Welcome
March 8, 2017 Webinar

Palliative Care, Value-Based Payment and the Patient Experience: A Guide for a Changing World

This Webinar is the first in a professional education series to address critical issues in providing value-based, person-centered care.

National Patient Advocate Foundation

Association of Community Cancer Centers

Oncology Nursing Society

Community Oncology Alliance

Center to Advance Palliative Care

Introduction

Gwen Darien
EVP Patient Advocacy

NPAF
National Patient Advocate Foundation

Opening Poll

Which of the following best describes your oncology practice?

- Considering palliative care options
- Actively planning for pursuing training in palliative care skills
- Actively planning to strengthen relationships with palliative care specialists
- My practice already provides all the palliative care that our patients need
- Not planning on pursuing additional palliative care training or collaboration with palliative care specialists
- Not applicable

Palliative Care, Value-Based Payment and the Patient Experience: A Guide for a Changing World

Diane E. Meier, MD
Director of the Center to Advance Palliative Care (CAPC)

Center to Advance Palliative Care™
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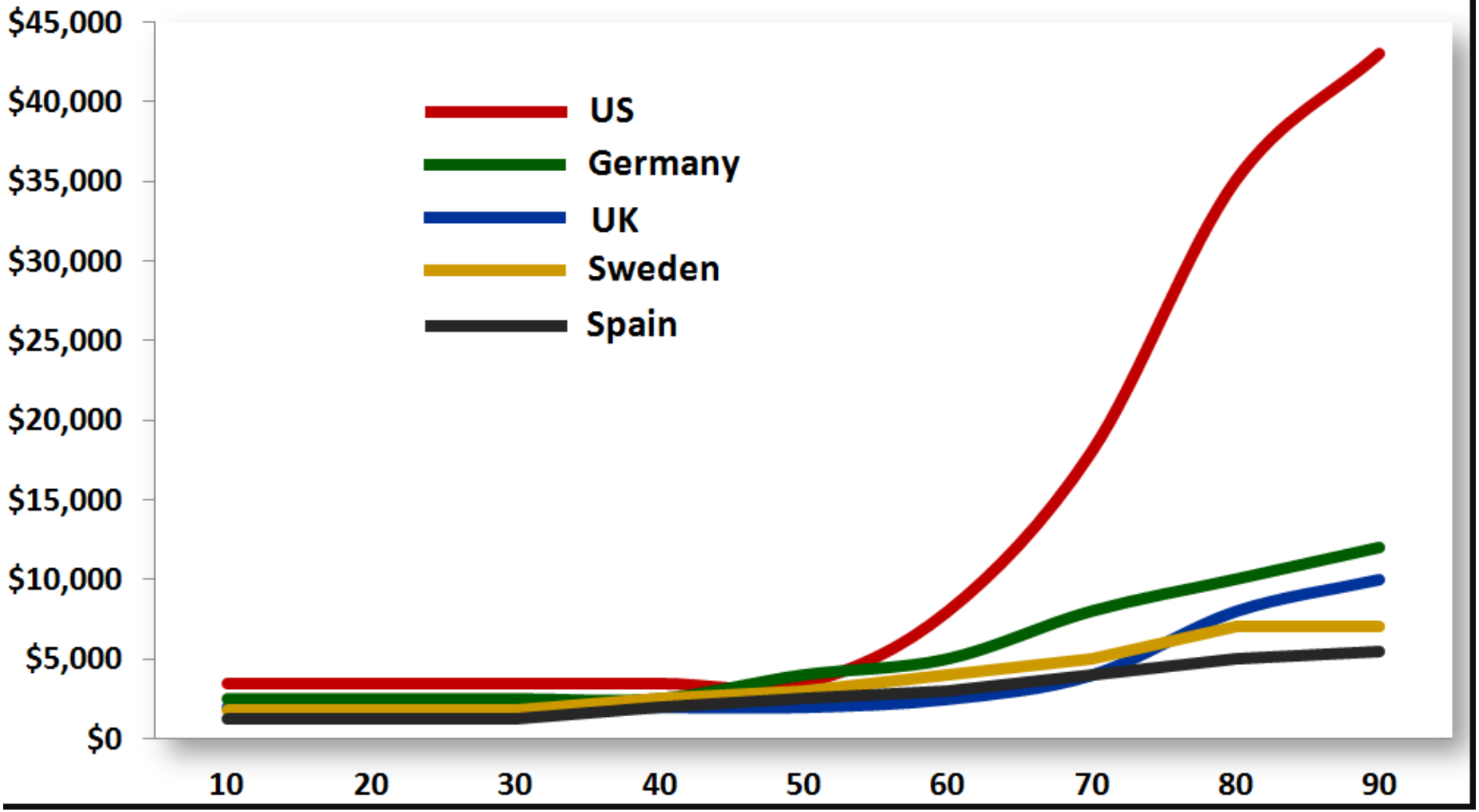
Annual Per Capita Healthcare Costs by Age



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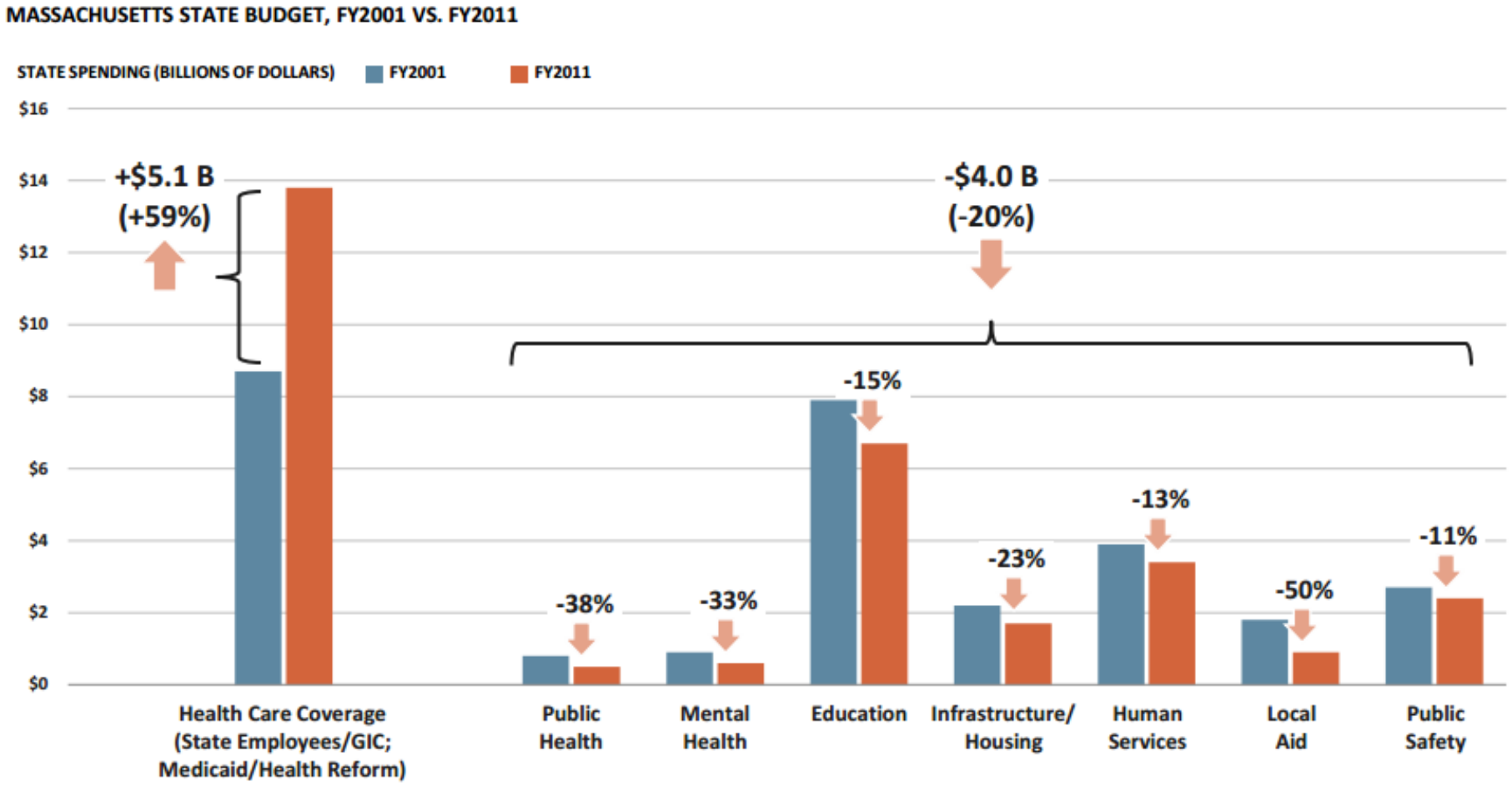
The Increasing Costs of Health Care Squeeze Out Other Public Spending Priorities



SOURCE: Massachusetts Budget and Policy Center Budget Browser.

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WHEN CANCER COST-SHARING **TURNS TOXIC.**

Are insurers' cost-shifting policies pricing cancer patients out of care?

AfPA
Alliance for Patient Access

$4,800

The average amount that an insured cancer patient pays out of pocket per year is $4,800

50% $$$$$$$$$$

of Medicare beneficiaries with cancer spend **more than 10%** of their income on out-of-pocket health care costs.

28% $$$$$$$$$$

spend **more than 20%.**

Between 1999 and 2013, patients' share of premiums has **increased by 196%.** Deductibles have almost doubled.

2.65x

Cancer patients were **2.65 times more** likely to go bankrupt than people without cancer.

70%

Patients with higher co-payments **($53 or more) were 70% more** likely to discontinue therapy in the first six months of treatment.

When cost-sharing turns toxic, patients may fall into nonadherence—spacing out chemotherapy appointments, delaying care, declining diagnostic procedures, and replacing prescription therapies with over-the-counter medications.

Pharmacy Practice News, January 2015

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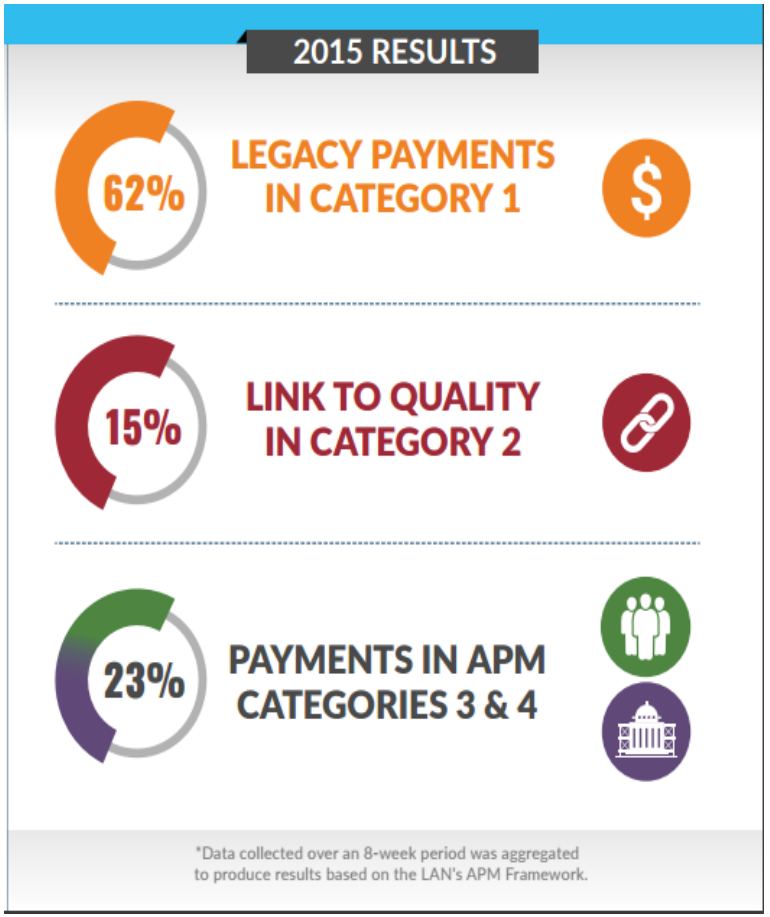
A new study reveals that nearly one in three non-elderly cancer patients are not taking their prescribed drug regimens because they can't afford it.

Zheng et al. CANCER 20 Feb 2017

Fueled by the high cost of health care, the demand for value-based care is growing

In 2015, >1/3 of all health care payments in the US were value-based - a process that grew dramatically in 2016.



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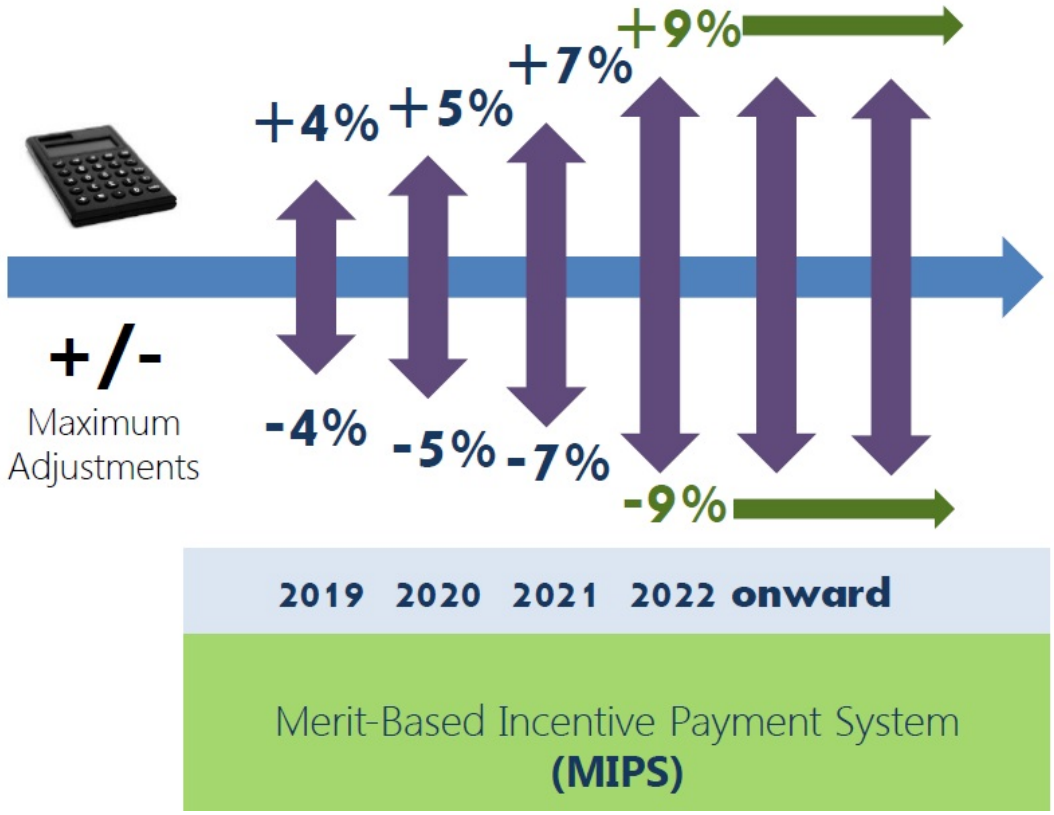
Under MACRA, Medicare's Quality Payment Program expedites the need for high-quality, cost-effective care



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What is the Oncology Care Model?

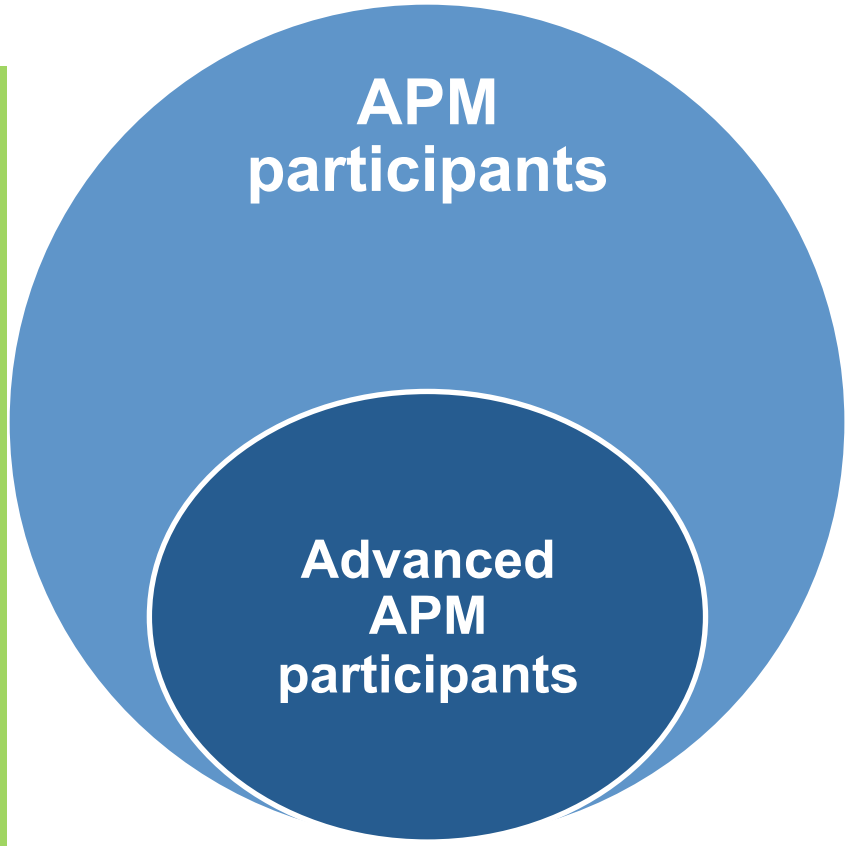
- **Payment for quality and cost→** Financial and performance accountability for episodes of chemotherapy administration by CMS and 17 commercial payers.
  - ✓ OCM practices provide enhanced care coordination, navigation, and adherence to national guidelines.

- **Two payment options→** Incentivizes quality and enhanced services via two forms of payment:
  1. A per-beneficiary *Monthly Enhanced Oncology Services* (MEOS) payment of $160 for the duration of the episode to assist practices to coordinate care and
  2. The *potential* for a performance-based incentive payment for reduced total cost of care and improved quality.

Automatic benefits for alternative payment model (APM) participation

The Oncology Care Model is an APM.

Those accepting downside risk in 2018 will be in an Advanced APM and qualify for an automatic 5% bonus under the Medicare QPP.



What do OCM practices have to do?

- Provide enhanced services, including:
  - The core functions of patient navigation;
  - A care plan that contains the 13 components in the IOM Management Plan outlined in "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis";[2]
  - Patient access *24 hours a day, 7 days a week* to an appropriate clinician who has real-time access to practice's medical records; and
  - Treatment with therapies consistent with *nationally recognized clinical guidelines.*
- Use data to drive continuous quality improvement.
- Use certified electronic health record technology.

OCM-FFS Quality Measures that Affect Performance-Based Payment

OCM #	Measure Description	Source
OCM-1	Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode	Claims
OCM-2	Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode	Claims
OCM-3	Proportion of patients who died who were admitted to hospice for 3 days or more	Claims
OCM-4a	Oncology: Medical and Radiation – Pain Intensity Quantified (NQF 0384/PQRS 143)	Practice
OCM-4b	Oncology: Medical and Radiation – Plan of Care for Pain (NQF 0383/PQRS 144)	Practice
OCM-5	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (NQF 0418/ eCQM CMS2.6.3)	Practice
OCM-6	Patient-Reported Experience	Survey
OCM-7	Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer (NQF 0390/PQRS 104)	Practice
OCM-8	Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	Practice
OCM-9	Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer (NQF 0559)	Practice
OCM-10	Trastuzumab administered to patients with AJCC stage 1 (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy (NQF 1858)	Practice
OCM-11	Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387/eCQM CMS140v5.0)	Practice
OCM-12	Documentation of Current Medications in the Medical Record (NQF 0419/eCQM CMS68v6.1)	Practice

OCM-FFS Risk Arrangement Options

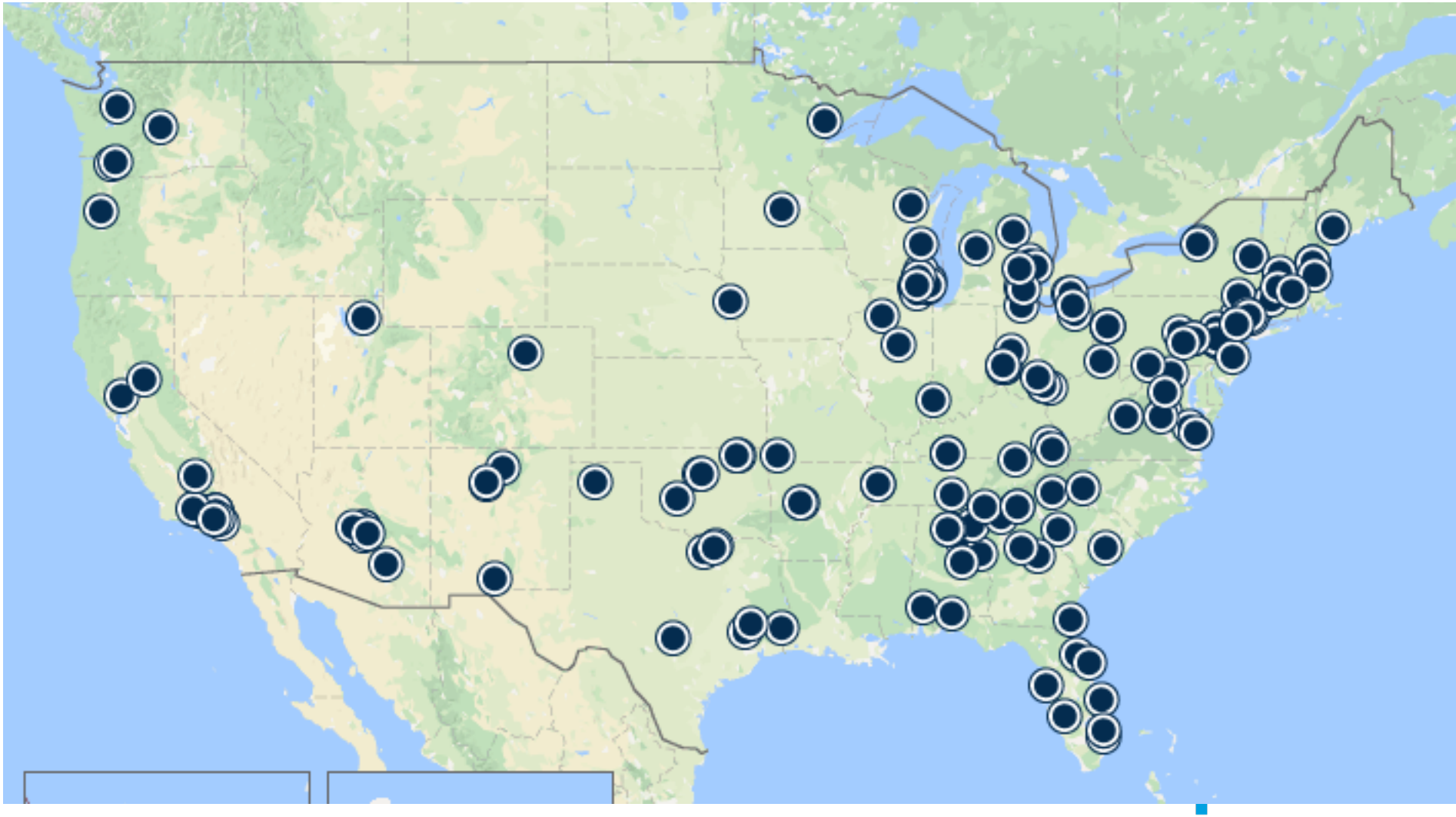
One-Sided

- OCM practices are NOT responsible for Medicare expenditures that exceed the target price
- Medicare discount = 4%
- *Must qualify for performance-based payment by mid-2019 to remain in one-sided risk*

Two-Sided

- OCM practices are responsible for Medicare expenditures that exceed target price
- Option to take two-sided risk begins in 2018
- Medicare discount = 2.75%

190 practices, 17 payers + CMS



Success in value-based care depends on:

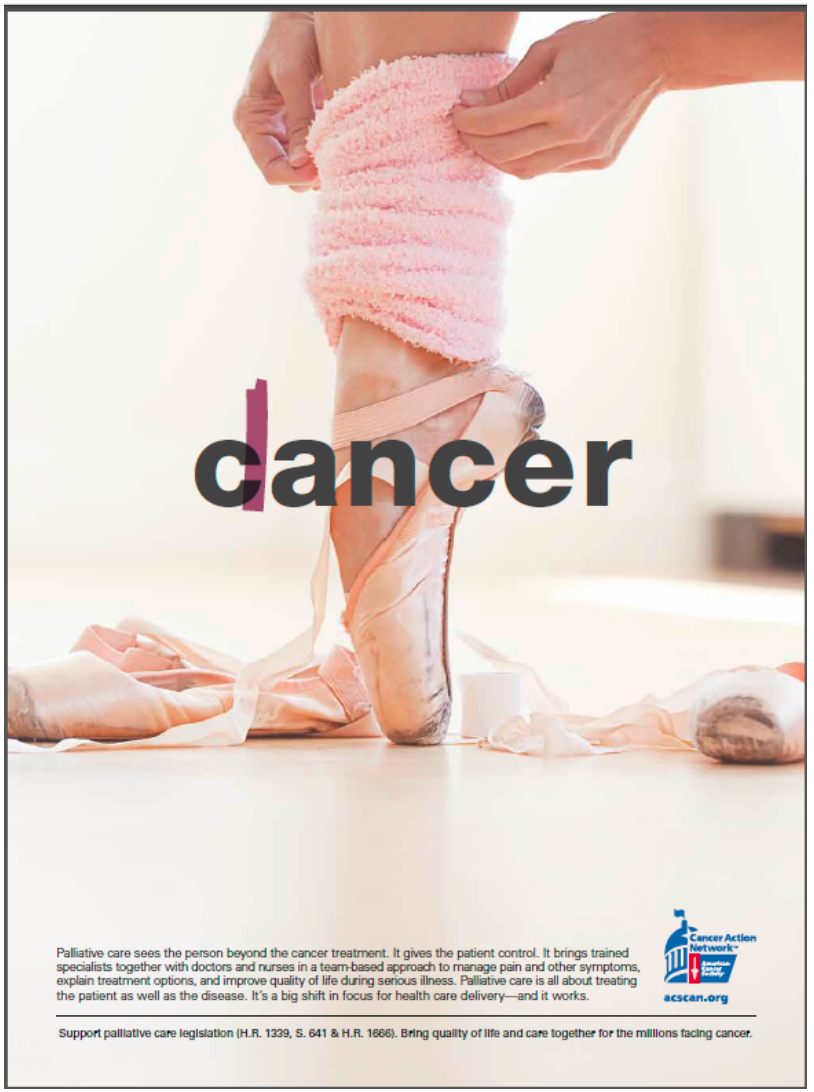
- Attention to the **Patient Experience**
  - Assessment and treatment of pain, depression, and other symptoms
- Efficient **Health Services Utilization**
  - Reduced ED and hospital use
  - Improved hospice utilization and length-of-stay
  - Keeping **Costs below Target**

Better Patient Experience at Lower Cost

Palliative Care = better quality →lower cost

Palliative Care is:

- → Medical care focused on quality of life by providing relief from the symptoms and stresses of serious illness
- → Appropriate at any age and any stage of illness
- → Provided along with curative treatment as an added layer of support



Early concurrent palliative care *delivers a better patient experience*

- Dramatic reduction in depression (16% vs. 38%)
- Higher score on FACT-L (quality of life measure: 98.0 vs. 91.5%)
- *Increased survival by 2.7 months*

Temel JD, Greer JA, Muzikansky A, et al. Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer, New England Journal of Medicine, August 19 2010:733-742

Early concurrent palliative care *controls utilization*

Early versus late referral to palliative care for decedents:

- ➔ Reduced hospital admissions (33% vs. 66%)
- ➔ Reduced ED use (34% vs. 54%)
- ➔ Reduced ICU use (5% vs. 20%)

Scibetta C, Kerr K, Mcguire J, Rabow MW. The costs of waiting: implications of the timing of palliative care consultation among a cohort of decedents at a comprehensive cancer center. Journal of Palliative Medicine, Nov 30, 2015

Early concurrent palliative care *delivers cost savings*

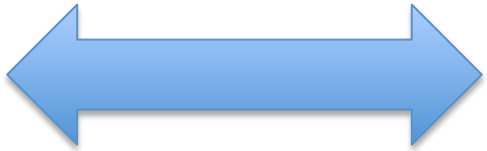
- Early palliative care shifts expenditures from inpatient to outpatient and hospice
- Over $2,500 saved per case

- *Greer JA, Tramontano AC, McMahon PM, et al, Cost Analysis of a Randomized Trial of Early Palliative Care in Patients with Metastatic Non-small-Cell Lung Cancer, Journal of Palliative Medicine, November 8, 2016 Vol 18 (8): 842-848*

How does palliative care achieve the Triple Aim? *Case Study - Bernard*

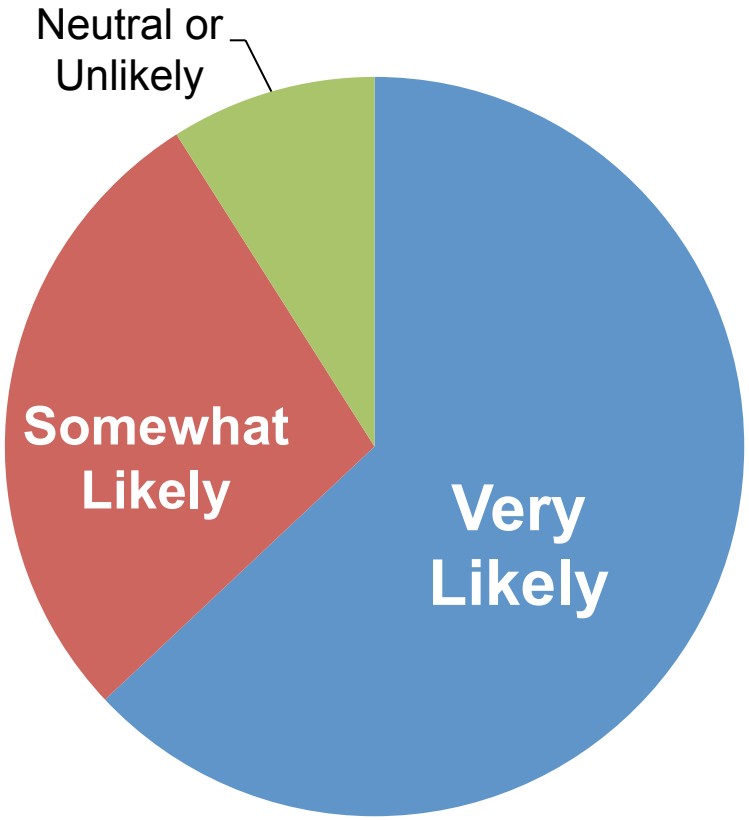
- Stage III pancreatic cancer, with "terrible" pain
- Overwhelmed and exhausted wife – calls 911 for *third* time. Bernard admitted to hospital.
- Palliative care consult called
  - low-dose morphine, bowel regimen, prescribed and monitored
  - Social services (meals-on-wheels, respite care) added
- Next Oncologist visit, wife explains "it's the first time I've seen him smile for months."
- No ED visits 15 months so far . . .

How to provide early concurrent palliative care

Oncology Team  Palliative Care Specialist Team

Remember that Patients WANT Palliative Care

Once Informed, Consumers Want Palliative Care



Data from CAPC/ACS Public Opinion Strategies national survey of 800 adults conducted June 2011. www.capc.org

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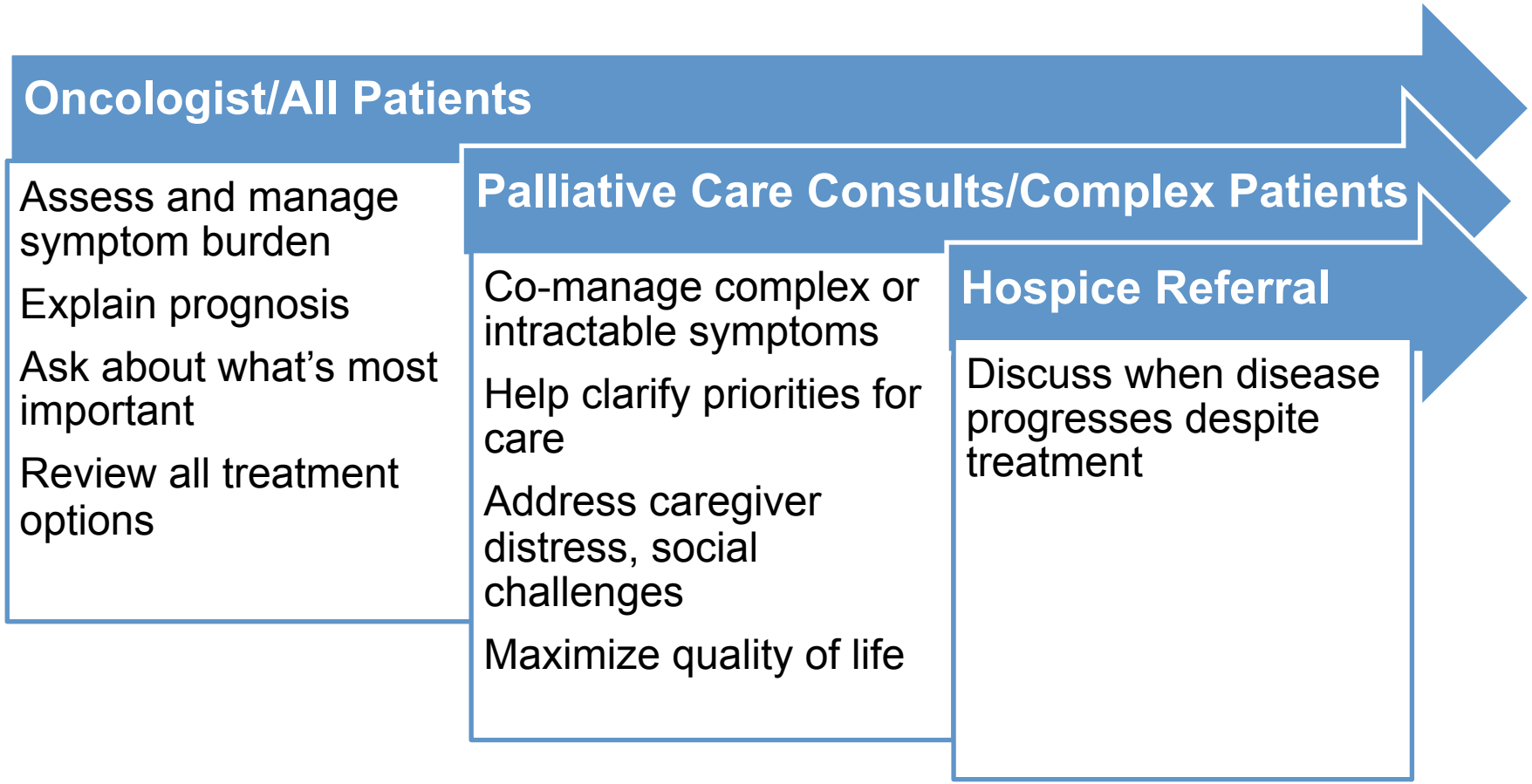
ASCO Clinical Practice Guideline, 2016

Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment.

Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.

https://www.asco.org/practice-guidelines/quality-guidelines/guidelines/supportive-care-and-treatment-related-issues#/9671

ASCO and AAHPM Joint Statement Provides Guidance on Defining and Providing High-Quality Palliative Care



Easier said than done: We didn't get this stuff in medical school

OCM participation means oncology teams must conduct:

- ➔ Expert and effective pain and symptom management (the #1 reason for 911 calls);
- ➔ Skilled communication about achievable and affordable priorities for care; and
- ➔ Coordination over time and across settings.

SUPPORT IS AVAILABLE THROUGH THE CENTER TO ADVANCE PALLIATIVE CARE

Providing tools, training and technical assistance on the care of those with serious illness www.capc.org

Communication skills for Oncologists

Communication Skills				
Delivering Serious News	Discussing Prognosis	Clarifying Goals of Care	Conducting a Family Meeting	Advance Care Planning Conversations

Pain management for Oncologists

Pain Management						
Comprehensive Pain Assessment	Matching the Drug Class to the Pain	Patient Factors that Influence Prescribing Decisions	Assessing Risk for Opioid Substance Use Disorder	Opioid Trials: Determining Design, Efficacy and Safety	Prescribing an Opioid	Prescribing Short-Acting Opioids: Four Case Studies
Monitoring for Opioid Efficacy, Side Effects and Substance Use Disorder	Converting from Short-Acting to Long-Acting Opioids	Prescribing Practice and Opioid Conversations	Advanced Conversations and Opioid Side Effects	Special Populations and Patient-Controlled Analgesia	Managing Pain in Patients at Risk for Substance Use Disorder	Pain Management: Putting it All Together

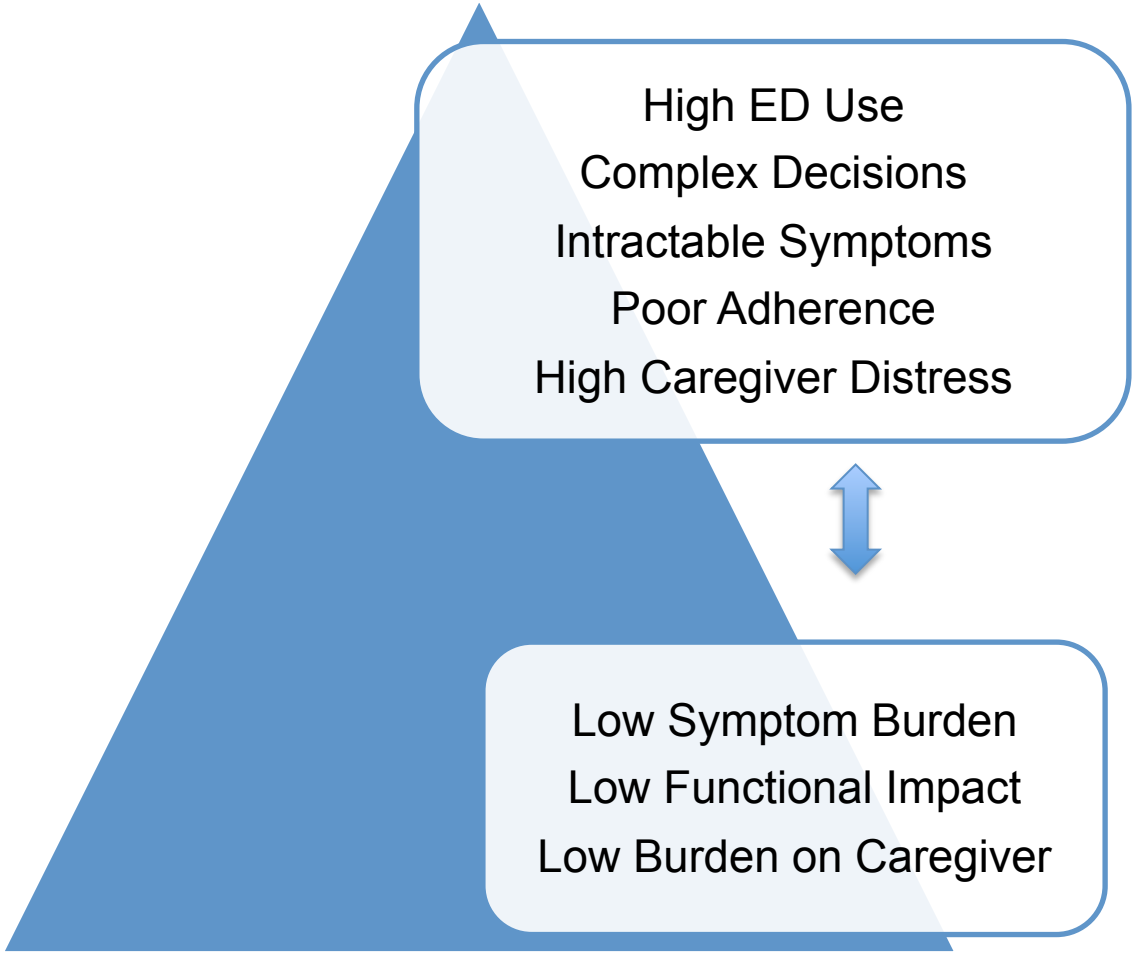
Symptom management for Oncologists

Symptom Management				
Shortness of Breath	Constipation	Nausea & Vomiting	Anxiety	Depression

Over 1,000 hospitals and health systems are members and all staff have access to CAPC resources

- Online training in difficult patient conversations
- Online training in pain and symptom management
  - Includes safe opioid prescribing
- CMEs and CEUs for all staff
- Best practice assessment tools
- Best practice conversation guides
- Access to experts during webinars, virtual “office hours”
- Peer support

Palliative care specialists for highest complexity cases



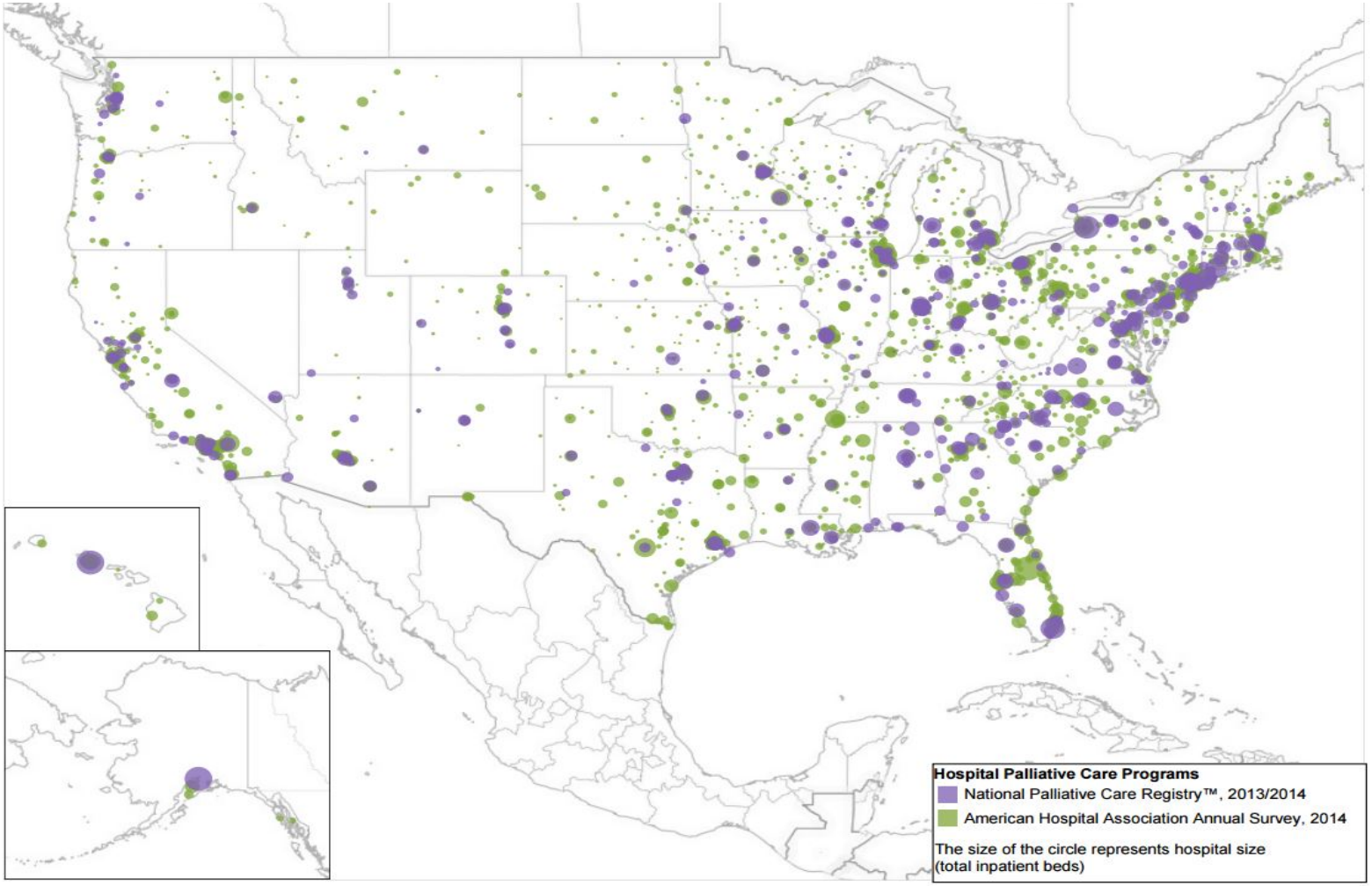
These are the patients that would benefit from palliative care consults and/or co-management

Using consultants is the standard of practice in medicine

We already do this . . .

We need to do the same with this . . .

Many oncology practices already have access to palliative care specialists



www.getpalliativecare.org

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Some cancer centers are embedding palliative care teams into their practice

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How does concurrent palliative care work? *Case Study - Jenny*

- Metastasized lung cancer, responding to new treatment
- Oncologist and Palliative Care Specialist co-managed Jenny for more than 2 years as disease progressed
  - Cancer treatments overseen by Oncologist
  - Pain and symptom management overseen by Palliative Care consultant
- When disease progressed, patient entered hospice

CAPC resources can help with value-based care success

	Measure Description	Potential Risks to Practice	How Strong Palliative Care Skills Mitigate the Risks	CAPC Skill-Building Resources	The Role of a Specialty Palliative Care Team
OCM-1	**Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode**	Poorly managed pain or other symptoms send patient to ED, where they are admitted for their medical complexity	Appropriate management of pain and symptoms	• Online CE courses in pain and symptom management • Master Clinician guidance	Effective response to pain and symptom crises 24/7
OCM-2	**Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode**	Poorly managed pain or other symptoms send patient to ED Poorly understood disease progression or side effects results in alarm and an ED visit	Appropriate management of pain and symptoms Strong clinician communication ensures patient and family comprehension	• Online CE courses in pain and symptom management, communication skills • Master Clinician guidance	Effective response to pain and symptom crises 24/7

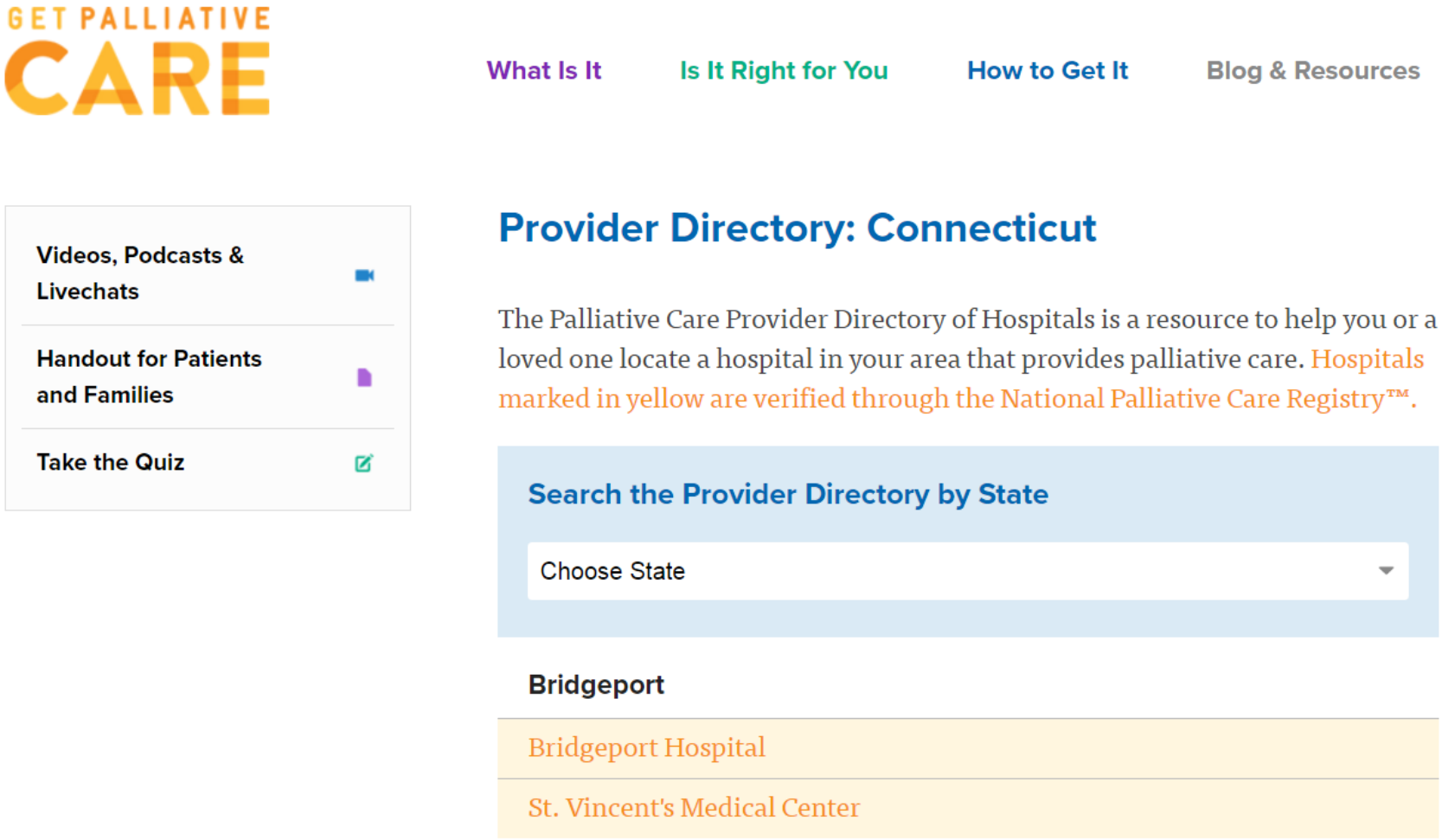
CAPC resources can help with value-based care success

	Measure Description	Potential Risks to Practice	How Strong Palliative Care Skills Mitigate the Risks	CAPC Skill-Building Resources	The Role of a Specialty Palliative Care Team
OCM-3	**Proportion of patients who died who were admitted to hospice for 3 days or more**	Inadequate communication early or throughout the course of treatment makes hospice seen as "giving up" – something to avoid	Strong clinician communication ensures shared decision-making throughout the course of treatment	• Online CE courses in communication skills • Master Clinician guidance	Bring up the hospice option without scaring the patient to death; Added layer of support during treatment eases transition to hospice
OCM-4a/4b	**Oncology: Medical and Radiation –Pain Intensity Quantified & Plan of Care for Pain**	Inadequate pain assessment and management– uncertainty on range of pain management options	Pain assessment tool understood and strong pain assessment skills SAFE and EFFECTIVE management of pain	• Online CE courses in pain management • Pain assessment tools	Consulting on intractable or complex pain management, including risk for substance use disorder

CAPC resources can help with value-based care success

	Measure Description	Potential Risks to Practice	How Strong Palliative Care Skills Mitigate the Risks	CAPC Skill-Building Resources	The Role of a Specialty Palliative Care Team
OCM-5	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan**	Inadequate depression assessment and planning due to focus on oncology treatment	Depression assessment tool routinized into work flow and appropriate management of depression	• Online CE course in depression management • Depression assessment tools	Consulting and supportive counseling role for anxiety and depression Attention to spiritual, family, social/financial issues
OCM-6	**Patient-Reported Experience**	Poorly managed pain or other symptoms leaves patients feeling unattended Poor clinician conversations – including avoided conversations – leave patients feeling unconnected	Safe and effective management of pain and symptoms Strong clinician communication about difficult topics improves patient experience Advance directives help patients feel heard and in control	• Online CE courses in pain and symptom management, communication skills, including advance care planning • Master Clinician guidance	Team can supplement Oncologist's time for meaningful discussions and difficult decisions Team can support ongoing advance care planning over time

Palliative care is an added layer of support. Website for your patients:



Virtual Office Hours with CAPC Experts

- Do you have questions or want more info on any of the topics discussed today? Join small group Q&A calls on any of the following dates:
  - 3/14: 3pm ET
  - 3/21: 2pm ET
  - 3/30: 1pm ET
- Office hours registration information will be sent in follow up e-mail to all webinar participants

Upcoming Webinar

Matching Treatments to Values:

Sharpening Person-Centered Communication Skills and Strategies

Anthony Back, MD
University of Washington and
Fred Hutchinson Cancer
Research Center
Seattle

Cofounder **Vitaltalk.org**

VITAL talk