QUALITY INITIATIVES IN ONCOLOGY....

DON’T WE ALREADY DO THAT?

Texas Society of Clinical Oncology
Fall Conference
2012
QUALITY ONCOLOGY INITIATIVES

- Defining Quality Health Care/Cancer Care
- What “Structured Systems” are we now working with?
- Why are these Quality Systems important to us?
- How do we best utilize the Systems currently available?
WHAT IS QUALITY HEALTHCARE/ONCOLOGY?

“I know it when I see it”

This does not work so well anymore!
Institute of Medicine – defines healthcare quality as the extent to which health services provided to individuals and patient populations improve desired health outcomes. The care should be based on clinical evidence and provided in a competent manner...

That’s it, we do that, we fit that, are we done?
WHAT IS QUALITY HEALTHCARE/ONCOLOGY?

- How does Medicare define quality – Sherry Ling, MD – Deputy Chief Medical Officer CMS says, “quality care is not yet fully defined, but to CMS quality care means safe, well coordinated and centered around patients and their families. Evidence of good outcomes is important and the delivery of care should be monitored through structured systems that are beginning to emerge.”
WHAT IS QUALITY HEALTHCARE/ONCOLOGY?

- CMS narrows the definition, with a focus on outcomes and then throws in this “little” piece about monitoring and reporting through structured systems.

- In Oncology what are these structured systems, who is developing them and why should we expend the blood, sweat and cash to develop them and use them in our practice?
Not more than 7 years ago very few measures of quality existed in Oncology not to mention structured systems to monitor them...

- NCCN – provided guidelines
- PQRI (now PQRS) – touched on a couple of measures that could be applied to Oncology
Structured Quality Measurement Systems

- Today... plethora of quality measures and reporting systems... some that are specific to Oncology.

- Many have been developed and implemented by CMS with the continued focus on......

“Paying for Value not Volume.”
PQRS

- CMS foray into pay for performance
- 190 measures in 2011
- Incentive payments until FY2015 when penalty will be imposed
- 2% penalty once fully rolled out in 2015
- There is a hospital version that is being used as a basis for withhold in FY2013
### 2011 Physician Quality Reporting Initiative

**Measure Specifications Manual for Claims and Registry Reporting of Individual Measures**

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
<th>Reporting Options</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>72</td>
<td>Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients</td>
<td>C, R</td>
<td>173</td>
</tr>
<tr>
<td>79</td>
<td>End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD</td>
<td>C, R</td>
<td>179</td>
</tr>
<tr>
<td>81</td>
<td>End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients</td>
<td>R</td>
<td>181</td>
</tr>
<tr>
<td>82</td>
<td>End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis</td>
<td>R</td>
<td>183</td>
</tr>
<tr>
<td>83</td>
<td>Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia</td>
<td>R</td>
<td>186</td>
</tr>
<tr>
<td>84</td>
<td>Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment</td>
<td>C, R</td>
<td>188</td>
</tr>
<tr>
<td>85</td>
<td>Hepatitis C: HCV Genotype Testing Prior to Treatment</td>
<td>C, R</td>
<td>191</td>
</tr>
<tr>
<td>86</td>
<td>Hepatitis C: Antiviral Treatment Prescribed</td>
<td>C, R</td>
<td>194</td>
</tr>
<tr>
<td>87</td>
<td>Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment</td>
<td>C, R</td>
<td>197</td>
</tr>
<tr>
<td>89</td>
<td>Hepatitis C: Counseling Regarding Risk of Alcohol Consumption</td>
<td>C, R</td>
<td>200</td>
</tr>
<tr>
<td>90</td>
<td>Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy</td>
<td>C, R</td>
<td>202</td>
</tr>
<tr>
<td>91</td>
<td>Acute Otitis Externa (AOE): Topical Therapy</td>
<td>C, R</td>
<td>205</td>
</tr>
<tr>
<td>92</td>
<td>Acute Otitis Externa (AOE): Pain Assessment</td>
<td>C, R</td>
<td>207</td>
</tr>
<tr>
<td>93</td>
<td>Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use</td>
<td>C, R</td>
<td>209</td>
</tr>
<tr>
<td>94</td>
<td>Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility</td>
<td>C, R</td>
<td>211</td>
</tr>
<tr>
<td>99</td>
<td>Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade</td>
<td>C, R</td>
<td>213</td>
</tr>
<tr>
<td>100</td>
<td>Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade</td>
<td>C, R</td>
<td>216</td>
</tr>
<tr>
<td>102</td>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients</td>
<td>C, R</td>
<td>219</td>
</tr>
<tr>
<td>104</td>
<td>Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients</td>
<td>C, R</td>
<td>222</td>
</tr>
<tr>
<td>105</td>
<td>Prostate Cancer: Three-Dimensional (3D) Radiotherapy</td>
<td>C, R</td>
<td>225</td>
</tr>
<tr>
<td>106</td>
<td>Major Depressive Disorder (MDD): Diagnostic Evaluation</td>
<td>C, R</td>
<td>228</td>
</tr>
<tr>
<td>107</td>
<td>Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
<td>C, R</td>
<td>232</td>
</tr>
<tr>
<td>108</td>
<td>Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy</td>
<td>C, R</td>
<td>234</td>
</tr>
<tr>
<td>109</td>
<td>Osteoarthritis (OA): Function and Pain Assessment</td>
<td>C, R</td>
<td>237</td>
</tr>
<tr>
<td>110</td>
<td>Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old</td>
<td>C, R</td>
<td>239</td>
</tr>
<tr>
<td>111</td>
<td>Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older</td>
<td>C, R</td>
<td>241</td>
</tr>
</tbody>
</table>
EHR - Meaningful Use

- Again driven by CMS for certified EHRs
- A total of 20 measures to be reported
- Process and quality measures included (PQRS included again)
- Incentives up to $44,000 per physician over 5 years
- 2015 penalties start for non participation
Meaningful Use

Measures:

1. Use CPOE for medication orders entered by provider who can enter orders into the medical record. (This is physician orders being input electronically into the EMR)
2. Implement drug-drug and drug-allergy interaction checks. (This is done with Medi-span)
3. Maintain an up to date problem list of current and active diagnoses.
4. Generate and transmit permissible prescriptions electronically (E-Scribe)
5. Maintain active medication list (MA’s obtain this information)
6. Maintain active medication allergy list (MA’s obtain this information)
7. Record preferred language, gender, race, ethnicity, and DOB for patients.
8. Record and chart height, weight, blood pressure, and calculate BMI.
9. Record Smoking Status.
10. Report ambulatory clinical quality measures to CMS.
11. Provide patients with an electronic copy of their health information.
12. Implement one clinical decisions support rule relevant to specialty or high clinical priority along with the ability to track that rule.
13. Provide clinical summaries for patients at each office visit within 3 business days.
14. Capability to exchange key clinical information among providers of care and patient authorized entities electronically (HIE).
15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. (Conduct a security risk assessment).

Menu Objectives:

1. Implement drug formulary checks (Medi-Span).
2. Incorporate clinical lab test results into the EHR (interfaces with Lab Corp/Quest).
3. Generate list of patients by specific conditions to use for quality improvement. (i.e. breast cancer patients >50, ER/PR +, stage IV).
4. Use EHR technology to identify patient specific education resources and provide those to the patient when appropriate.
5. Capability to submit electronic data to immunization registries (provided via interface). Provide patients with an electronic copy of their health information
E – Prescribe

+ Another CMS driven initiative – again incentives to start...penalties ongoing
+ 25 E-Prescribes per unique traditional Medicare patients per physician annually
+ 1% penalty if no reporting in 2012
+ 1.5% penalty in 2013
+ Incentives to participate in 2011 to be paid in October 2012
QOPI

- ASCO Initiative – payers becoming interested-Aetna Humana and United
- Comprehensive review of process of Oncology Care through medical record abstraction
- More focus on outcomes and survivorship coming in the future
- Site visits by reviewers starting in earnest to evaluate actual processes for chemo administration in reference to policies
- Specific to Oncology practice – 3 year certification
## QOPI® THE QUALITY ONCOLOGY PRACTICE INITIATIVE

Summary of Measures, Fall 2012

<table>
<thead>
<tr>
<th>Module</th>
<th>#</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>1</td>
<td>Pathology report confirming malignancy*</td>
</tr>
<tr>
<td>Core</td>
<td>2</td>
<td>Staging documented within one month of first office visit*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0386 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>3</td>
<td>Pain assessed by second office visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0383/#0384 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>4a</td>
<td>Pain intensity quantified by second office visit (includes documentation of no pain)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0384 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>5</td>
<td>Plan of care for moderate/severe pain documented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0383/#0384 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>6</td>
<td>Pain addressed appropriately (defect-free measure, 3, 4a, and 5)*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0383 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>6a</td>
<td>Pain assessed on either of the two most recent office visits (Test Measure)</td>
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<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0383/#0384 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>6b</td>
<td>Pain intensity quantified on either of the two most recent office visits (Test Measure)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0383/#0384 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>6c</td>
<td>Pain addressed appropriately on either of the two most recent office visits (defect-free measure, 6a, 6b, and 6c) (Test Measure)</td>
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<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0383/#0384 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>6d</td>
<td>Pain addressed appropriately on either of the two most recent office visits (defect-free measure, 6a, 6b, and 6c) (Test Measure)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0383/#0384 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>6e</td>
<td>Pain addressed appropriately by second office visit and during most recent office visits (defect-free measure, 6 and 6d) (Test Measure)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NQF Endorsed #0383/#0384 (adapted)</td>
</tr>
<tr>
<td>Core</td>
<td>7</td>
<td>Effectiveness of narcotic assessed on visit following prescription</td>
</tr>
<tr>
<td>Core</td>
<td>8</td>
<td>Constipation assessed at time of narcotic prescription or following visit</td>
</tr>
<tr>
<td>Core</td>
<td>9</td>
<td>Documented plan for chemotherapy, including doses, route, and time intervals*</td>
</tr>
<tr>
<td>Core</td>
<td>10</td>
<td>Chemotherapy intent (curative vs palliative) documented*</td>
</tr>
<tr>
<td>Core</td>
<td>11</td>
<td>Chemotherapy intent discussion with patient documented</td>
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<tr>
<td>Core</td>
<td>12</td>
<td>Number of chemotherapy cycles documented</td>
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<tr>
<td>Core</td>
<td>13</td>
<td>Chemotherapy planning completed appropriately (defect-free measure, 9, 10, and 12)</td>
</tr>
<tr>
<td>Core</td>
<td>13a</td>
<td>Performance status documented prior to initiating non-curative chemotherapy regimen (Test Measure)</td>
</tr>
<tr>
<td>Core</td>
<td>13oral1</td>
<td>Documented plan for oral chemotherapy (defect-free measure, 13oral1a-13oral1e) (Test Measure)</td>
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<tr>
<td>Core</td>
<td>13oral1a</td>
<td>Documented plan for oral chemotherapy: dose (Test Measure)</td>
</tr>
<tr>
<td>Core</td>
<td>13oral1b</td>
<td>Documented plan for oral chemotherapy: administration schedule (days of treatment/rest and planned duration) (Test Measure)</td>
</tr>
</tbody>
</table>
STRUCTURED QUALITY MEASUREMENT SYSTEMS

- NCQA
  - PPC/PCMH
  - Broad Review of process from patient registration to care management to electronic communication
  - Focused on practice structure and process
  - Criteria constantly updating – may be looking at outcomes and survivorship in the future
  - Specific OMH criteria also coming in the future
  - Blue Cross of Texas using NCQA as a physician designation item
**Table 1: PPC 2006 to PPC-PCMH Crosswalk**

**SCORING IN PPC-PCMH:**
1. The number of overall points is the same but in some cases the distribution has changed:
   - The number of points increased for some elements.
   - As indicated below, some standards and elements have been added and others have been deleted.

2. One of the scoring options at the element level changed:
   - Increased from 20%-25%.

3. The number of factors increased in some elements but this did not change the scoring for those elements.

<table>
<thead>
<tr>
<th>PPC 2006 and PPC-PCMH Standards</th>
<th>PPC 2006 and PPC-PCMH Element Titles</th>
<th>PPC 2006 Points</th>
<th>PPC-PCMH Points</th>
<th>Description of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPC 2006 and PPC-PCMH Standards</td>
<td>PPC 1A: Access and communication processes</td>
<td>4</td>
<td>4 Must-Pass</td>
<td>Added factor: Identifying health insurance resources for patients without insurance.</td>
</tr>
<tr>
<td>PPC 1B: Access and communication results</td>
<td>4</td>
<td>5 Must-Pass</td>
<td>None</td>
<td></td>
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<tr>
<td>PPC 2B: Electronic system for clinical data</td>
<td>3</td>
<td>3</td>
<td>Added factor: Head circumference for patients ≤2 years</td>
<td></td>
</tr>
<tr>
<td>PPC 2C: Use of electronic clinical data</td>
<td>3</td>
<td>3</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>PPC 2D: Organizing clinical data</td>
<td>6</td>
<td>6 Must-Pass</td>
<td>Added factor: Screening tool for developmental testing and growth charts.</td>
<td></td>
</tr>
<tr>
<td>PPC 2E: Identifying important conditions</td>
<td>4</td>
<td>4 Must-Pass</td>
<td>Added explanation for risk factors associated with practice’s demographics.</td>
<td></td>
</tr>
<tr>
<td>PPC 2F: Use of system for population management</td>
<td>2</td>
<td>3</td>
<td>Added factor: Patients who might benefit from care management. Added explanation for pediatrics.</td>
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</tr>
</tbody>
</table>

**PPC-PCMH Changes, Additions or Deletions**

<table>
<thead>
<tr>
<th>PPC-PCMH Changes, Additions or Deletions</th>
<th>Standards</th>
<th>Elements</th>
<th>Factors</th>
<th>Explanation</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
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Structured Quality Measurement Systems

- Pathways
  - 3-4 vendors in the market
  - Compliance used as a quality indicator
  - All generally based on NCCN guidelines
  - Many times considered a tool to manage process of care – create standardization and measurable outcomes
So why should we invest in all these “structured systems and........what do we do with them?
WHY INVEST IN QUALITY SYSTEMS?

- ACA – Obamacare – Value Based Payment Modifiers
- Medical Home & Shared Savings Programs
- ACO’s & Market Consolidation
- Payment Cuts and Bundled Payment Structures
WHY INVEST IN QUALITY SYSTEMS?

- Medical Home & Shared Savings Programs
  - PCPs picking up value and momentum in the new healthcare environment
  - PCMH contracts with shared savings in place with PCPs in most major market with most payers
  - Shared Savings programs now utilized by Medicare in pilots (ACOs, Pioneer ACOs, MSS) 33 quality measures
  - In all cases shared savings payouts contingent on meeting defined quality parameters
  - Specialists challenged to prove standardization and quality to participate in the referral network
WHY INVEST IN QUALITY SYSTEMS?

 It really happens!

+ Our group began a conversation with a large PCP group about their PCMH with several payers...the first question to us...."how do we know you provide quality care?"

+ Our options for responding...
  a. Because we said so....
  b. We “typically” follow national guidelines
  c. Pathways in place for standardization
  QOPI Certified
  NCQA Recognition
  Meaningful Use attested
WHY INVEST IN QUALITY SYSTEMS?

- ACOs & Market Consolidation
  - Large markets seeing rapid consolidation of hospitals and physicians and accelerated development of ACOs
  - Goals of ACOs as defined by ACA
    - Promote use of Evidence Based Medicine – standardization/pathways
    - Promote Patient Engagement – Meaningful Use
    - Report on Quality and Cost
    - Coordinate Care - common reporting
ACO & Market Consolidation (cont)

- Specialists will compete for ACO participation based on proven ability to meet these goals – Documented Value
- As Oncology practices in competitive markets we must be prepared for these negotiations with hospital and payer based ACOs as well as Medicare...remember Medicare is adding 7000 new members to the roster every day this year!
WHY INVEST IN QUALITY SYSTEMS?

- It is already happening......
  - CMMI grant for OMH submitted on behalf of a group of practices across the country...ultimately to be a shared savings program...
  - Qualifying criteria from CMS for each practice to participate...
    - Clinical Pathways in place
    - QOPI Certified
    - NCQA Recognition in process
WHY INVEST IN QUALITY SYSTEMS?

- Payment Cuts and Payment Models like Bundled payments - JUST WONT GO AWAY!

- Current SGR System is unsustainable economically and politically
- The impact of payment cuts on the quality/value of care is indefinable without standard quality measures
- All alternative payment systems (shared savings, bundled payments, OMH, QRUR) tie payment to measured quality and value..NOTE – The Center for American Progress (Ezekiel Emanuel) is currently recommending to CMS that by 2022, 75% of all payments should be through a bundled system..also recommends removal of all in office ancillary exemptions unless you are in a bundled system
WHY INVEST IN QUALITY SYSTEMS?

Payment Models (cont.)
+ Valuing your piece of the Bundle – How do you negotiate your component of the bundle?
  ❌ Cost Plus – Not Likely
  ❌ Scope of Services – No one understands it
  ❌ Measured Value – A Value Equation – tied to quality/outcomes and savings

+ Bonus Payments to Payers for “your” Quality services –
  ❌ ACA currently provides for bonus payments to Medicare Advantage plans with 4 or 5 star ratings based on performance on defined quality measures including PSS – assumed that exchanges will adopt the same model – for practices invested in quality structures this is something to keep in mind during negotiations with these entities.
WHY INVEST IN QUALITY SYSTEMS?

- Won’t all these ACOs and Bundled Systems go away in few years just like the 1990s?
  - Today Feds leading the charge under the banner of Quality and Value - $Billions available in Grants, Shared Savings, ACOs and tied to quality scores
  - In 90s Hillary Care focused on costs...very little meaningful discussion about quality...certainly no focus on Value
  - In 90s the Lexicon revolved around Gatekeepers with locked-in networks and referral requirements
  - Today Lexicon is all about Value Based Purchasing and Evidence Based Medicine. Large Integrated Networks promote coordination and value through electronic interchange
WHY INVEST IN QUALITY SYSTEMS?

Won’t all these ACOs and Bundled Systems go way in few years just like the 1990s? (cont)

Today PCPs and Specialists on the same team often employed by the same entity – common goals – NOTE
- Current prediction are that by 2017 80% of Oncologists will be working for hospitals or systems – today it is 50% - 5 years ago it was 20%

Value Based Purchasing nomenclature loved by Washington, Media and ultimately the public -Note
- there is even a new Value Based Cancer Association - AVBCC

Today, the technology is available and in many cases in place to support the efforts –

Also remember SGR is unsustainable
WHAT DO WE DO WITH ALL THESE QUALITY SYSTEMS?

- Identify a person in your practice who can carry the flag for the development and use of quality systems.
- Use all the quality systems available, evaluate them and help improve them – feedback is being asked for and is essential – Ex. QRUR.
- As a Specialty we must collectively agree on a defined set of quality/value measures. We must proactively get involved in the development of the tools and the definitions before they are permanently defined for us.
- We should talk to the payer market about these issues every chance we get – we must define the measures and the dialogue but it must be collective and consistent.
WHAT DO WE DO WITH ALL THESE QUALITY SYSTEMS?

- Many societies and organizations are involved in defining quality measures and payment methodologies
  - ASCO
  - ACS – Clinical Affinity Groups
  - COA
  These groups are actively proposing alternatives to House Ways and Means, Senate Finance, Energy & Commerce

- Facilitate these conversations in your own practices and use Forums such as TXSCO to stay involved and participate in the efforts underway to define Value Based Care
QUESTIONS