Redefining Quality: Quality Measures & Value-Based Care

Gabrielle Rocque, MD, MSPH

8/24/18
Disclosures

• Research Funding: Genentech, Pfizer, Carevive®, Pack Health
• Consulting: Genentech, Pfizer

Portion of this work was made possible by Grant Number 1C1CMS331023 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The research presented was conducted by the awardee. The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
Agenda

1. Setting the stage: the Patient Care Connect Program
2. Oncology Care Model (OCM) treatment planning
3. Future directions
If you cannot measure it, you cannot improve it

-Lord Kelvin
Setting the stage: early steps toward value

Patient Care Connect Program (Center for Medicare and Medicaid Innovation Award)

• Goal of improving **VALUE**
  • Quality Measures (aligned with Commission on Cancer, National Quality Forum)
  • Healthcare Utilization
  • Cost
Patient Care Connect Program

- ~40 Lay (non-clinical) navigators
- Provides extra layer of support to cancer patients across the continuum of care
- All Medicare patients
- Activities anchored by distress screening

## UAB Health System Cancer Community Network

<table>
<thead>
<tr>
<th>Site</th>
<th>Location</th>
<th>Number of Affiliated Medical Oncologists</th>
<th>Rural vs. Urban Status</th>
<th>Practice Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorial Hospital (1)</td>
<td>Chattanooga, TN</td>
<td>15</td>
<td>Urban</td>
<td>Private Practice</td>
</tr>
<tr>
<td>Northside Hospital Cancer Institute (2)</td>
<td>Atlanta, GA</td>
<td>58</td>
<td>Urban</td>
<td>Hospital Owned</td>
</tr>
<tr>
<td>Gulf Coast Regional Medical Center (3)</td>
<td>Panama City, FL</td>
<td>4</td>
<td>Urban</td>
<td>Private Practice</td>
</tr>
<tr>
<td>Ft. Walton Beach Medical Center (4)</td>
<td>Ft. Walton Beach, FL</td>
<td>4</td>
<td>Urban</td>
<td>Hospital Owned</td>
</tr>
<tr>
<td>Singing River Health System (5)</td>
<td>Pascagoula, MS</td>
<td>5</td>
<td>Urban</td>
<td>Hospital Owned</td>
</tr>
<tr>
<td>SE Alabama Medical Center (6)</td>
<td>Dothan, AL</td>
<td>6</td>
<td>Urban</td>
<td>Private Practice</td>
</tr>
<tr>
<td>Russell Medical Center (7)</td>
<td>Alexander City, AL</td>
<td>2</td>
<td>Rural</td>
<td>Hospital Owned</td>
</tr>
<tr>
<td>NE Alabama Regional Medical Center (8)</td>
<td>Anniston, AL</td>
<td>5</td>
<td>Urban</td>
<td>Private Practice</td>
</tr>
<tr>
<td>Marshall Medical Center (9)</td>
<td>Albertville, AL</td>
<td>2</td>
<td>Rural</td>
<td>Hospital Owned</td>
</tr>
<tr>
<td>Mitchell Cancer Institute (10)</td>
<td>Mobile, AL</td>
<td>6</td>
<td>Urban</td>
<td>AMC</td>
</tr>
<tr>
<td>Medical Center Navicent Health (11)</td>
<td>Macon, GA</td>
<td>14</td>
<td>Urban</td>
<td>Private Practice</td>
</tr>
<tr>
<td>UAB Comprehensive Cancer Center (12)</td>
<td>Birmingham, AL</td>
<td>28</td>
<td>Urban</td>
<td>AMC</td>
</tr>
</tbody>
</table>
Enrollment in Navigation

Number of Patients

8/21/13 11/21/13 2/21/14 5/21/14 8/21/14 11/21/14 2/21/15 5/21/15 8/21/15 11/21/15
PCCP Patient Contacts (3/2013-12/2015)

Number of Contacts

- Person to Person (0-15 minutes)
- Person to Person (16-30 minutes)
- Person to Person (31-60 minutes)
- Person to Person (>60 minutes)
- Telephone (0-15 minutes)
- Telephone (16-30 minutes)
- Telephone (31-60 minutes)
- Telephone (>60 minutes)

>88K contacts
Hospitalizations by Navigation Status

Per quarter reduction
(Navigated compared to matched comparison)
• 6% in ER visits
• 8% in hospitalizations
• 10% in ICU visits

Cost by Navigation Status

~$19M across health system

Innovative Oncology Care Models Improve End-Of-Life Quality, Reduce Utilization And Spending

*Health Affairs* 36, no.3 (2017):433-440
Payment reform only viable option for **sustainability** for navigation for oncology practices

- Medicare → Oncology Care Model
- VIVA → Oncology Care Model Collaborator

Demonstration projects were a **model** for payment reform

- Patient Care Connect, Come Home project, Sutter Health demonstration project
- Measures provide ability to define success
UAB Perspective: Reasons to participate in alternative payment models from a specialty perspective

1. Opportunity to use new resources to transform our healthcare delivery system
2. Gain experience with value-based care
3. High expense population, room for improvement
4. Limited risk because not entire population
5. Provide leadership in helping define payment models
6. Better care for patients
Oncology Care Model (OCM) Overview

Standard Fee-for-service payments

$160 per beneficiary per month payment for enhanced care coordination

Performance-based payments = portion of Medicare savings and achievement of quality measures

NO CHANGE IN BASELINE FEE STRUCTURE

→ physician and administrator comfort

INVESTMENT

→ capacity for infrastructure build

LIMIT ON POTENTIAL REVENUE LOSS

→ Key for hospital buy-in

FOCUS ON QUALITY

→ Safeguard for poor care
OCM Practice Requirements

- **24/7 patient access** to a clinician who has real-time access to their medical records

- **Use data for continuous quality improvement**

- **Document comprehensive care plan** that contains IOM’s 13 recommended components

- **Meaningful Use of EHRs**: attestation to Stage 1 by end of PY1¹, with intention to attest to Stage 2 by end of PY3²

- **Provide for the core functions of patient navigation**

- **Use nationally recognized clinical guidelines**

Opportunity to embrace the spirit of the OCM and not just “check the box” to meet practice requirements
Limited data available on treatment plan use

In early stage breast cancer, treatment plans showed improved:
  • patient knowledge about cancer
  • patient-clinician communication
  • coordination of care
  • patient preparedness

Barriers to delivery of treatment plans

1. Documentation in multiple locations, multiple providers
   • Challenges with reporting to Medicare

2. No current system to generate treatment plans
   • Difficulty meeting Commission on Cancer survivorship care plan requirements
     • Time-consuming, personnel-intense nature
     • Lack of dedicated staff

3. Medical staff reluctant to add “another thing” to their responsibilities
Identify and Leverage Partnerships

• Administration looking to build value-based healthcare at UAB
• Physician Champions: Radiation Oncology, Urology, and General Surgery
• Existing Navigation Program
• Partnership with Mitchell Cancer Institute (Mobile, AL)
• Carevive®
  • experience with electronic survivorship care plans
  • algorithm-driven content
  • platform able to incorporate patient-reported outcomes
Feasibility of Treatment Planning

Pilot study with Carevive®: Achievement of National Quality Standards in Breast Cancer: A Pilot Study on the Impact of Certified Education Plus a Novel Care Planning Tool

Design: Pre-post evaluation of impact of treatment plans on selected ASCO Quality Oncology Practice Initiative (QOPI) measures

Outcomes: QOPI Core, Symptom, and Breast measures
How the Care Planning System (CPS) Works

Patient completes a disease and treatment-specific questionnaire on a mobile device prior to clinic visit.

Care team enters diagnosis and treatment data or we pull information from the electronic health record or cancer registry.

The Carevive System generates a personalized draft of a patient friendly care plan.

Oncologist finalizes and nurse counsels patient on care plan recommendations. A copy of the care plan is given to the patient and is stored in the EMR.
Patient Information
Name: MetBrCA Patient
Date of birth: 01/04/1960
MRN/ID: 0824011601

GENETIC COUNSELING
Avoid making an appointment with a cancer genetics professional for a personalized discussion of risk and possible genetic testing.

Schedule:
- Ask your oncologist if you need a referral to a genetic counselor or find a local genetics specialist at https://url.carevive.com/1000210. If you have these or other risk factors that may suggest a family history of cancer:
  - Ashkenazi Jewish heritage
  - Personal or family history of ovarian cancer
  - Family history of breast cancer in both breasts
  - Breast cancer before age 50 in yourself or first degree relatives (mother, sister, daughter)
  - Two or more first or second degree relatives (grandparent, aunt, uncle) with breast cancer

TREATMENT GOALS
You are receiving metastatic therapy. This means the cancer has spread to another part of your body. The goal of treatment is to stop or slow the growth of the cancer, or to relieve symptoms caused by it. In some cases, treatments for metastatic cancer can help prolong life.

Read: About metastatic cancer. Read online: https://www.cancer.gov/types/metastatic-cancer#what

Discuss with your cancer care provider the goal or intent of your cancer treatment. This can help you make decisions about your treatment.

Read: Making Decisions About and Understanding the Goals of Treatment. Read online: http://url.carevive.com/1000806

ADVANCE DIRECTIVE
Learn where your advance directive should be kept once filled out or updated.

Read: Communicating your advance directive. Read online: https://url.carevive.com/1000805

Do:
- Bring a copy of your advance directive to the clinic for scanning into the medical record


TREATMENT PLAN AND EDUCATION
CARE TEAM
PRIMARY CARE PROVIDER
John Johnson, MD
Primary Care Associates of Sanderson
(813) 987-2450
CANCER CARE PROVIDER
Gabrielle Roque, MD
Medical Oncology Associates of Sanderson
(813) 987-2455
NURSE PRACTITIONER / NURSE
Jane Adamsen, NP-C, MSN
Medical Oncology Associates of Sanderson
(813) 987-2455

DIAGNOSIS
CANCER TYPE: BREAST
Age at time of Diagnosis: 56
Current Age: 57
Date of Diagnosis: 1/2016
Pathology: Invasive Ductal Carcinoma
Laterality: Right origin of primary
Stage IV (TNM)
Tumor Grade N/A
Staging Characteristics:
- Hormone/Biomarker Status: ER negative, PR negative, HER2 negative
- Other / Comment: N/A
QOPI Measure Performance

- **ACTION TAKEN TO ADDRESS PROBLEMS WITH EMOTIONAL WELL-BEING**
  - Control: 17
  - Intervention: 96

- **DOCUMENTATION OF PATIENT'S ADVANCE DIRECTIVES**
  - Control: 19
  - Intervention: 81

- **PAIN ASSESSED**
  - Control: 83
  - Intervention: 100

- **PAIN INTENSITY QUANTIFIED**
  - Control: 75
  - Intervention: 100

- **PLAN OF CARE FOR MODERATE/SEVERE PAIN DOCUMENTED**
  - Control: 50
  - Intervention: 100

*unpublished data*
Modifications Based on Pilot

1. Need for a treatment dashboard
2. Integration with electronic medical record
Engage Stakeholders

• Clinicians
  • clinic managers, physicians, nurses, social workers, navigators, pharmacy, patient access team (registration)
    • workflow and personnel needs

• Administration
  • CFO, CEO, OCM leadership team
    • financial support for new staff, system changes, IT solutions

• Information Technology (IT) and Clinical Informatics staff
  • data integration
New patient identified as OCM patient → Power form and staging → Treatment Plan Created → Navigator helps patients sign up to patient portal → Navigator patient-reported outcomes → Treatment Plan Delivered.

Meet OCM Requirement:

1. Discrete data fields needed for reporting

2. Use of Patient Portal

3. Capture of population for distress screening and triage of navigation services

4. Integration of navigator into care team

5. Improved documentation → better communication between providers

6. Systematic referral of patients to financial counselors, social work psychology, palliative care

Nurse Care Coordinator
Oncologist or Nurse Practitioner
Lay Navigator
Implementation

<table>
<thead>
<tr>
<th>Treatment Plans completed</th>
<th>Survivorship Plans completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>506</td>
<td>137</td>
</tr>
</tbody>
</table>

Research opportunities

- common data elements
- patient-reported outcomes
- quality improvement platform
Early Results

National

• Only 25% of participants nationwide are anticipated to receive shared savings (ACCC Oncology Care Model Collaborative Workshop)

UAB

• UAB received shared savings
• Observed decreases in emergency department visits and hospitalization rates
• Full points for quality metrics
Next Steps at UAB: Aligning measurement with improvement

1. Continuing focus on meeting requirements
   • Improving work-flow

2. Harnessing patient reported data
   • Increasing supportive care services

3. Improving quality monitoring through innovative partnerships (Flatiron)
   • Physician report cards → behavioral change
OCM Measures
Prostate Cancer: Adjuvant hormonal therapy for high-risk prostate cancer patients (NQF 0390)

Colon Cancer: Adjuvant chemotherapy considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer (NQF 0223/NCI Community Cancer Centers Program/CAP)

Breast Cancer: Combination chemotherapy considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or Stage III hormone receptor negative breast cancer (NQF 0559)

Trastuzumab administered to patients with AJCC stage 1 (T1c- III) human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy (NQF 1858)

Breast Cancer: Hormonal therapy for Stage IC-IIIC estrogen receptor/progesterone receptor (ER/PR) positive breast cancer (NQF 0387/PQRS 71)
Quality measures: reported by practice (Process measures)

Communication and Care Coordination

• Advance Care Plan (NQF 0326/ PQRS 047)
• Closing the Referral Loop: receipt of Specialist Report (CMS50v4)
• Chemotherapy intent documented

Person and Caregiver-Centered Experience and Outcomes

• Oncology: Plan of Care for Pain (NQF 0383, PQRS 143) and Pain Intensity Quantified (NQF 0384, 144)
• Preventive Care and Screening: Screening for Clinical Depression and Follow-Up (NQF 0418, PQRS 134)
Quality measures: reported by CMS (Outcome measures)

Communication and Care Coordination

- Risk-adjusted proportion of OCM Beneficiaries with all-cause hospital admissions within the 6-month episode
- Risk-adjusted proportion of OCM Beneficiaries with all-cause emergency department visits that did not result in a hospital admission within the 6-month episode
- Proportion of OCM Beneficiaries who died who were admitted to hospice for 3 days of more
- Patient Reported Experience of Care
Predictions for Quality Measures & Value-Based Care

Evolution of measurement

1. Removing “topped out” measures
2. Process measures that can influence practice
3. Increase number of relevant measures for reporting
   - Emphasis on documentation
   - Electronic capture
4. Modifications to measures based on clinical data (adjustments)
5. Emphasis on cost (in and outside of OCM)
If you cannot measure it, you cannot improve it

-Lord Kelvin

Measurement must align with improvement for a successful transition to value-based care
Questions?