Bridging the gap: Improving Primary Care and Specialty Coordination

Becoming a Good Neighbor

Oncology Patient-Centered Medical Home®

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Oncology Management Services, LLC.
CMOH 2001 - 2003

- 9 Hematologists & Oncologists
- 4 Practice Sites, suburban Philadelphia
- 2 Health Systems
- 1998 Failed attempt at Clinically Integrating Oncology Network SEPA / SJ (successful IPA; did not achieve CI)
- 2000 Focused CMOH on internal data collection
- 2001 Achieved enhancement of 1 payer contract based on manually collected and reported ER utilization
- 2004 Evaluation and Implementation of Oncology EMR
CMOH: 2004 – 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)

**Credentialing by a third party**
- QOPI Certification
- NCQA Recognition as Level 3 Patient Centered Medical Home
Quality, Service & Delivery Parameters

- ASCO - QOPI standards
- NCCN Guidelines
- American College of Surgeons, NQF
- CMS - PQRS, e-Rx
- NCQA – PPC-PCMH™
- 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
  - 2012 Best Care at Lower Cost
Evolution of a Practice

- June 2004 – Implement Oncology EMR for entire practice except Physicians
  - Build a complete chart before the physician even touched the system.
- October 2004 – Bring physicians on board
- December 2004 – Duck for cover!
Simplicity is at the root of all genius.

Out of clutter, find simplicity.
- Einstein
How can a physician-led care team reliably deliver care?

Critical Physician Solutions

- **Standardized** process of care and data collection
- Consistent presentation of pertinent consumable data that can support decision making relevant to each visit
- **Documentation & Communication** tools to relieve the largest burden on a physician’s ability to execute care consistently
- **Standardized** communication format to all stakeholders
IRIS Software Suite

**Physician-Centric Software**

*Enabling Patient-Centered Care*

- Clinical Decision Support System (CDSS) at the point of care
  - Work-flow integrated with delivery, documentation & MU
  - Speech-recognition integrated into work-flow
  - Immediate document completion and auto-dissemination
- Personalized Patient Assessment and Verification Tool
- Enhanced Patient Queuing/tracking program
- Individual patient test result and appointment tracking
- Screening and Immunization prompts
- Longitudinal performance status & NCI graded symptom tracking
- Physician document and lab management review
- Portal access for patients and referring physicians
- Physician performance reports
- Unscheduled visit tracking
- Palliative and End-of-Life Care Management prompts
Oncology Patient-Centered Medical Home®

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
**Process Measurement**

**Rapid Learning Cycle**

- Function of **mutually reinforcing** care-team
  - Every staff member’s role, responsibility, documentation and hand-off process has changed.
- Merging Work-Flow & Clinical Decisions
- **Guidelines**, staging, screening, prevention
- **Medication Reconciliation**
- Triage & Symptom Management algorithms
- Communication/Documentation turn around
- Coordinating/tracking all tests & referrals
- **Performance Status & Palliative Care** tracking
- End of **life care**/promoting shared decisions
- Patient & referring physician portal utilization
- Management of at risk populations
Oncology Patient-Centered Medical Home® Outcome Measures

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

- **Performance Monitoring**
  - Staging compliance
  - Chemotherapy guideline adherence
  - Emergency Room evaluations
  - Hospital admissions / length of stay
  - Outpatient visit reduction
  - End of Life Care parameters
  - Diagnostics: imaging & laboratory
NCQA Standards & The Four Habits of High-Value Health Care Organizations

“The ability to disseminate and deliver high value clinical innovation is based on similar, portable “habits” of care management ... implemented simultaneously” Richard Bohmer, M.B.,Ch.B. NEJM 12/1/11

- Specification and Planning
  - Merging operational and clinical decisions with documentation
- Micro-system design
  - Matching subpopulations and pathways, triage algorithms
- Measurement and oversight
  - Targeting internal operational issues
- Commitment to ongoing process improvement
  - Insights for better outcomes fuels modification of Specification and Planning
**USON/Milliman:** Approximately 1 hospital admission per chemotherapy patient per year
(n=14 million commercially insured; 104,473 cancer patients)

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)

9.63% of patients were seen in the office within 24 hours of call
Documentation Turn-Around Time (from Patient Visit to Faxing of Completed Note)

New IRIS version incorporated Dragon NS functionality
(single MD -- yellow line -- beta in Jan ‘10 followed by adoption of entire practice in May ‘10)
Unscheduled Visits PCPPY from 2005-2011 As a Result of Clinical Calls

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Unscheduled Visits</th>
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<tr>
<td>2006</td>
<td>0.258</td>
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<tr>
<td>2007</td>
<td>0.269</td>
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<tr>
<td>2008</td>
<td>0.372</td>
</tr>
<tr>
<td>2009</td>
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<tr>
<td>2010</td>
<td>0.679</td>
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<tr>
<td>2011</td>
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OPCMHTM End of Life Care Data

- Hospice Average Length of Stay:
  - 2009: 26 days
  - 2010: 32 days
  - 2011: 35 days
  \[34\% \text{ increase}\]

- 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
Medical Neighborhood

Policy Paper, ACP Council of Subspecialty Societies (CSS)

- Published October 2010
- Addressed relationship between primary care PCMH model and specialty/subspecialty practices
- Highlights:
  - Established definition of Patient Centered Medical Home Neighbor
  - Approved a framework to categorize interactions between PCMH and PCMH - N
  - Approved guiding principles of the development-of-care coordination agreements between PCMH and PCMH - N

Neil Kirschner, Ph.D.
American College of Physicians, Senior Associate
Regulatory and Insurer Affairs
Care Coordination Agreement
Primary Care PCMH & Oncology PCMH-N

Hematology Oncology Practice Responsibilities

- **Pre-consultation exchange** - *Clarify & expedite referral*
- **Initial consultation**
  - **Standardized** orientation, patient engagement & responsibilities
  - Planned evaluation, goals of care plan, symptom management
  - Focus on *potentially avoidable complications* of therapy and disease
- **Oncology practice - point of first triage**
  - All symptom related calls channeled through practice
    - Symptom palliation and pain management coordination
  - **Standardized 24/7 telephone triage service**
    - Documentation of disposition of every call
    - Referral of non-oncologic medical issues to Primary PCMH
Hematology Oncology Practice Responsibilities

- **Communication** of clinical course, test results, procedures
  - **Progress note** in standardized format for easy data consumption by providers, payers, and patients
  - Regular updates regarding palliation of symptoms, performance status, co-morbid conditions and goals of therapy
  - **Documentation to PCMH within 48 hours of all visits**
  - Referral back to PCMH for co-morbid condition management
  - Communication of plan during inpatient - outpatient transitions

- **Schedule all** diagnostic testing and referral to other specialists
  - Consultants selected based on primary PCMH preference
Hematology Oncology Practice Responsibilities

- **Emergency room utilization and hospital admissions**
  - Management of ER/hospital admissions, with these exceptions: acute cardio-respiratory, neurologic, and orthopedic related events.

- **End of life discussions**
  - Documentation of EOLC discussion driven by performance status changes and progression of disease relayed to PCMH
  - Promote shared decision making – patient, primary care, specialist

- **Survivorship care planning**
  - Execution and delivery of Survivorship Care Plan upon completion of therapy to patients and primary care physician

- **Cancer risk registry for family members**
  - Direct communication of **genetic testing results** to the PCMH
Oncology PCMH-N
Primary PCMH Responsibilities

- **Pre-consultation exchange** – clarify & expedite referral
  - Via designated PCMH care team member or referring physician
- Review and accept **Coordination of Care Agreement**
- Reinforcement of the oncology practice as **point of first triage**
- PCMH establishes a **preferred specialists list**
- **Forwarding** diagnostic laboratory, radiology, pathology results
- PCMH continues to manage all **non-oncologic** medical issues
- **Real time communication** to Oncology care team of PCMH
  - driven ER, hospital admissions
- PCMH participation in **End-of-life discussions**
- Execution of **Survivorship Care Plan** within PCMH
- Acceptance of **genetic evaluation data** and utilization of it in
  the identification of high risk patients within the PCMH
Era of Health Care Reform

Value and Demonstration of Results

- **Value = quality/cost**
  - **Quality**: driven by enhancing **reliability of delivery**
    - Focus on execution (processes) of care delivery
    - Incorporation of High Reliability Principles
  - **Cost**: driven by reduction of **unnecessary** utilization
    - Unnecessary utilization = waste
    - Failures of delivery, coordination, overtreatment

- **Demonstration of results**
  - Data transparency, accountability, rapid learning
“Only those giving the care can improve it”

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

- **Standardization of delivery = waste reduction**
  - Standardization of Chemotherapy guidelines & pathways
  - Standardization of Care delivery *beyond* chemotherapy selection
    - Requires practice transformation
Oncology Patient-Centered Medical Home® Value Proposition

- **OPCMH – clinical & business methodologies**
  - Achieves practice/patient care efficiencies
  - Community and hospital-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
Questions

For more information on CMOH practice transformation:

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For more information about Oncology Patient Centered Medical Home:

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