PATIENTS have clear and accurate information to make informed care decisions

PHYSICIANS generate ideas to support better decision making and more efficient, evidence-based care

PAYERS and HEALTH SYSTEMS create innovative mechanisms to encourage and reward best practices
National Initiatives

ASCO Guidelines

NQF National Quality Forum

QOPI The Quality Oncology Practice Initiative

Commission on Cancer

NCCN National Comprehensive Cancer Network

Choosing Wisely An initiative of the ABIM Foundation

American Society of Clinical Oncology

CANCER LINQ Learning Intelligence Network for Quality

Five Things Physicians and Patients Should Question
Why Launch the Value in Cancer Care Initiative?

• We are **broad**, quality metrics are often highly specific
• We start at our end goal – a **better patient experience**
• We think about **costs**
• We are **committed** to developing metrics that everyone can understand
• We have the **opportunity** to test specific programs to improve care
• We don’t want to report for reporting sake, we want to report to **drive changes**
Process for Success

• Build a regional **consortium of stakeholders** invested in improving value in cancer care

• Support a regional **learning cancer care system**

• **Collaborate** to prioritize opportunities and metrics

• Drive **value concepts** into the process

• Facilitate **community-based research** to learn what works

• Embed **transparency** into all aspects
Welcome

Your participation makes this effort possible

Thank You
National Context

Daniel Wolfson, MHSA | Executive VP, Chief Operating Officer, ABIM Foundation
The Value of Value Metrics

Thomas Brown, MD, MBA | Executive Director, Swedish Cancer Institute
Value in Cancer Care Initiative: Overview

- A coalition of provider groups, payers, patient advocacy groups and policy-makers who are working to define, collect and share oncology value measures.
  - The measures must be meaningful, feasible to collect, and actionable.

- Employ an interactive, inclusive, and iterative process to identify opportunities and ultimately test interventions to improve care.
Improving Value: Unique Challenges for Oncology

- Sense of urgency as many cancer patients have a poor prognosis and are facing imminent death
- Pressure to use newest technologies/treatments
- Treatments expensive, making appropriate cancer care a hardship or unaffordable
- Treatments can be highly toxic/life-threatening
- Providers often reluctant to switch to best supportive care, even at end of life

Source: 2009 IOM Report: Assessing and Improving the Value in Cancer Care
Motivation for change

US health spending is 17.7% of GDP and rising
Higher spending does not increase life expectancy
Patients are bearing more of the costs
Cancer care costs rising faster than overall healthcare costs
Our Opportunity as a Region

• **Translate** national policy perspective to regional implementation

• Opportunity to develop **demonstration** projects and **scale up**

• Opportunity for our state to serve **national leadership role** in implementation
Participation Benefits

- Lead the process (get a jump on coming changes)
- Understand trends, costs and outcomes in your own system
- Regional comparison
- Articulate regional vision and priorities
- Improving value of care
- Improve patient experience
- Shared priority setting
Process Overview &
2014 Summit Results

Gary Lyman, MD, MPH | Hutchinson Institute for Cancer Outcomes Research
The First Step: 2014 Summit

- The Summit opened an engaging, highly interactive dialogue
  - 70+ participants representing 20 different organizations
- Over 750 unique metrics were proposed
- Formal prioritization and consensus building process, emphasizing transparency
Evaluation Criteria

✓ Desirability
  - Actionable
  - Clinically relevant
  - Meaningful to multiple stakeholders

✓ Feasibility
  - Ease to collect
  - Acceptable to report State-wide
Results of Consensus building

Prioritization of top ranked areas/metrics:

- **Desirability**
  - A: Biomarker / molecular testing
  - B: Adherence to primary therapy guidelines
  - C: Financial transparency, access to counseling
  - D: Use of navigator, care coordinator, case manager
  - E: Multidisciplinary plan of care
  - F: Re-admittance
  - G: Documentation of consult / conversation about palliative care / hospice
  - H: Rate of chemo in last 14 days of life
  - I: Early detection
  - J: Consistent reporting of symptoms
  - K: Oral systemic therapy
  - L: Staff training in safety

- **Feasibility**

Top Six
Top Six Metrics

- Rate of chemotherapy in last 14 days of life
- Documentation of conversation or consultation about hospice or palliative supportive care
- Re-admittance and Rate of avoidable ED visits
- Use of navigator, care coordinator, case manager
- Adherence to primary therapy guidelines and appropriate use of targeted therapies
- Biomarker and molecular testing
Post-Summit Survey

![Bar chart showing general support and willingness to report for various topics such as EoL, Chemo, Palliative, ED visits, Navigator, Guidelines, and Biomarker.](image_url)
High level Process

Brainstorm, prioritize & build consensus around areas of interest & metrics

JAN 2014: VCC SUMMIT

Broad community input to refine metrics

MAY 2014: TOWN HALL

Pilot data collection and reporting; Data integration and report generation

FALL 2014: DATA

Demonstration project promoting best practices; Intervention design

2015: SUMMIT

Align cancer care with BEST PRACTICES: IMPROVING OUTCOMES and DECREASING VARIATION

Today
Domain: Palliative Care

Information about the measure would appear here, including: literature support, context of development, and similar existing metrics.

- Lorem ipsum dolor sit amet, consectetur adipiscing elit.
- Quisque sit amet metus eget enim volutpat consectetur eu et libero.
- Curabitur sit amet arcu a elit interdum laoreet.
- Aliquam accumsan risus nec lobortis pellentesque.

Rate of chemotherapy in last 14 days of life

Inclusion Criteria:
- Any cancer type
- Advanced stage
- Patient died
- [Specific criteria here]

Measure:
- Chemotherapy in the last 14 days of life
- [Specific details here]

REGIONAL RATE: 10%

Rate by Participating Clinic

Limitations:
- A list of specific limitations will appear here.
- Curabitur sit amet arcu a elit interdum laoreet.
- Aliquam accumsan risus
Metric Discussion & Refinement

Gary Lyman, MD, MPH | Scott Ramsey, MD, PhD
Hutchinson Institute for Cancer Outcomes Research
We need your input for these metrics to be valuable benchmarks for our region
Three Domains for Prioritized Metrics

End of life and palliative care
1. Rate of chemotherapy in last 14 days of life
2. Conversation or consultation about hospice or palliative supportive care

Coordinated and efficient care
3. Re-admittance & rate of avoidable ED visits
4. Use of navigator, care coordinator, case manager

Best practices
5. Adherence to primary therapy guidelines, appropriate use of targeted therapies
6. Biomarker and molecular testing
End of Life and Palliative Care

1. Rate of chemotherapy in last 14 days of life
2. Conversation or consultation about hospice or palliative supportive care

VALUE RATIONALE
Better quality of life and lower costs by minimizing futile therapy in weeks prior to death. Better management of symptoms and expectations at all phases of care.

Patients: Understand goals of treatment. Understand risks and benefits of chemotherapy for terminal cancer. Advocacy transforms culture so that palliative care is not seen as “giving up.” Enjoy better quality of life.

Providers: Have tools to convey information and support recommendations for end of life and palliative care.

Payers: Support novel delivery of palliative care and reimburse for difficult conversations and tools for providers. Minimize payment for futile treatments.
Concerns, Barriers and Discussion

- Rate of chemotherapy in last 14 days of life
- Conversation or consultation about hospice or palliative supportive care

› Is “14 days” the right timeframe?
› Use of All Cause Death versus disease-related death?
› Defining of palliative care and hospice
› Addressing culture implications of palliative care, i.e. false perception that palliative care is ‘giving up’
› When is the conversation most pertinent, i.e. at diagnosis, start of treatment, or disease?
› Messaging and transparency
Coordinated and Efficient Care

3. Re-admittance & rate of avoidable ED visits
4. Use of navigator, care coordinator, case manager

VALUE RATIONALE

Infrastructure that allows patients timely access to necessary care while eliminating duplicate and inefficient care

**Patients:** Receive clear instructions and plans for treatment and appropriate management of symptoms. 24-hour access to non-ED care when difficulties—pain, nausea, etc.—arise. Mechanism for shared communication and coordination

**Providers:** Minimize care fragmentation. Better coordination and clinical efficiency. Ability to provide and reimbursement for infrastructure that supports enhanced services.

**Payers:** Avoid paying for duplication, hospitalizations and inefficiencies. Streamline preauthorization. Payment mechanisms will support enhanced services.
Concerns, Barriers and Discussion

- Re-admittance & rate of avoidable ED visits
- Use of navigator, care coordinator, case manager

› Should we focus on re-admittance or ED visits?
› Is “avoidable” ED visits a necessary qualifier?
› Defining ‘case manager’ or ‘care coordinator’?
› Focusing on the existence versus utilization of a program?
› Standardization?
Best Practices

5. Adherence to primary therapy guidelines, approp. use of targeted therapies
6. Biomarker and molecular testing

VALUE RATIONALE
Leverage the capacity of evidence-based research to lower costs and improve outcomes

Patients: Understand evidence-based options for their treatment through education, treatment plans, and/or novel tools.

Providers: Seamless integration of best practices into their care pathways.

Payers: Minimally intrusive payment policies drive value-based care.
Concerns, Barriers and Discussion

- Appropriate biomarker and molecular testing
- Appropriate use of primary therapy based on biomarker

› Which guidelines/therapies/molecular testing procedures are supported by the literature? AND may be under- or over-utilized, i.e. low adherence?

› Rapidly evolving paradigm

› Are there specific disease groups where there is more/less interest, utilization, and opportunity for improvement?
  - Biomarker: HER2, KRAS, EGFR, Oncotype DX
Closing Thoughts

Scott Ramsey, MD, PhD | Hutchinson Institute for Cancer Outcomes Research
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*FALL 2014: DATA*

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*2015: SUMMIT*

Align cancer care with BEST PRACTICES: IMPROVING OUTCOMES and DECREASING VARIATION
“You cannot operate a system that gathers data about patient experience, synthesizes available science, applies it to the patients at hand, and tracks your performance without substantial resources and expertise.”

- Mark Smith, MD, MBA

CEO of California HealthCare Foundation
Our Ask

- Engage
- Lead
- Advocate
VALUE in CANCER CARE TOWN HALL

THANK YOU