

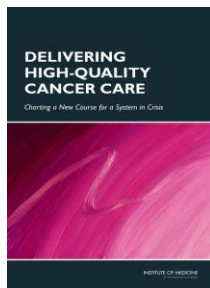
Linking Registries, EHRs and Comprehensive Care Programs to Drive Quality in Cancer Care

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Charting a New Course for a System in Crisis



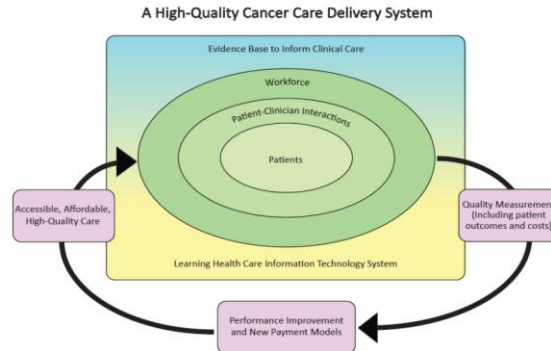
Institute of Medicine
2013

Care often is not patient-centered, many patients do not receive palliative care to manage their symptoms and side effects from treatment, and decisions about care often are not based on the latest scientific evidence.

IOM Recommendations to improve the quality of cancer care

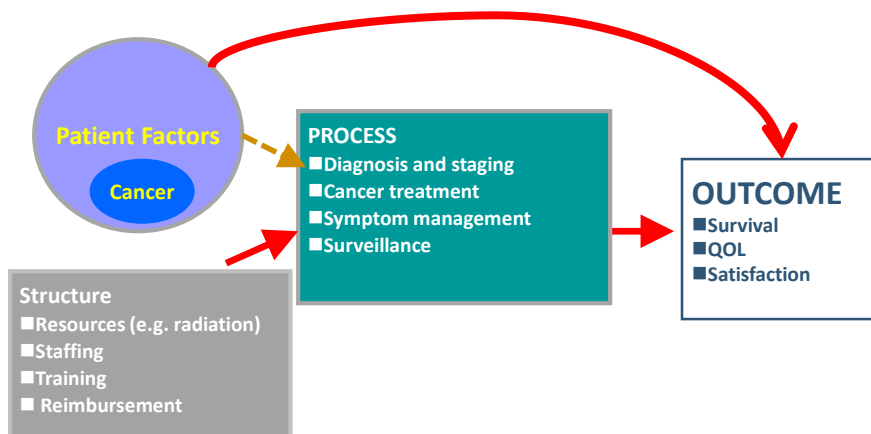
- A national quality reporting program with meaningful quality measures
- Improve the affordability of cancer care by leveraging existing efforts to reform payment and eliminate waste
- Reimbursement aligned to reward affordable, patient-centered high quality care

IOM highlights importance of quality measurement and new payment models



Delivering on IOM Recommendations to Chart a New Course will require quality measurement to be used for accountability

Framework for Measuring Quality of Care



Charting a new course for quality cancer care

Surveillance

Quality Improvement

Accountability



*To make progress on the quality and affordability of cancer care will require that we shift quality measurement from efforts focused largely on surveillance and QI to **accountability***

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Data Sources

Payer	Practice	Hospital
<ul style="list-style-type: none">• Claims data• Pharmacy data• Data collected for administrative purposes – e.g. pre-authorization	<ul style="list-style-type: none">• EHR data• Billing data• Medical record data (paper)	<ul style="list-style-type: none">• EHR data• Billing data• Medical record data (paper)• Registry data

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Present
ed by:

Data Elements included in Data Sources for Cancer Quality Measurement

	Cancer Registry	Claims	Medical Record	Patient Self-report
Diagnosis of cancer	Yes	Yes	Yes	Yes
Timing of diagnosis	Yes	No	Yes	Yes
Tumor size	Yes	No	Yes	No
Stage	Yes	No	Yes	No
Patient refusal	No	No	Yes	Yes
Comorbidity	No	Yes	Yes	Yes
Contraindications	No	No	Yes	?

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Utility of Administrative Data for Measure Quality of Cancer Care and Other Outcomes

	Definition	Availability
Case Identification	Diagnosis of cancer	Cannot differentiate incident vs. prevalent
Disease characteristics	Stage, biomarkers	Not available (except ICD-9 codes for mets)
Comorbid conditions	Chronic health conditions	Medical claims
Diagnostic testing	Imaging, lab tests	Medical claims
Treatment	Infusions, oral medications	Medical and pharmacy data
Hospitalizations	Admissions	Medical claims
Providers	Practices, facilities	Medical claims provider ID
Cost	\$ paid for service, episode	Medical claims
Outcomes	PFS, OS	Not available
Patient preferences	PROs	Not available

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Potential Methods of Attribution

Payer	Practice	Hospital
<ul style="list-style-type: none"> Provider with most visits Provider with any visits Provider with most chemo billed Provider with any chemo billed Highest cost provider 	<ul style="list-style-type: none"> Any patient with visit within last year Any patient with chemotherapy in last year New patients in last year 	<ul style="list-style-type: none"> Cancer registry Any admission Any chemotherapy billed Most chemotherapy billed

Table 3. Medicare-Reimbursed Care Delivered by Physicians to Their Assigned Patients.^{a,c}

Physician and Practice Characteristics	No. (%)	Percentage of Physicians' Medicare Patients Who Were Assigned to Them		Percentage of Total Visits That Were with Assigned Patients		Percentage of Evaluation and Management Visits That Were with Assigned Patients ^d		Total Charges Billed That Were for Care of Assigned Patients ^e	
		median	IQR	median	IQR	median	IQR	median	IQR
All Community Tracking Study physicians	8604 (100)	12	2–37	20	3–60	40	17–77	205	6–648
Specialty ^f									
PCPs	5527 (45)	39	14–57	62	23–77	77	56–87	467	42–1293
All medical specialists	1406 (25)	6	1–14	10	1–28	28	15–49	186	2–477
Oncologists	97 (2)	28	21–34	62	53–70	66	56–74	1616	619–6637
Cardiologists	213 (4)	7	3–13	17	9–32	34	21–52	945	198–1591
Neurologists	114 (2)	7	4–12	14	7–21	21	15–31	205	23–277
Dermatologists	88 (2)	7	4–10	10	7–17	15	12–21	233	80–227
Surgeons	1261 (23)	9	4–14	14	7–23	18	10–27	136	12–147
Emergency medicine physicians	390 (6)	0	—	0	—	6	0–16	0	—
Practice size and type									
1 or 2 physicians	3092 (36)	16	4–46	26	7–69	46	17–83	311	18–838
3–10 physicians	1696 (22)	11	4–27	20	7–50	31	16–68	323	27–793
11–50 physicians	633 (8)	9	2–34	17	4–60	33	17–74	333	16–1007
≥51 physicians	279 (3)	11	1–35	23	2–63	46	18–75	228	1–994
Medical school	555 (7)	9	2–22	15	2–42	28	15–60	61	2–154
All other	2349 (25)	8	0–37	13	0–59	51	17–79	40	0–341
PCPs only ^g	5527 (45)	47	20–68	70	33–86	87	68–94	541	53–1458

^a The numbers of physicians are unweighted, and all percentages are weighted. Assignments of patients to individual physicians were made using the plurality provider algorithm, first allowing for assignments to any physician and then allowing for assignment to only primary care physicians. Medians were based on Medicare claims billed by 8604 Community Tracking Study physician survey respondents for 1.79 million beneficiaries they treated in 2000 and were weighted with Community Tracking Study survey weights. We excluded beneficiaries under 65 years of age, those with end-stage renal disease or disability, and those who did not have claims in 2000. IQR denotes interquartile range, and PCP primary care physician.

^b Charges are reported as relative value units, derived from the Physician Fee Schedule tables of the Centers for Medicare and Medicaid Services.²⁰

^c Estimates of the percentage of physicians' evaluation and management visits that were with assigned patients were based on the subgroup of 7630 Community Tracking Study physicians who billed for at least one evaluation and management visit in 2000 (4955 primary care physicians, 1309 medical specialists, 1245 surgeons, and 121 emergency medicine physicians).

^d Specialty data were missing for 20 physicians. Selected types of medical specialists are listed.

^e Assignment was to any physician except for these data, for which assignment was to PCPs only.

Initiatives to Measure Cancer Care Quality



PQRS

PCHQR



QCP
QOPI Certification Program
Quality Cancer Care: Recognizing Excellence

QOPI THE QUALITY ONCOLOGY
PRACTICE INITIATIVE

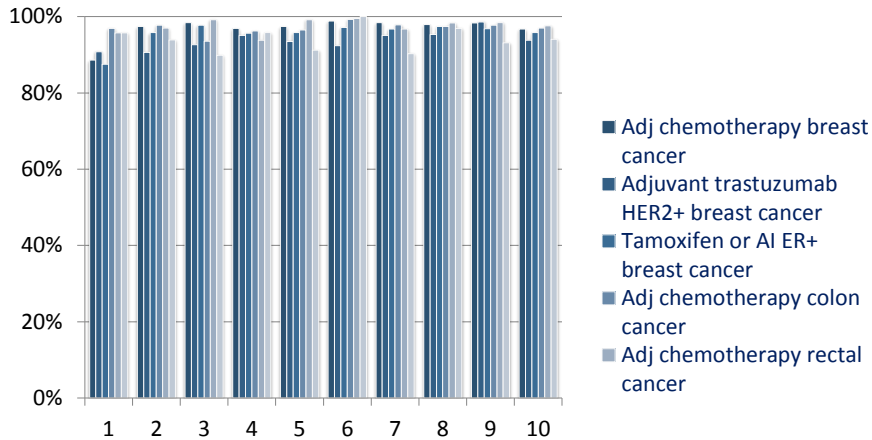
Quality Cancer Care: Pursuing Excellence

Existing Cancer Quality Measures

	Process Measures	Outcome Measures	NQF Endorsed
JCAHO	5	0	0
RAND QATOOL	117	0	0
RAND ASSIST	41	0	4
Commission on Cancer	8+	0	6
ASCO QOPI®	134	16*	43
AMA PCPI	21	0	16
PPS Exempt Cancer Centers	3†	2	5
Dartmouth Atlas	0	11*	0
OSHPD	0	2	0
30-day post-surgical mortality	0	7	1

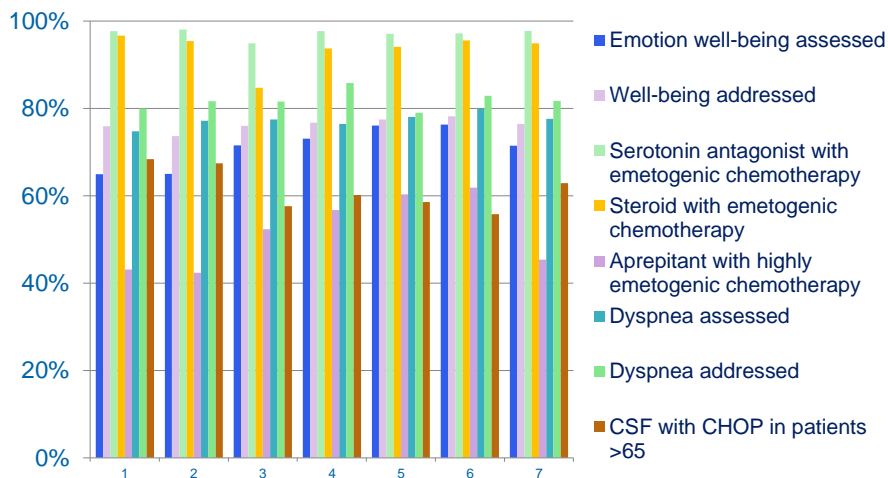
ASCO Quality Oncology Practice Initiative (QOPI)

Very high adherence to adjuvant therapy quality indicators



ASCO Quality Oncology Practice Initiative (QOPI)

Little change in quality of supportive care over time



Cancer surgery outcomes vary substantially by hospital volume

Adjusted Perioperative Mortality and Survival for Cancer Surgery Hazard of Death at Lowest Volume vs. Highest Hospitals

Cancer Type	Adjusted Perioperative Mortality	Adjusted 5-Year Survival	Adjusted 5-Year Conditional Survival*
Colon	1.23	1.12	1.10
Esophagus	1.76	1.34	1.29
Liver	2.11	1.21	1.08 [†]
Lung	1.31	1.09	1.06
Pancreas	2.26	1.22	1.13
Rectal	1.33	1.18	1.17
Stomach	1.43	1.13	1.10

[†] NS

Bilimoria K Y et al. JCO 2008;26:4626-4633

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Gaps in cancer quality measures

Lack of variability on many of the NQF endorsed measures of quality limits utility of measures for public reporting or P4P

- Many measures are not be specific enough (e.g. any adjuvant therapy)
- Low scores often represent data problems – public reporting of these measures would lead to resources being spent on data infrastructure/quality

Few validated outcome measures

Few measures of overuse

No measures of patient experience

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Our model: a Quality Initiative

The **Cancer Care Quality Program** provides a framework for **rewarding high quality cancer care**

Oncologists participating in the Cancer Care Quality Program will receive **additional payment** for treatment planning and care coordination when they select a treatment regimen that is **on Pathway**

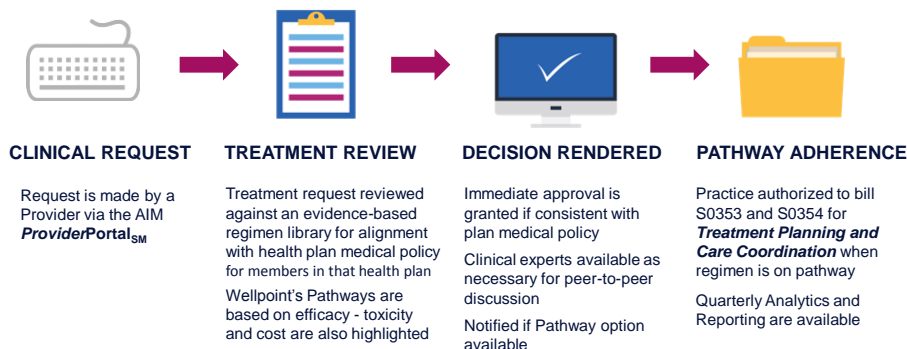
Web-based platform with decision-support for Quality Initiative also **improves efficiency** of review against Health Plan Medical Policy and **decreases administrative burden** for practices



www.cancercarequalityprogram.com

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Cancer Care Quality Program administered by AIM Specialty



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The WellPoint Cancer Care Quality Program will be administered by WellPoint subsidiary AIM Specialty Health, a separate company

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Clinical data entered by practice staff through web portal

Practice identifies patient

Selects drugs in regimen

Enters clinical info:

- Cancer type
- Disease stage
- Biomarkers
- Performance Status
- Line of therapy

ProviderPortal

Order Request

[Logout](#)

Step: 1 2 3 4 5 6

Step 4: Please enter Patient Clinical Details. Data will be automatically saved in the system.

Refresh
Save and Exit

Joe Demo - Male
 Height: 65in | Weight: 165lb | BSA: 1.85

Enter Diagnosis

* Pathology: Select Pathology

* Stage: Select Stage

* ICD9: 162.9 Malignant neoplasm of bronchus and lung, unspecified site

Performance Status:

* Line of Treatment: Select Line of Treatment

Previous
Save and Continue

Clinical detail: stage and biomarkers

Here we will collect more detailed information regarding your patient's diagnosis

Please confirm:

- Specific cancer type
- Disease stage
- Bio-Markers as needed
- Line of treatment
- Performance Status

PATIENT2 TEST - Female

Enter Diagnosis

Height: 65in | Weight: 165lb | BSA: 1.85

Regimen Selected: TAC [Taxotere (Docetaxel), Adriamycin (Doxorubicin) and Cytoxan (Cyclophosphamide)] (Adjuvant/ After Surgery)

Enter Diagnosis

* Pathology: Adenocarcinoma - Invasive Lobular Carcinoma ✓

* Stage: IIA ✓

* ICD9: 174.4 Malignant neoplasm of upper-outer quadrant of female breast

* Bio-Markers & Tumor Characteristics:

Estrogen Receptor: Positive ✓

HER2/NEU: Negative ✓

Menopausal Status: Post-Menopausal ✓

OncotypeDX® Breast: Not reported ✓

Progesterone Receptor: Negative ✓

* Line of Treatment: Adjuvant/ Post-operative ✓

* Performance Status: 1 - Symptoms present but ambulatory without restriction ✓

Pathway option available

Based on the information you entered, you may be offered an alternative Pathway regimen. By choosing a Pathway regimen, your practice will be eligible for enhanced reimbursement

Choose "View Details" for additional information.

Consider Alternative Regimens			
All evidence-based regimens available for the patient are below. Please consider selecting a Pathway () regimen that meets the patient clinical scenario. To proceed with the current regimen click "Save and Continue".			
Name	Line of Treatment	Stages	Actions
<input checked="" type="checkbox"/> AC (Adriamycin (Doxorubicin) and Cyclophosphamide) every 2 weeks, followed by Taxol (Paclitaxel) Weekly (Adjuvant After Surgery)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> AC (Adriamycin (Doxorubicin) and Cyclophosphamide) every 3 weeks (Adjuvant After Surgery) (W)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> AC (Adriamycin (Doxorubicin) and Cyclophosphamide) every 3 weeks, Followed by Taxol (Paclitaxel) Weekly (Adjuvant After Surgery) (W)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> TC (Taxotere (Docetaxel) and Cyclophosphamide) (Adjuvant After Surgery)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> AC (Adriamycin (Doxorubicin) and Cyclophosphamide) every 2 weeks, followed by Taxol (Paclitaxel) every 2 weeks (Adjuvant After Surgery)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> AC (Adriamycin (Doxorubicin) and Cyclophosphamide) every 3 weeks, followed by Taxotere (Docetaxel) every 3 Weeks (Adjuvant After Surgery)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> Anastrozole (Arimidex) after Surgery (Adjuvant, Stage I-II)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> Anastrozole (Arimidex) after Initial Tamoxifen (Adjuvant After Surgery, Stage I-II)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> CMF (Cyclophosphamide, Epirubicin, Fluorouracil (5-FU)) (Adjuvant After Surgery)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details
<input checked="" type="checkbox"/> CMF (Cyclophosphamide, Methotrexate and Fluorouracil (5-FU)) (Adjuvant After Surgery)	Adjuvant Post-operative	I, IA, IB, IIA, IIB, IIC	View Details

Not perfect... but a way forward

Quality Measures

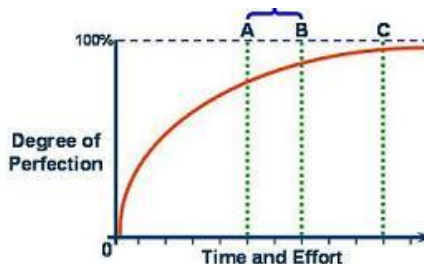
- Pay for performance based on pathway adherence
- Reporting to practices will include adherence to % of evidence-based regimens, NQF endorsed measures (e.g. hospice), hospitalizations

Data Sources

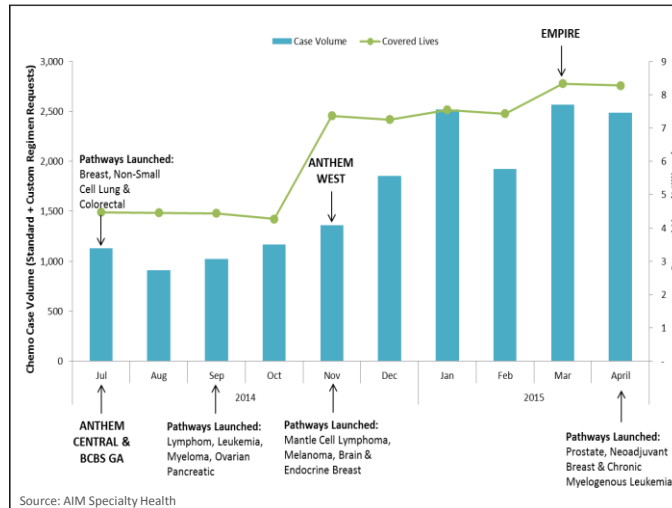
- Clinical data captured via portal
- Medical claims
- Pharmacy claims

Attribution

- Practice self identifies when registers patient with Program



Program growth since July 2014



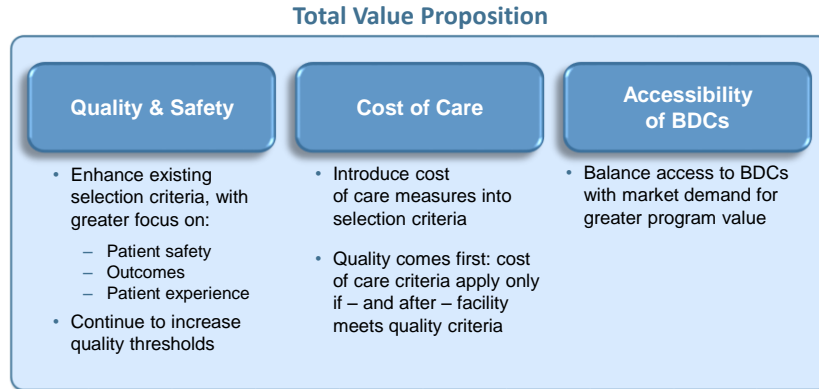
Where do we go from here?



A national designation awarded by Blue Cross and Blue Shield companies to hospitals and medical facilities that have demonstrated expertise in delivering quality healthcare in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery and transplants. The designation is based on objective, evidence-based selection criteria established in collaboration with expert physicians and medical organizations.

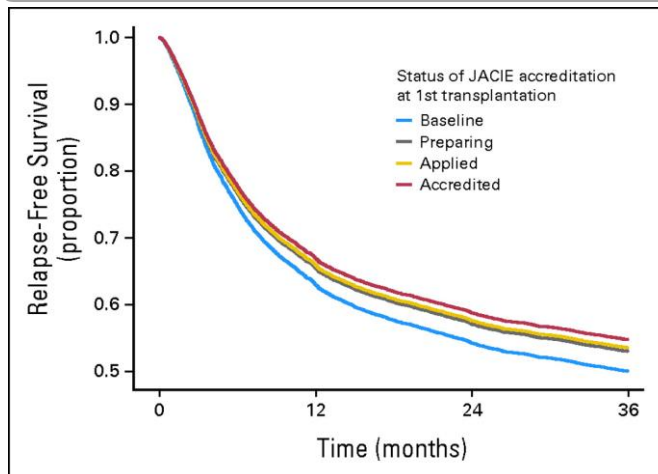
Refining Program to Meet Market Needs

The Blues are responding with a value-based approach



As always, each Blue Plan will decide independently how it handles pricing with respect to its own provider agreements.

Accreditation associated with better RFS after ASCT



~4% improvement in RFS per JACIE accreditation step resulting in an overall improvement of 14% (HR=0.86) for patients with chronic leukemia s/p allo-SCT in 2003.

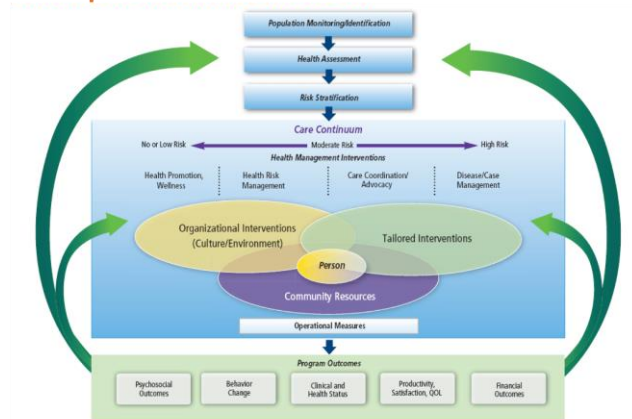
What about other outcomes?

Long Term Outcomes of ASCT

	All Survivors (N=324)	Siblings (N=309)
Health Condition		
No condition	84 (25.9%)	189 (61.2%)
Psychological Distress		
Somatization	35 (10.8%)	12 (3.9%)
Global distress	19 (5.9%)	10 (3.2%)
Health Care Utilization		
Medical contact	322 (99.4%)	308 (99.7%)
Cancer/HCT visit	182 (56.2%)	6 (1.9%)
Health Status		
Excellent/good	283 (87.6%)	292 (94.5%)
Fair/poor	40 (12.4%)	17 (5.5%)

New Focus: Population Health Management

Conceptual PHM Framework



Source: Care Continuum Alliance, Outcomes Guidelines Report, Vol. 5, 2010.

PHM will shift focus from procedure outcomes to disease and population outcomes

Long Term Outcomes of ~~ASCT~~ Acute Leukemia

	Health System A	Health System B
Survival		
1-yr RFS	??%	??%
Health Condition		
No condition	??%	??%
Psychological Distress		
Somatization	??%	??%
Global distress	??%	??%
Health Care Utilization		
Medical contact	??%	??%
Health Status		
Excellent/good	??%	??%

Discussion

