Society for Radiation Oncology Administrators
32nd Annual Meeting

Competency Development:
Oncology Services Clinical Redesign

October 20, 2015
Competency Development: Oncology Clinical Redesign

Session Presenter:
Joseph M. Spallina, FAAMA, FACHE
Director
Arvina Group, LLC
Ann Arbor, Michigan
jspallina@arvinagroup.com

Where to find this presentation:

- SROA website.
- Arvina Group, LLC, website, www.arvinagroup.com:
  - “About Us”, then
  - “Publications”, then
  - Scroll to “Cancer Presentations and Publications”.
Discussion Topics
October 20, 2015

I. Some General Assumptions.
II. Background – Value Oriented Insurance Design.
III. Organizational Competencies Required for Success.
IV. Redesign Approach.
General assumptions:

- For SROA, members will continue to have broader cancer program responsibilities.
- Value oriented insurance products will “include” (packaged, bundle, etc.) the broader continuum of care thereby diminishing (eliminating?) traditional provider organizational boundaries.
- Your markets represent varying stages of value development.
- Your organization is developing strategies to address the development of value oriented health insurance products.
- Cancer program value oriented competency is not fully developed in your organization.
General assumptions (continued):

- Session objective = getting starting with developing a value competency in your cancer program.
- Oriented towards the clinical enterprise:
  - Recognizes the additional considerations required for academic medical centers.
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BROADER CONTEXT: VALUE DEVELOPMENT IN HEALTHCARE ENTERPRISE STRATEGIC PLANNING

Enterprise Strategic Planning

- Primary & Urgent Care Strategies.
- Population Health Management.
- Physician Alignment (employed & private practice) Strategies.
- Commercial Insurance Specific Strategies.
- Service Line Specific Strategies.
- Etc.

Service Line Strategic Planning

- Costs, Quality, Research, Capabilities, Facilities, Care Protocols, etc.
- Access, Markets, Networks, Marketing, Medical Home/Population Health, Telemedicine, etc.
- Value Development, Governance & Leadership, Provider Goal and Incentives Alignment, Technology Infrastructure, etc.

Value: Potential Strategy Achilles Heel?

Enterprise Value Development

Service Lines

- Cancer Program
- Cardiovascular
- Orthopedics
- Medicine
- Surgery
- Etc.

Physician Alignment, Medical Home, Decision Support and Analytics, Finance, Quality, IT, etc.
Meaning of “Value” in the healthcare industry?

- Traditionally, “Value” defined in terms of the price and quality relationship.
- Proxies for price (cost) and quality are used.
- Linked directly to reimbursement:
  - Value oriented insurance design reflects a variety of payment mechanisms.
  - Typically “Value” is defined in the mechanics of reimbursement and is achieved by the provider of healthcare services assuming some type of financial risk (incentives, upside, downside).
What does “Value” mean for healthcare (continued)?

- **Payor goals:**
  - **Primary:** Cost and quality role – efficient and effective care:
    - Safe, what patients need.
    - Lowest possible cost.
    - Satisfied customers (patients, family, employers).
  - **Secondary:**
    - Reduce ALOS and readmissions.
    - Reduce “unnecessary” ancillary utilization.
    - Procedure preparedness.
    - Post procedure/stay follow up, care coordination.
    - Reduce post acute transfers and SNF costs.
What does “Value” mean for healthcare (continued)?

- Payors goals:
  - Accessible, convenient information and data sharing.
  - Tools to support the above (referral management, cloud based data repositories, reporting, analytics, real time feedback, status & alters monitoring, etc.).
What does “Value” mean for healthcare (continued)?

- Price and quality data are retrospective (at the moment). Measurement is not as straightforward as it may appear.
- Quality is multidimensional (acute, chronic care, prevention measures, clinical outcomes, functional status, patient experience, etc.).
What does “Value” mean for healthcare (continued)?

- Medicare:
  - Targeting 90% of payments to be value based by 2018.
  - Very clear about its intent to restructure oncology payment architecture:
    - Future reimbursement is “Value” based (e.g., 2016 Oncology Care Model demonstration project).
  - Recent activity to employ physicians, maximize hospital based billing (and 340B Drug Pricing where in place) creates exposure for providers.
  - Economic alignment doesn’t automatically translate to strategic alignment (and success in a value market).
## Competency Development: Oncology Clinical Redesign

### Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Category 2:</th>
<th>Category 3:</th>
<th>Category 4:</th>
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</thead>
<tbody>
<tr>
<td>Fee for Service—No Link to Quality</td>
<td>Fee for Service—Link to Quality</td>
<td>Alternative Payment Models Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
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<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
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<tr>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
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<tr>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
</tr>
<tr>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)</td>
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<th>Medicare FFS</th>
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<tr>
<td>Limited in Medicare fee-for-service</td>
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<tr>
<td>Majority of Medicare payments now are linked to quality</td>
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<tr>
<td>Hospital value-based purchasing</td>
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<td>Physician Value-Based Modifier</td>
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<td>Readmissions/Hospital Acquired Condition Reduction Program</td>
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<th>Medicare FFS</th>
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<td>Accountable care organizations</td>
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<td>Medical homes</td>
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<tr>
<td>Bundled payments</td>
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<td>Comprehensive primary care initiative</td>
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<td>Comprehensive ESRD</td>
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<tr>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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<table>
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<tr>
<th>Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018</th>
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<tbody>
<tr>
<td>Category</td>
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<tr>
<td>All Medicare FFS (Categories 1-4)</td>
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<tr>
<td>FFS linked to quality (Categories 2-4)</td>
</tr>
<tr>
<td>Alternative payment models (Categories 3-4)</td>
</tr>
</tbody>
</table>

Emergence of healthcare value orientation:

- National healthcare CEO view of physician alignment (Health Leaders Media Intelligence Report, 2015) emphasis on:
  - Clinical integration.
  - Employ physicians.
  - ACO’s, risk sharing and, shared savings agreements.
  - Bundled payments.

Are these adequate strategies for success in the future?
Key challenges moving forward:

- Success with value oriented healthcare in general and with oncology specifically, requires redesigning approaches to clinical care delivery (complementing other enterprise initiatives).

- The transition to value must be managed within a healthcare organization as a Distinctive Competency!

- “It is an imperative that we balance the morale obligation of medicine with the emerging healthcare reimbursement mechanisms.” (J. Levine, M.D., Professor of Medicine).
Additional Challenges

- Adequately continuum of care development.
- Focus shifts from cost of drugs ➔ cost and quality of care across the continuum.
- 25% - 35% of cost and quality of cancer care is outside the control of the hospital and physician practices.
ORGANIZATIONAL COMPETENCIES REQUIRED FOR SUCCESS
COMPETENCY DEVELOPMENT: ONCOLOGY CLINICAL REDESIGN

VALUE AS AN ORGANIZATIONAL DISTINCTIVE COMPETENCY

- Organization, Infrastructure & Systems
- Value Development Strategic Direction
- Physician Leadership & Engagement
- Data & Information
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- Organization and Infrastructure:
  - Culture and organizational *expectations*:
    - Value is an element of the organization’s vision (as fee for service phases out).
    - Disease/care centric, not “hospital” or “volume” centric.
    - Organizational strategies are nimble, responsive, contributes toward operational and practice efficiency.
    - Innovative thinking encouraged, mentored and, rewarded.
    - Encouragement and support for a team approach.
    - Value strategy is an essential responsibility of the cancer program leadership team.
Organization and Infrastructure (continued):

- Cancer program value oversight Steering Committee (physician leadership committee).
- Disease and processes specific Work Groups.
- Educational platform for value focused leadership development.
- Enhanced matrix reporting and working relationships (effective communications, work progress and, decision making).
- Compensation evolves to something other than 100% wRVU dependent.
- Analytics capability (access to the data, analytical analysis [drill down] software and tools, staff support, etc.).
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Organizational Considerations

- Cancer Program Governance & Leadership
- Value Development Steering Committee
- Other Committees
  - Workgroup: Breast
  - Workgroup: GI
  - Workgroup: Processes of Care
  - Workgroup: Others

Workgroup:
Breast
GI
Processes of Care
Others
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- Health Analytics Software (selected list):
  - Organization’s decision support software.
  - IBM
  - McKesson
  - MedeAnalytics
  - OptumHealth
  - Oracle
  - The Advisory Board Company: Continuum of Care.
  - Truven Health Analytics
  - Verisk Analytics
  - Modules included in your electronic health record,
  - and, use of spreadsheets.
Value Development Strategic Direction:

- *Direction and timing* about value development in healthcare organizations must be established and address the cancer program’s role.
- Focus on care transformation and care coordination across the oncology continuum.
- Goals guide the maturation of this development; address the complexities and uniqueness of cancer as a disease.
- Data and information, systems and tools, leadership and, infrastructure required (organizational priorities) for value success in oncology are addressed.
Physician Leadership and Engagement:

- Value transformation must engage physician leadership in a meaningful fashion to be successful:
  - Employed: contracts with incentives addressing contributions to value.
  - Leverage “all in the same boat” platform and professional development opportunity (clinical integration, care standardization and quality improvement, taking on risk).
Physician Leadership and Engagement (continued):

- Value transformation must *engage physician leadership*:
  - Steering committee formation:
    - Ask potential physician leaders for opinions about discussion and approach design.
    - Invite key physicians to leadership roles (disease specific).
    - Financial incentives (stipends, reinvest savings into the cancer program, etc.) for key physician leaders.
Data and Information:

- Up to date, accurate clinical and financial data repositories.
- Access to analytical support:
  - Transform data into meaningful information.
- Key data elements include, not limited to:
  - Patient billing (hospital inpatient/APR-DRG and outpatient, health system practice).
  - Core measures and other quality metrics.
  - Cost accounting.
  - Ongoing Professional Practice Evaluation (OPPE), patient satisfaction.
  - Evidence-based order sets.
Data and Information (continued):

- For initial screenings and detailed assessments, data comparisons are dependent on the healthcare enterprise’s analytical tool capabilities:
  - Intra-group (group) comparisons.
  - Intra-hospital/healthcare enterprise.
  - Regional (typically payor specific).
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REDESIGN APPROACH
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**CANCER PROGRAM CLINICAL REDESIGN INITIATIVE**

1. Assessments & Opportunities Identification (cost, quality, etc.)
2. Progress Monitoring, Assessment, Adjustments
3. Drill Down (DRG, procedure, process, etc.)
4. Knowledge Based Solutions Research, Selection and Design
5. Dissemination & Education

**SC = Steering Committee**

**WG = Work Group**
Getting started:

- Steering Committee established.
- Complete *initial screening*, identify and focus on major opportunities:
  - Initial overview/survey for opportunities.
  - Utilization and cost position.
  - Quality position.
- Projects identified (disease specific +/- processes of care).
- Complete selected project *detailed assessment and discussions* around quality improvement +/- care delivery innovations.
Getting started (continued):

- Initial Screening:
  - **Key aim**: reduce unnecessary costs while maintaining, improving quality.
  - Reduce ALOS, readmissions and, HAC’s.
  - Improve processes of care and eliminate unnecessary utilization:
    - Procedure preparedness.
    - Reduce SNF (and other post acute care) costs.
    - Care coordination and post procedure/stay follow up (including active management of patient transfers and real time patient monitoring outside of the hospital).
Getting started (continued):

- Initial screening opportunities - focus on large volumes, large variations:

  Hosp: Dx’s = 16.7% (9/50)
  Sys. Dx’s = 4.9%
  Std Dev = 2.95

Colo/rectal Surgery 30-d Mortality

3+ Std Dev

2 Std Dev

< 1 Std Dev
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- Initial screening:
  - Overview *survey* metrics:
    - CMI.
    - ALOS.
    - Cost per discharge/case.
    - Mortality.
    - Average risk of mortality.
    - % surgical DRG.
    - Stats by attending vs. consulting physician.
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- Initial screening (continued):
  - Overview *quality* metrics:
    - 30 day readmission.
    - 30 day readmit observed/expected.
    - Core measure significant negative performance.
    - DRG’s/cases with high % complications.
    - HAC’s observed/expected.
    - High mortality rate (raw and observed/expected).
    - % inconsistent with guidelines (medications, labs, diagnostic procedures).
    - % of cases not meeting prevention and maintenance guidelines (mammography, colonoscopy, PSA, etc.).
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- **Initial screening (continued):**
  - Overview *utilization* metrics:
    - % discharges above ALOS.
    - ALOS observed/expected.
    - Top ALOS DRG’s/cases (raw and GMLOS).
    - Top high average charge DRG’s/cases.
    - DRG’s/cases with higher ICU charges as a % of total room.
    - Average consultant specialists used.
    - Discharge disposition comparison (home, expired, SNF, hospice/home, etc.).
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- Initial screening (continued):
  - Overview *utilization* metrics:
    - Top denial reasons.
    - High utilization in specific areas ($):
      - Blood.
      - ER.
      - Imaging.
      - Lab.
      - OR.
      - Pharmacy.
      - Respiratory.
      - Etc.
Based on the initial screening, identify opportunities for detailed, drill down assessments and, Steering Committee discussions about priority next steps, focusing on:

- Cost position and utilization.
- Quality.
- Process of care and continuum management.
- Functional status.

- Workgroup specific project assignments.
Next, Work Group detailed assessments:

- **Quality metrics:**
  - Top complications of care.
  - Top HAC’s.
  - Top mortality factors.
  - Top guideline variances.
  - Functional status (30, 60, 90 day).
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- Next, Work Group detailed assessments (continued):
  - **Utilization** metrics:
    - Factors and providers contributing to:
      - High total charges.
      - Long ALOS.
    - Significant utilization variances ($ by specific service):
      - Blood.
      - ER.
      - Imaging.
      - Lab.
      - OR.
      - Pharmacy.
      - Respiratory.
      - Etc.
Next, Work Group detailed assessments (continued):

- Conclusions about opportunities based on completed assessments.
- Discussion and research, solution options.
- Selection of the preferred solution and implementation design.
- Dissemination of and education about the solution.
- Progress monitoring and adjustments to implementation design as required.
- Reporting recommendations and progress to the Steering Committee.
SUMMARY

- Get organized!
- Build on your health system’s value development infrastructure.
- Include, but look beyond:
  - Your health system’s initiatives.
  - Advanced (oncology) medical home.
  - ERAS protocols.
  - More significant role of hospice and palliative care.
- Develop a meaningful configuration to engage physicians.
- Include value development as a routine and priority cancer program leadership and governance discussion topic.