Transitioning to Value Based Oncology: Strategies to Survive and Thrive
Transitioning to Value Based Oncology: Strategies to Survive and Thrive

Building the Oncology Medical Home

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Oncology Management Services, LLC
Oncology Patient-Centered Medical Home® Update

- Background
- Principles / Components
- Practice Results – 2011
- New Programs
Era of Health Care Reform

Value and Demonstration of Results

- Value = quality/cost
  - Enhance Quality = Increasing reliability of delivery
  - Focus on execution (processes) of care delivery
  - Incorporation of High Reliability Principles
- Control Cost = Reducing unnecessary utilization
  - Unnecessary utilization = waste
  - Failures of delivery, coordination, overtreatment

Demonstration of results
- Data transparency, accountability, rapid learning
Era of Health Care Reform

*Cancer Care Provider Responsibility*

Only those giving the care can improve it

- Failure to *control cost through reduction of waste*
  - Diminishes Value (payer, patient and employer)
  - Uncontrolled costs will result in further funding cuts
  - Unintended clinical consequences for the most vulnerable
    - Reduced access, increased co-pays, reduced compliance

- **Standardization of delivery = waste reduction**
  - Chemotherapy guidelines & pathways
  - Care delivery *beyond* chemotherapy selection
    - Requires practice transformation
CMOH: 2003 – 2011

Standardization & Streamlining

- Re-engineer processes of care - IT infrastructure/support
- Maintain a patient-centric approach
- Fix accountability at the patient-physician locus
- Minimize clinically irrelevant physician activity
- Communication, coordination, access, engagement

Demonstration of Value

- Measured quality and cost
  - Improving quality of care and reducing utilization (cost)
Evidence Based Guidelines

Quality & Service Parameters

- ASCO - QOPI standards
- NCCN Guidelines
- American College of Surgeons, NQF
- CMS - PQRS, e-Rx
- NCQA – PPC-PCMH™
- OPCMH™ – services
- Institute of Medicine
  - 1999 Ensuring Quality Cancer Care
  - 2001 Improving Palliative Care for Cancer
  - 2006 From Cancer Patient to Cancer Survivor: Lost in Transition
  - 2009 Assessing & Improving Value in Cancer Care
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Value Proposition

- **OPCMH – clinical & business methodologies**
  - Achieves practice/patient care efficiencies
  - Community based practices
- **OPCMH - organizational construct**
  - Oncology “plug-in” to PCMH as a PCMH-N
  - Establishes care management accountability
  - Communication that bridges specialists and PCMH
- **OPCMH – as PCMH bridge**
  - Aligns oncologists for ACO, Clinical Integration, etc
  - Establishes a platform for pricing oncology bundled or episode of care payment
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Based on NCQA PPC-PCMH™

NCQA Standards drive Quality, Service & Utilization
Enhanced Access & Continuity
Identify and Manage Populations
Plan and Manage Care
Self-care Support & Community Resources
Track and Coordinate Care
Measure and Improve Performance
Oncology Patient-Centered Medical Home® Model

Re-engineered Process of Care & Coordination

- Ownership of all aspects of cancer care delivery
- Focus on patient needs and evidence-based care
- Reduction in unnecessary variation & resource utilization
  - Failures of delivery, coordination & overtreatment
- Enhanced communication with PC PCMH & Specialists
- Real-time physician/practice performance measurement
  - Continuous process improvement
- Encourages Clinical Integration between practices
**Process Measurement**

Rapid Learning Cycle

- Function of *mutually reinforcing* care-team
- Merging Work-Flow and Clinical Decisions
- Guidelines, staging, screening, prevention
- Medication Reconciliation
- Triage & Symptom Management algorithms all
- Communication/Documentation turn around
- Coordinating/tracking *all tests and referrals*
- Track *Performance Status & Palliative Care*
- End of life care/promoting shared decisions
- Patient & referring physician portal utilization
- Management of at risk populations
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Outcome Measures

**Patient Experience**
- AHRQ CAHPS: Consumer Assessment of Healthcare Providers and Systems

**Utilization**
- Chemotherapy guideline adherence
- Emergency room evaluations
- Hospital admissions/length of stay
- Outpatient visit reduction
- End of Life Care parameters
- Diagnostics: imaging/laboratory
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RESULTS
Guideline & Pathway Adherence

- Chemotherapy care plans are NCCN compliant
  - Deviation requires customization (controlled)
  - Physician selects care plan within EMR
    - Selection shared with billing and nursing staff
- NCCN Compliance
  - Adjuvant and first line metastatic
    - Adherence > 95% 2007 – 2010 (practice)
    - Individual physician performance followed
- Pathway Compliance
  - Small number of patients > 80%
Telephone Triage Management

OMS Algorithms

Operational **10 hours/day** (8 AM – 6 PM)
Centralized, staff training & feedback
Scripted patient & family engagement

**Proactive EARLY** intervention

Assessment prompts

Guide nurses to deliver & record specific interventions

Patient, physician & practice efficiency

**Data:** number of calls, disposition, and outcomes

Standardized patient instructions **embedded in algorithms**
Outcomes of Clinical Phone Calls
to the Nurse Triage Line
from 2006 to 2010 (n=13,881)

- Manage Symptom(s) at home: 75.98%
- Go to nearest ER: 5.84%
- Office visit today: 5.74%
- Chemo Suite Intervention: 0.65%
- Direct Admission: 0.14%
- Sent for Radiographic Study: 1%
- Referred to Primary/Specialist: 5.55%
- Office visit tomorrow: 4.49%
- Sent for Radiographic Study: 1%
- Manage Symptom(s) at home: 75.98%
Average emergency room (ER) Evaluations per chemotherapy patient per year (APCPPY) for the CMOH patient population, 2004-2011.

USON/Milliman: Approximately 2 emergency room visits per chemotherapy patient per year (n=14 million commercially insured; 104,473 cancer patients)

Average Admissions per Chemotherapy Patient Per Year (APCPPY)
for CMOH patient population, 2007-2011

USON/Milliman: Approximately 1 hospital admission per chemotherapy patient per year
(n=14 million commercially insured; 104,473 cancer patients)

OPCMH End of Life Care

Consistent delivery of **Rational Care**

- **Performance Status Documentation**
  - Standardized assessment & **longitudinal tracking** of PS
  - Impact of disease & therapy on abilities, QOL
  - Influences ongoing treatment decisions
  - **Auditing** for PS decline (ECOG 3)

- **Ongoing Discussion of Goals of Therapy**
  - Documentation at **initial visit**, Stage IV disease
  - Documentation of **ongoing discussion** with decline in PS and change in therapy
  - **Goal:** Promote **shared decision-making**
## OPCMH™ End-of-Life Care

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Dartmouth</th>
<th>OPCMH™</th>
<th>QOPI</th>
<th>Measure</th>
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<td>ICU admissions, last 30 days, %</td>
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<td>Hospice days, last 30 days</td>
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<td>Advanced care plan documented, %</td>
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<td>ECOG performance status documented at each visit</td>
<td>X</td>
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<td>Practice</td>
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</table>
Oncology Practice: Hospice Average Length of Stay:

- 2009: 26 days
- 2010: 32 days
- 2011: 35 days

Place at time of death: 70% home 2010
                        74% home 2011

ER visits & hospital admissions last 30 days of life:
- 2010: 39.3% total practice Admissions
- 2011: 36.4% total practice Admissions
- 2010: 23.8% total practice ER visits
- 2011: 20.1% total practice ER visits

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Level of Oncology Accountability for Cost:

*Models for Cancer Care Payment*

FFS  Pathways  OPCMH  Bundled Payment
New Programs

• Expansion of the model
• NCQA
• Southeastern Pennsylvania Regional Network
• ION Solutions/ABSG
Expansion of the Model

**Four Key Steps**

- **Specialty societies** define quality parameters
  - COA steering committee (COA, ASCO, payers, patients)
- **NCQA** Specialty Practice Recognition Program
  - Application of PCMH principles to cancer care
  - Oncology standards expected Q1 2013
- **Payer** engagement and support
  - IBC, Aetna support for SEPA network
  - Regional networks – Other national payers
- **Phases of construction** of OPCMH
  - Payer Incentives & Practice Deliverables defined
NCQA Patient-Centered Medical Home

- **Framework** for performance / process improvement
- Drives service, quality and **resource utilization**
- Integrates **Meaningful Use**
- Keeps Patient – Family at the center of the decision-making
- Coordinates care along the **continuum**
- Encourages ‘Accountable Care’
- **Rapid** uptake and recognition possible (PC–PCMH)
- **Payer recognition** of the value in primary care
- Extension throughout cancer programs (**radiation & surgery**)

NCQA recognized Primary Care practices operate differently
They are looking for like-minded specialists to refer their patients
Recognizing the Disconnects

Operate in Silos
- Fragmentation
  - No one coordinating and integrating
- Duplicated Services/Redundancies
  - Cost / Wasted Resources
- Safety Issues with Transfers and Transitions
  - Missing Information
  - No “Closing the Loop”

Operate on Assumptions
- There is no “system” for coordination
- Integration depends on the diligence of the individual physicians
- No payment for care coordination
- Assume it will “just happen”…
American College of Physicians
PCMH-Neighbor Model

Proposes a *Framework* for Interactions between
PCMH practices & Specialty Practices

- An infrastructure/ scaffolding upon which Care Integration and Information Exchange can be built
- Restore Professional Interactions needed for Patient Centered Care
- Improve Care Transfers and Transitions to enhance Safety and Stewardship
Southeastern PA Network Development

- Expand, verify and refine OPCMH model
- Implement NCQA Oncology Specialty Practice Recognition Program
- Pilot Payer Projects
Incentives Driving OPCMH™
Phases of Construction

1. Laying the foundation
   - Workflow analysis, IT assessment, policy & procedure, job descriptions, baseline data
     • FFS + prior authorization relief

2. Introduction of new services
   - Access, telephone triage, care coordination, communication, manage transitions, portals
     • Phase I enhancements + case management fee

3. Optimization of performance
   • Phase II enhancements + gain sharing model

Adopted from: Barr, M.S. (2010). Medical Care Research and Review, 67 (4), 492-499
ION Solutions and OMS: Partners for Medical Home Success

- **Relationship goals**
  - Sustainable *payer support* for community oncology
  - Facilitate *practice transformations* to O-PCMH
  - Ensure that practices seeking NCQA recognition of medical home status can achieve it *simply and directly* as part of a well-managed program
  - Develop *scalable, affordable methodologies* to achieve NCQA recognition
ION Solutions and OMS: Partners for Medical Home Success

- ION Solutions partners with OMS to bring Medical Home capabilities to community oncology
  - Assessments
  - Transformations
  - Payer reimbursement strategies
  - Toolkits
  - Education
- OMS’ roles
  - Consulting Medical Director
  - Content experts on OPCMH model and execution
  - Design and process expertise and experience
  - Tools to drive physician, practice, and patient efficiencies
  - Consult on payer reimbursement strategies

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Thank you

• For more information about the Oncology Patient Centered Medical Home visit www.opcmh.com
• John Sprandio, MD jsprandio@cmoh.org
Steps Towards OPCMH™ Transformation

1: Fully implement an oncology-specific EMR
2: Define Clinical & Financial Goals
3: Secure “Buy-in” from physicians via efficiencies
4: Engage Payers & Commit to New Value Proposition
5: Standardize processes of care
6: Overlay Clinical Decision Support System (CDSS)
7: Improve Communication & Coordination
8: Integrate horizontally and vertically
9: Commit to continuous process improvement