Patient-centered cancer care (PCCC) as a roadmap to success in Alternate Payment Model (APM): A case study-based learning

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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 as 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 of life quality. 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.

METHODS

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 disproporationately 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.

FIGURE A:

FIGURE B: Focus on expanded access on PCCC

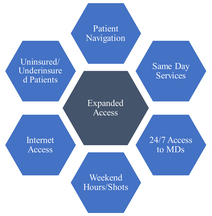

FIGURE C: Proposed steps and PCCC transition

Process/Intervention	Outcome	Savings	Quality of Life
Weekend access to MD	Reduced ER visit/hospitalization		Improved
Triage process/Navigation	Reduced ER visit; enhanced access to care		Improved
On-site radiology	Improved care coordination and enhanced patient experience		Improved
Weekend infusion	Reduced ER visit/hospitalization		Improved
Partner with local urgent Care	Reduced ER/hospitalization		Improved
Supportive care pathways	Reduced ER visits and hospitalizations; proactive side effect and symptom management		Improved
In house palliative and spiritual care	Holistic, patient-centered care		Improved

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 stays fell from 19 per 100 patients in April 2015 when the project was initiated to 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 CAHs 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 it's 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.
Please see exhibits D through G for the quantitative impact of our steps along with patient engagement elements.
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FIGURE D: Impact of PCCC on Trends in In Patients Admissions; CMS data for OCM-426 (CBCCA)

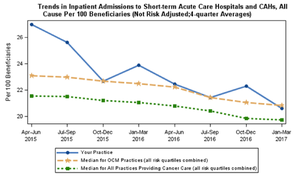

FIGURE E: Impact of PCCC on Trends in ED Visits; CMS data for OCM-426 (CBCCA)

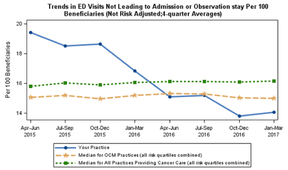

FIGURE F: Impact of PCCC on Trends in Observation stay; CMS data for OCM-426 (CBCCA)

FUTURE STEPS

What we are doing at CBCCA is take a new approach to the delivery of cancer care that will help resolve the ongoing healthcare crisis. With costs spiraling out of control, it is of the 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. We are proud to report that our practice transformation into PCCC resulted in achieving these triple aims, with measurable reductions in cost of care, in ER visits and hospitalizations, and significantly improved patient experiences.

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 series of 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 un-insured patients, and would specialize in finding grant assistance or drug replacement assistance to ensure that patients would receive the treatments they needed. Not a single patient has had to be turned 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 log 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 possible was through the collaboration, communication, and engagement across all individual stakeholders in the process, and we are proud to say that we achieved it.

Critical to a successful transformation on overall 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 NCQA 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 served areas can also be replicated should the transformation be 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.

The concept of a value driven approach to cancer treatment is entirely new. As a part of our practice transformation, we have taken part in the Oncology Care Model (OCM). OCM is the first major initiative by the Center for Medicare and & Medicaid Innovation (CMMI, a division of CMS) to pilot the transition from fee-for-service toward value-based care and PCC.
Our approach to patient centric care has aligned us well towards the objectives of OCM, which revolve around creating an approach to cancer care that emphasizes value over volume. As such, when practices were invited to enroll in the pilot, our previous transformation allowed us to be a prime candidate for this innovative reimbursement model. We were selected to participate in the OCM model through a highly competetive selection process and have subsequently exhibited significant success and scored routinely in the top range of the shared savings model.
Additionally, our approach to patient centric care allowed us to expand our patient services to beyond cancer treatment to lifestyle adjustment. We have hired a dietician to provide lifestyle modification help to patients who are candidates. We furthermore offer tobacco cessation interventions, transitional care management to prevent frequent re-hospitalizations, and chronic care management, while allows us to proactively monitor our most vulnerable patients with multiple chronic conditions.
Our population health approach is not limited to what is suggested by accreditation boards: we seek to leverage patient engagement at all levels, and lifestyle change beyond cancer treatment is an
additional means of improving population health in the rural, underserved South Carolina population we serve.

FIGURE G: The role of Care Coordination in PCCC

FIGURE H: How PCCC Elements of Patient Engagements Led to Fulfil triple aims of lowering costs, improve outcomes and improve Patient Experience

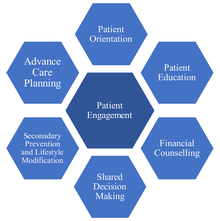
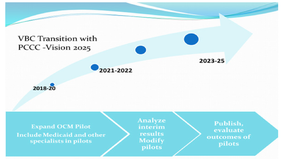
FIGURE I: Future of VBC and OCM