

# Center for Cancer Care Innovation

Year 1 Steering Committee Meeting  
(2023-2024)

November 7, 2024



Memorial Sloan Kettering  
Cancer Center

# Agenda

Topic	Time
Arrivals and Lunch served	12:00
Mission and Goals	12:05
Recruitment of Faculty and Staff	12:10
Review Request for Proposals	12:15
Uniting Stakeholders for Impactful Initiatives: Acute Care at Home, Goal Concordant Care	12:40
Academic Innovations: Research in Care Delivery	12:50
Cultivating Community	12:55

# CCCI

## Research Incubator & Innovative Practices

### Mission

- To build the evidence base in cancer care delivery by designing, testing, and implementing strategies to improve care delivery via pragmatic trials;
- To connect, train, and provide resources to physicians, nurses, engineers, quantitative scientists, staff, as well as patients and families.

### Goals

- To develop and test cancer care models using iterative, rigorous prospective research to ensure safety and effectiveness;
- To stimulate investigator-initiated research in cancer care delivery;
- To transform cancer care delivery by building the evidence base.

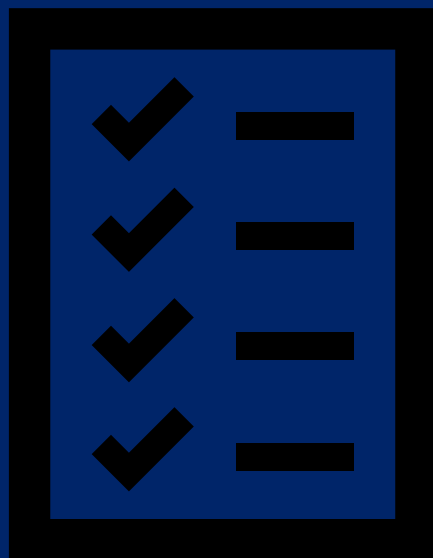
# CCCI

## Research Incubator & Innovative Practices

### Activities

- Furthering the Mission
  - Recruitment of Faculty and Staff
- Accelerating Science Through Pilot Awards
  - Request for proposals
- Uniting Stakeholders for Impactful Initiatives
  - Acute Care at Home and Goal Concordant Care
- Academic Innovations
  - Extramural grants and publications
- Cultivating Community
  - Journal Club
  - Open House

# Center Updates



**August 2024:** CCCI Internal OneMSK page

**September 2024:** Request for Proposal released

**November 2024:** Center MSK-wide Announcement

**December 2024:** CCCI External MSKCC.org page

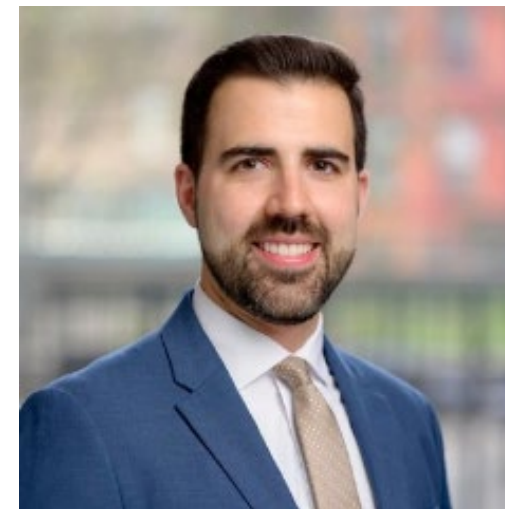
**January 2024:** Funding begins for proposals

# New Additions



## Recruitment:

- **Daniel Lage, MD, MBA, MSc** joins as a genitourinary medical oncologist, specializing in innovative care models and research leadership.
  - Acute Care at Home operations planning and research
- Post Doctoral Researcher, Analyst, Research Manager



# Request for Pilot Proposals

Innovative initiatives that target the reduction of inpatient census and readmissions;

Pilot projects designed to increase inpatient capacity, either by  
avoiding hospitalization via remote patient monitoring or hospital at home  
reducing length of stay,  
reducing readmissions via improved transitional care.

Projects must test key design features of a pragmatic trial that, if successful, should establish the readiness and feasibility of conducting a full-scale embedded pragmatic trial (Stage IV on the NIH Stage Model).

\$150,000 in direct costs over two years (January 1, 2025, to December 31, 2026)



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# CCCI 2024 Request for Proposals

## Patient Centered Research

### Discussion:

How do these proposals align with institutional priorities?

*\*Please note: The Patient Centered Research Review Committee will be evaluating the science of the proposal – no need to take research into account*

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Remote monitoring for patients with testicular cancer

*Erin Bange*

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Postsurgical Home-Based Oncology Intervention for Patients Undergoing Radical Cystectomy for Bladder Cancer

*Daniel Lage*

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Utilizing Telemedicine and Remote Monitoring to Reduce Hospital Care and Provide Caregiver Respite During Homebound Transplantation: A Phase 2 Trial

*Heather Landau*

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A Novel Pilot for Discharge Planning in Hospice-Eligible Patients: Embedding Case Management in Supportive Care

*Craig Blinderman*

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Comparing patient navigation programs to decrease inpatient admissions, identify and address patient needs, and improve patient-reported outcomes

*Francesca Gany*

## Remote monitoring for patients with testicular cancer

- Implement at-home monitoring to reduce inpatient admissions.
- Targeting tech-savvy patients for a feasibility study involving ~10 participants discharged after day 5 of treatment.
- Daily vital sign checks, weekly telemedicine visits, mobile phlebotomy, and nursing home visits for hydration.
- If phase 1 is successful, expand to an early discharge program for an additional 5 patients, monitored at home.
- Leverage MATCHES, MSK's NCI-funded telehealth center to inform a pragmatic trial aimed at reducing acute care utilization for testicular cancer.

PI: Erin Bange

## RECOVER-BC: Postsurgical Home-Based Oncology Intervention for Patients Undergoing Radical Cystectomy for Bladder Cancer

- Assess the feasibility and acceptability of the RECOVER-BC program (RECOVER after Bladder Cancer) for 60 patients post-radical cystectomy; three weeks post-discharge
  - Pre-discharge need assessment and psychoeducation.
  - Daily monitoring of symptoms, complications, and vital signs at home.
  - Hospital-at-home services including IV fluids, antibiotics, and in-home diagnostics.
  - Structured communication with the surgical oncology team.
- This will be the first hospital-at-home model in oncology tailored for post-surgical patients, aligning with MSKCC's plan for implementation in 2025.

PI: Daniel Lage

## Utilizing Telemedicine and Remote Monitoring to Reduce Hospital Care and Provide Caregiver Respite During Homebound Transplantation: A Phase 2 Trial

- Traditionally 3- to 4-week hospital stay, followed by home recovery needing full-time caregivers.
- Designed to allow patients to receive care at home or a "home-like" setting post-HCT.
- Nurses and advanced practice providers delivered care at home, with patients visiting the clinic only for transfusions.
- On average, patients required only 2 clinic visits, and fewer than half were readmitted during the acute post-HCT period.
- Feedback from patients and caregivers about the program was overwhelmingly positive.
- Current research is focused on integrating telemedicine and remote monitoring technology to further support caregivers during homebound HCT, reducing in-hospital care needs.

PI: Heather Landau

## A Novel Pilot for Discharge Planning in Hospice-Eligible Patients: Embedding Case Management in Supportive Care

- An internal study highlighted communication gaps and insufficient caregiver support during transitions to home hospice.
- Embed a case manager within the SCS to:
  1. Coordinate and facilitate GoC discussions for patients considering discharge options.
  2. Expedite hospice discharge.
  3. Enhance communication and support for patients and families.
- **Aim 1:** Evaluate feasibility of the embedded case manager.
- **Aim 2:** Assess acceptability among hospitalist teams and case management.
- **Aim 3:** Estimate effectiveness of the intervention.

PI: Craig Blinderman

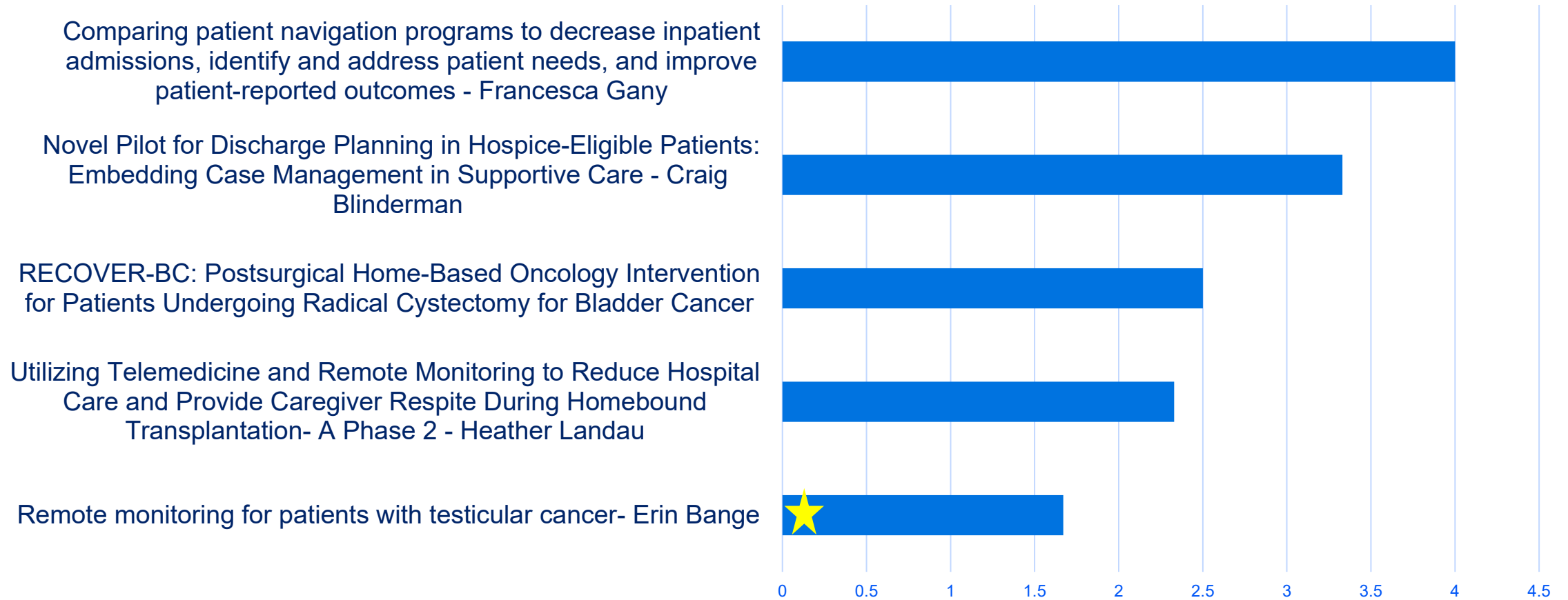
## Comparing patient navigation programs to decrease inpatient admissions, identify and address patient needs, and improve patient-reported outcomes

- A pragmatic trial will compare outcomes between Guideway Care and MSK's Integrated Cancer Care Access Network (ICCAN), a proven in-person navigation program.
- **ICCAN:**
  - In-person, multidisciplinary, multilingual patient navigation program targeting SDOH needs of underserved cancer patients.
  - Randomized controlled trial showed ICCAN significantly improved 12-month treatment completion rates and increased QOL and depression scores compared to usual care.
  - Impact on inpatient admissions remains unknown.
- **Guideway Care:**
  - Provides patients with call center-based non-clinical multilingual Care Guides to address SDOH needs.
  - Automated platform for assessing non-clinical and clinical barriers, task management, and resolution.
  - Integrates text-based AI for enhanced patient engagement.
  - Observational study indicated significant reductions in emergency visits, hospitalizations, and ICU admissions for patients using Guideway Care.
- The pilot implementation of Guideway Care at MSK represents a timely opportunity to evaluate the effectiveness of technology-based navigation alongside traditional methods.

PI: Francesca Gany

# Ranking by Institutional Priority

Institutional Priority 1- high; 5 low (Mean Score)



# Goal Concordant Care



## Objective

Align treatment with each patient's individual values, preferences, and needs, fostering a personalized care journey throughout their illness.



## Integrative Discovery Phase

Cross-departmental coordination and validation of efforts ensure that all stakeholders, as decision-makers within their teams, are actively engaged in shaping the Goal Concordant Care (GCC) strategy. Their involvement is crucial for leading their teams effectively as we establish the framework for GCC.

★ Current stage



## Patient-Centered Practices

Implementing practices that prioritize patient input and perspective in care decisions while establishing the support structures needed to make these changes feasible and sustainable. Ensuring that values are not only considered but there is a structure in place to deliver appropriate care.

**Spearheaded by Dr. Grudzen and Tracy Gosselin, PhD, RN**

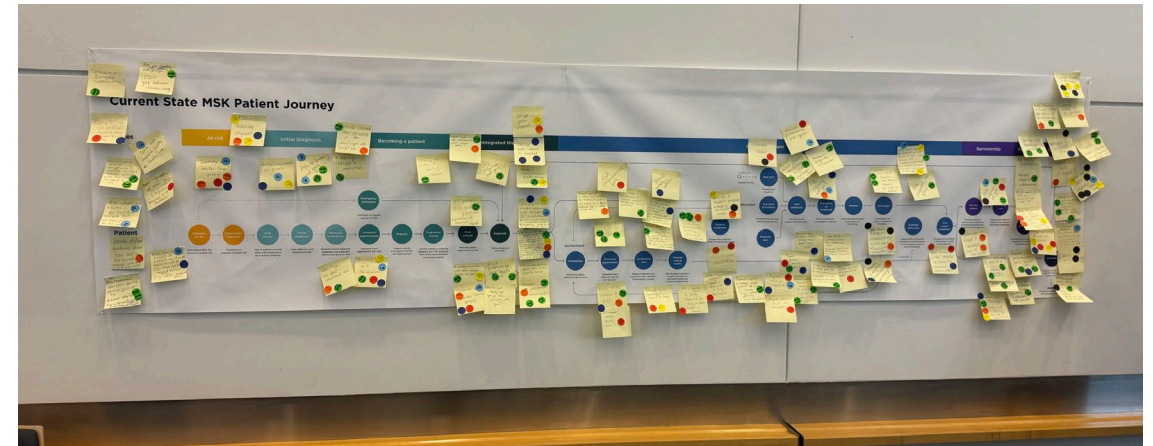
# GCC Visioning Session

## Interactive review of Patient Journey Map - Identifying and discussing points for GCC Interventions

- Support/resources for successful interventions
- Aligning the intervention with leadership priorities for buy-in

## Recurring themes we discovered during our session:

- Communication: Enhancing clarity and addressing nuances at various stages of the patient journey.
- Patient and Caregiver Education: Providing the necessary resources and support for informed decision-making.
- Documentation of Goals of Care: Ensuring that care plans are accurately recorded and easily accessible.
- Accountability: Aligning our efforts with national standards and metrics, in addition to utilizing Epic for documentation and metrics.



## Team

- Supportive Care Service
- Emergency Care Service
- Hospital Medicine Service
- Department of Nursing
- Department of Medicine
- Patient and Family Advisory Council
- Division of Quality and Safety
- Outpatient Operations
- Case Management
- Social Workers & Advanced Practice Providers

# Goal Concordant Care at MSK



## Next Steps

- Developing the vision for delivering goal-concordant care to patients
- Review and validate current initiatives
- Implement support structures for success
- Establish the culture

## Expected Outcomes

- Improved ACP
- Better patient experience
- Lower readmission rates
- Improved care transitions at EOL
- Collaborative processes

## Alignment with Best Practice

- Meets national rankings and metrics
- Supports delivery of high-quality, patient centered care

# Acute Care at Home

Aim: Enhance patient experience, improve care delivery efficiency, and reduce healthcare system burdens through care at home.



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- **Home-Based Acute Care:** Patients receive hospital-level acute care services in their own homes, ensuring comfort and familiarity.
- **Telehealth Integration:** Utilizes telemedicine for regular check-ins and consultations, allowing healthcare providers to monitor patient progress remotely.
- **Clinical Monitoring:** Utilizes advanced telehealth technologies to monitor vital signs and symptoms in real time, ensuring timely interventions.
- **Multidisciplinary Team Support:** Involves a coordinated team of healthcare professionals, including doctors, nurses, and social workers, to address various patient needs.
- **Reduced Hospitalizations:** Aims to decrease the need for inpatient admissions, minimizing exposure to hospital-related infections and complications.
- **Patient-Centered Care:** Provides personalized treatment in the comfort of the patient's home, enhancing their quality of life.

# Acute Care at Home

## Progression



**Stakeholder Engagement** - Engaged with stakeholders across MSK for alignment and support

**Technology Integration** - Planning with Department of Digital Informatics & Technology Solutions

**Financial Sustainability** - Working with financial experts to finalize efficient payer models for sustainable care-at-home. Collaborating with MSK legal advisers to meet regulatory requirements.

**Business Planning** - Developing a comprehensive business plan covering operational, financial, and strategic aspects.

**Vendor Sourcing** - following a review of requirements to select the right partners to deliver high-quality, patient-centered care in the home setting.

★ **Current stage**

Stay tuned for further developments!

MSK Confidential — do not distribute



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## Research Focus and Patient-Centered Care



### ***Dual focus on implementation and research efforts***

- Ensure decision-making for Acute Care at Home is supported by robust research findings
- Position MSK as the leading authority in Acute Care at Home research and best practices
- Prioritize patient experience to ensure care is tailored to individual needs and preferences
- Foster a culture of ongoing research to adapt and refine operational strategies while enhancing patient satisfaction

### ***Establishing a scientific foundation***

- National Consensus Panel on Hospital at Home in Oncology



**ED-LEAD: Emergency Departments  
LEading the Transformation of  
Alzheimer's and Dementia Care**

**ED-LEAD: Emergency  
Departments Leading the  
transformation of Alzheimer's and  
Dementia care**

15 health systems, 79 Emergency Departments (EDs)



ED-LEAD seeks to improve the care of PLWD and their informal care partners by addressing emergency and post-emergency care through different combinations of three PLWD-care partner dyad focused programs:

Emergency  
Care  
Redesign  
(ECR)

Community  
Paramedic  
Led  
Transition  
Intervention  
(CPTI)

Nurse-Led  
Telephonic  
Care  
(NLTC)

# ED-LEAD Study Aims

**AIM 1.** Optimize concurrent implementation of three interventions (programs) in two EDs to ensure efficient and effective multi-intervention use and intra-intervention communication pathways.

**AIM 2.** Test the effectiveness of the three programs, alone and in different combinations, for PLWD with serious illness using secondary data collection and analysis in a cluster-randomized multifactorial trial embedded in 79 EDs within 15 health systems.

**AIM 3.** Determine site, provider, patient, and care partner characteristics within a diverse population that are associated with variation in the implementation of each intervention using the RE-AIM framework.

# Implementation Core

- Overseeing Implementation Core which focuses on overseeing the harmonization, adaptation, and fidelity monitoring.
- Ensure tailoring of local contextual factors across settings via engagement with Lived Experience Panel and Lived Practice Panel (peer-to-peer learning networks).
- Prespecify allowable adaptations in form, including the mode of delivery, providers involved, materials or tools needed, dose, frequency and intensity.
  - Develop standard operating procedures that describe implementation strategies and how planned and unplanned adaptations will be managed, measured and documented, and reported over time.
- Cyclical small tests of change during pilot testing will identify optimal implementation strategies.

## **Implementation Core Aims:**

*Aim 1.* Harmonize core functions and processes across the three programs.

*Aim 2.* Optimize and integrate clinical decision support tool across the three programs.

*Aim 3.* Enable training and intervention fidelity across the three programs.

# Current Status: Preparing for Optimization



# Primary Palliative Care for Emergency Medicine (PRIM-ER)

# Primary Palliative Care for Emergency Medicine (PRIM-ER):

## Palliative Care Initiated in the Emergency Department (ED): a cluster-randomized clinical trial

**Aim:** To assess the impact of a multi-component intervention to initiate palliative care in the ED on hospital admission, subsequent healthcare utilization, and survival in older adults with serious, life-limiting illness.

**Outcomes:** Primary outcome measure was hospital admission; secondary outcome measures included subsequent healthcare utilization and survival at 6 months.

**Findings:** In a cluster-randomized clinical trial conducted in 29 U.S. EDs that included 98,922 initial visits, there was no difference in hospital admission in older adults with serious, life-limiting illness receiving care pre- versus post-emergency department clinical staff receipt of a multi-component primary palliative care intervention (64.4% versus 61.3%; aOR 0.94, 95% CI, 0.84-1.05).

**Meaning:** A multi-component intervention to initiate palliative care in the ED did not impact hospital admission, subsequent healthcare utilization, or short-term mortality in older adults with serious, life-limiting illness.

*Manuscript accepted to JAMA, citation forthcoming*

# Future Planning

**Standing up grant proposals, supporting and scaling**

**Building the community – CCCI Open House**

**WIP, Lectureships, Symposiums, Journal Club**

**Publications, Grants, Innovative Research**

Discussion on next steps for the Center, suggestions for 2025.