancer care and determine how to deliver them.

Essential elements of the CaLM Model include equitable access to cancer care and clinical trials, integrated interdisciplinary care, pro-active symptom assessment and self-management support, guideline concordant cancer treatment, and access to sub-specialty palliative care from the moment of diagnosis onward. The evaluation framework for the CaLM model incorporates quality standards from accrediting bodies such as the Commission on Cancer and the Quality Oncology Practice Initiative as well as the elements of care our stakeholders indicated were most important to them.

The evaluation process is ongoing. To date we have learned that care delivered in the CaLM model influences PRO reports of symptom burden in a positive direction – with fewer patients reporting severe or moderate disruption from symptoms including pain, depressive symptoms, and anxiety trended across time. Given the transition of more than 60% of appointments to telehealth since March 2020 we have added specific evaluations comparing populations served prior to the transition to telehealth and those who entered care after

the transition (See poster submissions among attached documents). We have learned that therapeutic “touches” by members of the CaLM core team did not drop off in a telehealth model, and that negative impact on PROs for patients served in a telehealth model was not observed.

An important planned evaluation is focused on whether patients served in the CaLM model who meet accepted criteria for engagement with pre-hospice palliative care are likely to receive that care in the CaLM model. Using criteria established by researchers at MD Anderson for referral to ambulatory palliative care we will undertake an analysis to identify whether CaLM patients who meet criteria for palliative care engagement receive that care.

Feasibility

From the outset, the CaLM model was designed to ensure that the cancer care delivery was hardwired to include whole person care and access to palliative care. Operationalizing that vision has meant educating not only our interdisciplinary team and oncology clinicians but also our patients and caregivers about how the CaLM model functions differently than other cancer care systems. To appreciate the uniqueness of the model it might be helpful to walk through how patients typically come into cancer treatment and how various team activities are prioritized.

At an initial visit, after completing PROs and intake, the patient meets with the SWAT team for whole person assessment. A patient first sees a disease-specific advanced practice provider and an oncology physician to address diagnosis and treatment options. Depending on the patient’s priorities, symptoms, and immediate needs, the palliative advanced practice provider or social worker from the SWAT team may have a “meet and greet” with the patient. During this initial visit components of the whole person assessment help the care team get to know the patient and what is important to them. Many of these domains are assessed over time as the team builds a strong and trusting relationship with the patient. The Whole Person Assessment was developed over a process of several months in 2019, and utilizes components of a medical oncology intake, psychosocial distress screen and intake; psychiatric intake; integrative oncology intake; and palliative care intake.

Typically in the week prior to the patient’s visit with SWAT team and Patient Support Team members, the patient’s case is reviewed during Multi-Disciplinary Tumor Boards. Once the Disease Team determines best treatment options, the oncologist(s) connects with the SWAT Team to review treatment options and patient issues, which may have surfaced through initial assessment, and then meets with the patient to discuss treatment protocols and options (including any clinical trials).

While initially we piloted a weekly interdisciplinary 60 minute case review with the SWAT, Disease and Patient Support team to discuss each new patient’s immediate clinical, practical, and psychosocial needs so that the team could develop a comprehensive care plan and coordinate clinical care as the clinic expanded this strategy was no longer feasible. We now have disease team weekly huddles, which are attended by at least one member of the SWAT team, and a weekly SWAT team huddle, focused specifically on patients with whole-person care needs that bubble up out of the disease team huddle. We are actively working with our research team to identify PRO phenotypes that will allow us to reinforce our organic strategy with a systematic approach to ensure that patients receive the right touch at the right time and that patients are not falling through the cracks due to clinician biases or other variables.

Scalability

The CaLM team is working on scalability issues both on-site in the LiveStrong Cancer Institutes UTHA Oncology Clinic and in partnership with teams we are assisting in adopting the model. This section will discuss primarily our internal scalability challenges. (External challenges addressed in sustainability.)

We were fortunate to receive an endowment from the LiveStrong Foundation to implement better whole-person cancer care. When we launched, our practice was small enough (both in disease types treated and total number of patients) that organic processes worked very well to ensure all clinicians and supporting personnel were aware of patient's issues. Working together was facilitated by sharing a common "bull-pen" work space, using a shared EMR, ensuring warm hand-offs to collaborating community-based partners, and weekly interdisciplinary team meetings that afforded each patient a focused review of strengths, potential barriers, and anticipated needs in treatment.

In the past year, our practice has grown 500% and we shifted the majority of appointments to the telehealth space. Both these factors challenged and ultimately "broke" our organic model, and we developed new processes to manage our growth. Team communication has been an evolving challenge that has influenced how we standardize communication processes and defined the tools that our team will use to ensure meaningful real-time communication related to patient needs. We created disease type "pods" to ensure at least one member of the SWAT team is collaborating with the disease-focused subspecialty team in a continuity model. This SWAT team member is responsible both for ensuring whole-person priorities are reflected in disease-specific care and decision-making, and for identifying and elevating to the SWAT team concerns that might require engagement of interdisciplinary personnel. We agreed that all significant clinical communication will be reflected in the EHR – either as visit summary notes or "patient cases" which are visible to all team members. We sent two team members to receive TeamSTEPPS Master training (AHRQ) and are planning, training, and implementing this approach to interprofessional care and communication in a rapid-cycling QI initiative.

Internal challenges have also occurred related to the need for implementation of technology solutions that support our vision of whole-person proactive person-centered cancer care. Our current EHR creates challenges for team-based care because of how the architecture of the system links visits to charges. We also struggle with this system's inflexibility with regard to note building that does not accommodate an information repository for issues that emerge across the cancer treatment trajectory. Our whole-person assessment document has to live in a separate system, which has created a non-scalable need for redundant data entry. Other elements of care that are central to our model that need a "living document" solution include updates on the patient's staging and illness understanding. Although we have engaged with academic oncology professionals drawn to our commitment to change how cancer care is delivered, for many of them this has meant sometimes challenging changes to their usual practice patterns. Overall, our team has demonstrated resilience and a solutions-focused commitment to address challenges.

While the CaLM Model launched as a new cancer treatment program in Austin, TX in 2018 with philanthropic support for the non-revenue generating components of cancer care, our sustainability within the project and for the programs we are coaching will be dependent upon demonstration of the positive impact of this type of care on quality metrics, patient outcomes, and value-based payment models. Within an academic model, knitting the

supportive and palliative care program into the fabric of the cancer treatment platform ensures that the revenue generating components of cancer treatment (chemotherapy infusion, radiation therapy) provide funds flow to support the non-revenue generating components of the cancer platform. Notably, all the components of CaLM are necessary for comprehensive cancer programs committed to delivering guideline concordant care – but in most programs these services (palliative care, psychosocial care, rehabilitation, survivorship care, nutrition care, genetic counseling) live in different silos. Despite the fact that oncology clinicians might recognize them as either “nice to have” or essential, most programs lack a systematic approach to identifying patient needs to ensure patients receive the right touch at the right time.

Organizing care in the CaLM model resolves this issue and creates an economy of scale for interprofessional care that will allow us to effectively estimate the FTE needed within the interprofessional team to support given volume of patients in active treatment/survivorship care/palliative care phases of the cancer trajectory. We have a seasoned team of health services researchers, policy experts, and cancer program administration experts working to develop the business case for delivering care in the CaLM model. Within fee for service environments sustainability is dependent on billing for every eligible service, optimizing time-based billing to recoup costs associated with care coordination, and creating the leanest feasible model through use of contractors for services that are not at scale to support FTE. As we look at partnering with payers the emphasis shifts to impact on outcomes—particularly pro-active management of symptoms and physiologic distress in active treatment to avoid unplanned emergency department or hospital utilization, and reduction of unhelpful aggressive care as end-of-life approaches. Another critical component of our evaluation will be to examine whether organizing care in this way reduces disparate access to palliative care by populations historically impacted by health disparities.

Our work to demonstrate and communicate this model of care and its impact on outcomes is ongoing, and not without challenges. We have found in particular that as a small volume cancer treatment program it is challenging to inspire payers to work with us to evaluate utilization. We have developed an independent entity dedicated to supporting teams seeking to replicate components of the CaLM model.

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About the Challenge

The John A. Hartford Foundation Tipping Point Challenge is a national competition to catalyze the spread of skills, ideas, and solutions that will improve health care delivery for all people living with a serious illness. It is sponsored by the [Center to Advance Palliative Care](#) and [The John A. Hartford Foundation](#).

For more information, visit tippingpointchallenge.capc.org.