Introduction: The US Healthcare system is in a state of crisis. Despite spending the highest amount on individual health in the world, the US ranked at the bottom of the 17 most developed nations in results per the Commonwealth Report. The Institute of Medicine described US healthcare as achieving “poorer health and shorter lives.” Spending is out of control, and patient’s are not seeing any corresponding gains in either lifespan or quality life. Significantly driving this trend within the oncology world is the emphasis on volume-based reimbursement versus a focus on value. With this in mind, our practice underwent a full practice transformation in 2011 to shift the focus of our care from volume to value. The basic goal of our transformation was to improve population health at a local level, by creating a practice that was patient-centric, and provided a regimen of treatment for cancer that was value-based as opposed to volume driven, taking into account factors such as patient quality of life, secondary prevention of hospitalizations, cost savings to Medicare, and adherence to pathways. We would measure our success across both quantitative and qualitative measures.

Method: At Carolina Blood and Cancer Care Associates, our oncology practice located in rural South Carolina, our transformation addressed the needs of our cancer patients in underserved areas of the state. Our patient population covered a disproportionately large percentage of Medicare/Medicaid patients. With an underserved and vulnerable population, the importance of our transformation was even more critical. Our transformation was multi-fold and occurred from top to bottom staff wise. The roadmap we followed was certified by the NCQA (National Center for Quality Assurance) accreditation as a PCSP (Patient Centered Specialty Practice). We focused our transformation along patient navigation, same day services, 24/7 access, NCCN/Via guidelines, Quality Reporting and an IOM Plan, and Expanded Access/Weekend Hours. All of these steps were with the end goal of improving the population health of patients with multiple co morbidities our served area.

Our Expanded Access (including same-day appointments and weekend access) resulted in reduced ER visits and hospitalizations by our patients. With the addition of IOM care plans, patient navigation, and clinical pathways, we predicted that the transition to PCCC would lower expenses, improve patient experience, and would be likely to improve outcomes. Based on our projected savings with the delivery of PCCC, we expected to deliver savings to Medicare reaching roughly $1 million. We achieved the population health goals that we set out to achieve.

Results: The population health impact of our practice transformation was profound. On a quantitative basis, we exceeded our goals significantly. Emergency Department visits not leading to admission or observation stayed at 19 per 100 patients in April 2015 when the project was initiated in 14 in March 2017, when implementation was full completed. The figure has not rebounded after the 26% decline in emergency department visits among our patient population. Inpatient admissions to short term acute care hospitals and EAs dropped from 27 per 100 patients in April 2015 when the project was initiated to 20 per 100 patients in March 2017, when implementation was fully completed.

Our patient satisfaction surveys are delivering upwards of 75% patient satisfaction across all major parameters.

Our actions have simultaneously delivered cost savings to Medicare upwards of $1 million.

Our transition has been wildly successful and achieved all of its objectives: improved quality of life, lower costs, and a patient-centric practice.

As a whole, the underserved population in South Carolina has seen population health measures among the cancer patients we serve improve both measurably and significantly, and our ability to serve the needs of our patients has also increased concurrently.

Future Steps: What we are doing at CBCCA is take a new approach to cancer care that will help resolve the ongoing healthcare crisis. With costs spiraling out of control, it is of utmost importance that a new approach that prioritizes the quality of care received over the delivery of a regimen based on how much revenue it will generate. Our approach to tackling this problem is a transformation which can be easily replicated at any other oncology clinic that fulfills the triple aims of reducing overall cost, improving patient experience, and improving outcomes.

Population Health Impact: Collaboration, communication, and engagement were critical aspects to successful implementation of this project at Carolina Blood and Cancer Care. Prior to the start of implementation, a team building activities were held to ensure that all stakeholders among the staff would be brought on board to the workflow changes that would result due to our implementation. Without successfully changing the mindset of our practice, from physicians, to nurses, to medical assistants, to front desk staff, our implementation would have failed. Our nurses became certified as patient navigators. Alongside our standard implementation, staff members also became designated as financial counselors for under- or uninsured patients, and who were specialized in finding grant assistance or drug reimbursement assistance to ensure that patients receive the treatments they need. Not a single patient has had to turn away from Carolina Blood and Cancer Care Associates due to financial hardships. We were able to raise over 1.5 million dollars in indigent funds from several foundations to support caring for all patients at our cancer clinics.

Furthermore, the transformational process involved an increase of visibility to the patient as well. We began offering patient portal for all of our patients to become more proactive in their treatment, and patients are now able to login in 24/7 through our website to access their care plan. Patient engagement has since become a critical and sustained component of our practice transformation, and we continuously attempt to implement new technology solutions to improve engagement further.

The only way for such a transformation to be successful was through the collaboration, communication, and engagement across all individual stakeholders in the process, and we are proud to say that we achieved it.

Conclusion: Critical to a successful transformation on population health is it’s ability to be replicated and scaled without undue difficulty. Our transformation plan can easily be scaled and implemented at any practice nationwide. We have already had our success story highlighted by NCCQA as an example of how an otherwise ordinary cancer care practice can engage in successful practice transformation. And the impact on population health of the underserved is needed to be replicated as the transformation model undertaken and implemented. Our formula for success is dependent on strict adherence to the facets of PCSP highlighted previously in this application. Patient navigation, same day services, 24/7 access, NCCN/Via guidelines, Quality Reporting and an IOM Plan, and Expanded Access/Weekend Hours are all factors that any oncology practice can implement in a timespan of six to eighteen months.

The primary difficulty is not in the complexities of the transformation, but rather, overcoming the inertia that has resulted in the oncology world from decades spent in the traditional buy-and-bill approach to cancer care; an approach that has relegated patients to the rear view mirror. If that mindset and inertia can be overcome, our model can be replicated at any oncology practice in the nation, and the populations served by new-patient-centric practices should see lower hospitalizations, higher patient quality of life, and improved population health measures accordingly.