THE CRISIS IN CANCER CARE
VALUE REFORM FROM THE BRINK

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YALE CANCER CENTER
AGENDA

• The history of quality in cancer
• Cancer economics
• Cancer care at the end-of-life
• Specific initiatives
• Impact of healthcare reform
THE CRISIS IN CANCER CARE

1. Costs are escalating exponentially.
2. There are no federally mandated cancer quality standards or quality reporting system to provide comparative feedback.
3. Entrenched fee-for-service payment system rewards overutilization.
4. Patients with cancer face increasing financial stress.
5. Underutilization of hospice and overly aggressive care at the end-of-life.
1999 INSTITUTE OF MEDICINE

“There is no national cancer care program or system of care in the United States...Efforts to diagnose and treat cancer are centered on individual physicians, health plans, and cancer care centers. The ad hoc and fragmented cancer care system does not ensure access to care, lacks coordination and is inefficient in its use of resources.”
15 Years Later

- Oncologists still have few ways to benchmark their performance or track patient outcomes.
- EHRs lack critical discrete fields to extract outcomes or share data.
- Still no national policy to guide how or when in the trajectory of illness resources are used.
- Costs continue to escalate unsustainably.
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 reforming payment and eliminating waste
• Align reimbursement to reward affordable, patient-centered high quality care
MICHAEL PORTER’S VALUE EQUATION

VALUE = QUALITY OF CARE (OUTCOMES) / COST OF CARE

In cancer, we do not measure our numerator and cannot curtail the escalating denominator.

We have a value problem.
VALUE = QUALITY \times COST

NO NATIONALLY MANDATED SYSTEM FOR QUALITY MEASUREMENT OR REPORTING
THE ALLIANCE OF DEDICATED CANCER CENTERS

• Argued that because they were providing “state of the art cancer therapies and conducting research” they should be **exempt** from the Medicare Prospective Payment System that the 4500+ other hospitals in the United States are subject to.

• In 1983 Congress exempted 11 Cancer Centers from PPS.

• While all other hospitals have had to adapt to lower and lower *ceilings* in medicare reimbursement, in 1999 Congress enacted a new *floor* on the PPS exempt Center’s payments—guaranteeing continued high rates of reimbursement.
THE ALLIANCE OF DEDICATED CANCER CENTERS

Ohio State, Columbus OH
City of Hope, Los Angeles CA
Dana Farber, Boston MA
Fox Chase, Philadelphia, PA
Moffit, Tampa, FL
MD Anderson, Houston, TX
Memorial Sloan Kettering, NY, NY
Roswell Park, Buffalo, NY
Seattle Cancer Care, Seattle, WA
USC, Norris, Los Angeles, CA
Sylvester Cancer, Miami, FL
IMPACT ON QUALITY IN CANCER

• Exempted from PPS, these 11 cancer centers did not have to report ANY quality metrics.

• For all other hospitals providing cancer-care, payment has been linked to reporting of non-cancer metrics (CLABSI, surgical site infections, pressure ulcers, etc.)

• Institutions had no external pressure to follow evidence-based guidelines or monitor outcomes in the cancer-care they provided.
VALUE = QUALITY COST

ECONOMICS OF CANCER CARE
• In 2004 the US spent $72 billion on cancer care.
• This rose to $125 billion in 2010.
• Spending is projected to rise to $173 billion by 2020.
MAJOR COST DRIVERS

1. FFS PAYMENT SYSTEM INCENTIVIZES OVERUTILIZATION
2. RISING DRUG PRICES
3. INPATIENT HOSPITALIZATION AT THE END-OF-LIFE
DRUG COSTS

• R&D has flooded the market with targeted cancer therapies that cost >$10,000 per month.

• National shifts from less expensive office practice sites to more expensive hospital based facilities

• The FDA is not allowed to consider cost and value in their approval process.

• Medicare is **required** to pay for all FDA approved drugs.
Over one-third of spending is concentrated in the top 5 therapies

<table>
<thead>
<tr>
<th>Therapy Area</th>
<th>$Bn</th>
<th>% Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>27.9</td>
<td>9.2%</td>
</tr>
<tr>
<td>Antidiabetes</td>
<td>24.3</td>
<td>12.1%</td>
</tr>
<tr>
<td>Mental health</td>
<td>23.8</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>20.4</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Pain</td>
<td>18.7</td>
<td>4.1%</td>
</tr>
<tr>
<td>Autoimmune</td>
<td>17.9</td>
<td>18.0%</td>
</tr>
<tr>
<td>Lipid Regulators</td>
<td>13.6</td>
<td>-17.5%</td>
</tr>
<tr>
<td>Antihypertensives</td>
<td>12.5</td>
<td>-5.3%</td>
</tr>
<tr>
<td>HIV Antivirals</td>
<td>12.5</td>
<td>9.9%</td>
</tr>
<tr>
<td>Multiple Schirosis</td>
<td>10.6</td>
<td>20.7%</td>
</tr>
<tr>
<td>Anti-ulcerants</td>
<td>10.1</td>
<td>2.7%</td>
</tr>
<tr>
<td>ADHD</td>
<td>9.9</td>
<td>-3.9%</td>
</tr>
<tr>
<td>Dermatologicals</td>
<td>8.9</td>
<td>15.0%</td>
</tr>
<tr>
<td>Antibacterials</td>
<td>8.6</td>
<td>9.3%</td>
</tr>
<tr>
<td>Nervous System Disorders</td>
<td>8.1</td>
<td>16.0%</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>7.4</td>
<td>-22.2%</td>
</tr>
<tr>
<td>Vaccines</td>
<td>6.0</td>
<td>0.1%</td>
</tr>
<tr>
<td>Sex Hormones</td>
<td>5.8</td>
<td>9.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5.6</td>
<td>12.0%</td>
</tr>
<tr>
<td>Hormonal Contraceptives</td>
<td>5.6</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Source: IMS Health, National Sales Perspectives, Jan 2014
COST OF NEW CANCER DRUGS AT THE TIME OF FDA APPROVAL

- Cost of cancer drugs at the time of approval have increased by 10-fold since 1990
- Doubled over past decade from $4,500 to $10,000
- Data is controlled for inflation

Adapted from Bach (2009); Howard and Conti (2014)
TODAY

Private payers raise premiums to cover rising costs and government payers struggle to find effective models of cost containment in a political climate intolerant to healthcare rationing.
FINANCIAL BURDEN Shifts TO Patients

- An increasing proportion of the financial burden of cancer-care has shifted to patients.
- Patient responsibility: typically 20% of total cost
UNEMPLOYMENT
COPAYS
PREMIUMS
FINANCIAL TOXICITY
46% SPENT SAVINGS
46% CUT BASICS

Yousef Zafar, ASCO Quality 2014
2.65x RISK OF BANKRUPTCY

Yusef Zafar, ASCO Quality 2014

Ramsey et al, Health Affairs 2013
42% higher likelihood of non-adherence

Dusetzina et al, JCO 2013
IMPACT OF 340B

• In 1992 Congress created the 340 B program to provide **uninsured** patients access to prescription drugs.

• Requires pharmaceutical companies provide institutions that treat uninsured patients with rebates on drug prices.

• In 2005 medicare reduced payment for chemotherapy

• Immediately after, the 340 B program ballooned.
  – # of qualifying institutions grew from 591 to 1693.
  – Profitable middleman contract pharmacies increased in numbers from 3,785 to 30,046
Today, 340 B discounts are applied to insured patients at 340 B qualifying institutions.

Hospitals charge insurers full price for drug but get the drug at large discounts.

Duke University Health System, earned $292 million in profits from 340B patients over the past five years.

95% of the patients for which the hospital claimed 340B discounts had Medicare, Medicaid or private insurance.
Higher Drug Prices

340 B Eligible Institution

Pediatrics
Social Work
Psychiatry
Primary Care
OVERUTILIZATION OF ACUTE CARE AT THE END-OF-LIFE DRIVES COSTS AND REDUCES QUALITY
Figure LCC3: Estimates of the proportion of national expenditures for cancer care in 2010 by cancer site and phase of care.


Cost estimates expressed in 2010 dollars using CMS cost adjusters and adjusted for out-of-pocket expenditures, including co-payments and deductibles.

Estimates for the population younger than 65 were developed using ratios of cost in the young than 65 and older 65 populations from studies conducted in managed care populations.

NCI, Cancer Trends Progress Report, 2011/2012
COST OF CARE AT THE END-OF-LIFE

• Commercial insurance claims for >28,000 patients (2002-2009)
• Average cost of cancer care in the last six months of life was > $74,000.

55% was spent on inpatient costs
41% on outpatient
4% on hospice

Chastek B, JOP 2012
ACUTE INPATIENT CARE DRIVES COST AT THE END OF LIFE

Mean cost of inpatient hospitalization in the last two months of life: $20,559

Far greater than all other care combined

Chastek, JOP 2012
END OF LIFE CARE IS OFTEN DISCORDANT WITH PATIENTS’ STATED WISHES

• Most patients say that they prefer to die at home and that quality of life is their priority.

• Among 2009 Medicare beneficiaries with cancer:
  – 80% were hospitalized within 90 days of death
  – 27% were admitted to the ICU in the last month of life
  – 20% transitioned to hospice in their last 3 days of life with 40% of these having a preceding ICU admission.

AGGRESSIVE INTERVENTIONS WITHIN 30 DAYS OF DEATH AMONG YALE PATIENTS WITH ADVANCED SOLID TUMORS

Average time from discharge to death: <90 days

- 27% of our patients are admitted to the ICU
- 38% present to the ED and the average number of ED presentations is 2.3
- 52% are admitted to an acute care inpatient service and the average number of hospitalizations is 2.3
- 18% receive chemotherap
- 13% aggressive radiatio
- 3% undergo an aggressive surgical procedure
IMPACT OF PATIENT UNDERSTANDING ON CARE RECEIVED

- Multiple studies have shown that patients with advanced cancer often do not understand their actual prognosis.

- When they do not, they are more likely to receive aggressive care.

- The Cancer Care Outcomes Research and Surveillance (CANCORS) study reported that 69% of patients with metastatic lung cancer and 81% of those with metastatic colorectal cancer thought chemotherapy was curative. Weeks et al, NEJM 2012
Patients with metastatic cancer with an unplanned hospital admission die on average of 3.4 months after discharge.

75% are deceased by one year.

Rocque, JOP 2013
 Physicians’ Preferences for Hospice if They Were Terminally Ill and the Timing of Hospice Discussions With Their Patients

JAMA Internal Medicine

70.3 % of medical oncologists strongly agreed they would enroll in hospice if terminally ill with cancer.
DISCONNECT BETWEEN THE END-OF-LIFE CARE WE GIVE TO OUR PATIENTS AND WHAT WE WOULD CHOOSE FOR OURSELVES

• Goals of Care Discussions are time consuming, emotionally difficult, and most oncologists have not received formal training in conducting them.

• Ambulatory oncologic care follows a pattern of treatment followed by imaging. Conversations revolve around side effects, test results, and next line of therapy.

• Payment system encourages short visits and infusion billing, not lengthy conversations.

• Oncologists report that not offering further treatment feels like a failure.

• There is a worry that discussions of prognosis will harm patient and eliminate hope.
EVENTS WE USED TO CONSIDER THE COST OF DOING BUSINESS ARE NOW PREVENTABLE “NEVER EVENTS”

REPORTABLE TODAY

- CLABSI
- CAUTI
- SURGICAL SITE INFECTIONS
- PRESSURE ULCERS

ENDORSED METRICS FOR CANCER CARE AT THE END-OF-LIFE

- ICU WITHIN 30 DAYS OF DEATH
- CHEMOTHERAPY WITHIN 30 DAYS OF DEATH
- REPEATED HOSPITALIZATIONS AND ED VISTS
- NO PALLIATIVE CARE FOR STAGE IV DISEASE

WE WILL BE HELD ACCOUNTABLE FOR THESE IN THE NEAR FUTURE
MOST IMPORTANT AND UNDERAPPRECIATED FACTOR IN QUALITY IMPROVEMENT

SUSTAINABILITY
Standardized Criteria for Required Palliative Care Consultation on the Solid Tumor Oncology Service
Kerin Adelson, MD

Julia Paris, Jay Horton, Sean Morrison, Cardinale Smith, Icahn School of Medicine at Mount Sinai
THE MOUNT SINAI  HEM/ONC DIVISION 
UNDERPERFORMED ON KEY INPATIENT 
QUALITY METRICS

UHC: UNIVERSITY HEALTH CONSORTIUM STATISTICS

<table>
<thead>
<tr>
<th>Metric</th>
<th>Rate</th>
<th>Goal/ Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mortality Index</td>
<td>1.45</td>
<td>&lt;1</td>
</tr>
<tr>
<td>30 day Readmission</td>
<td>21.5%</td>
<td>&lt;10.3%</td>
</tr>
<tr>
<td>Length of Stay Index</td>
<td>1.17</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>
Patients with: Metastatic Solid Tumor

<table>
<thead>
<tr>
<th>Medical Center</th>
<th>Percentage of Patients Receiving Palliative Care Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Commonwealth</td>
<td>44%</td>
</tr>
<tr>
<td>Mount Carmel Health System</td>
<td>39%</td>
</tr>
<tr>
<td>Pittsburgh</td>
<td>27%</td>
</tr>
<tr>
<td>Medical College of Wisconsin</td>
<td>16%</td>
</tr>
<tr>
<td>Mount Sinai</td>
<td>11%</td>
</tr>
</tbody>
</table>

* Of the three institutions with analyzed mortality data to date, Mt Sinai had the highest inpatient mortality rates.
Background

For patients with advanced cancer, integration of Palliative Care:

• improves symptom control
• clarifies understanding of prognosis
• increases utilization of hospice
• lowers utilization of health care resources
National Guidelines Call for Integration of Palliative Care

• In 2012 ASCO recommended incorporation of palliative care “for any patient with metastatic cancer and/or high symptom burden.”

• In 2013, the IOM recommended that cancer care teams “place primary emphasis on palliative care, psychosocial support and timely referral to hospice for end-of-life care.”
HYPOTHESIS:
INTEGRATION OF PALLIATIVE CARE WILL LEAD TO IMPROVEMENTS IN QUALITY
Prospective Cohort Study

Intervention Group: Palliative Care was automatically consulted on any solid tumor inpatient who met one of the following criteria:

1. Stage IV disease
2. Stage III lung or pancreatic cancer
3. Prior hospitalization within 30-days (excluding routine chemotherapy)
4. Hospitalization lasting longer than 7 days
5. Uncontrolled symptoms including pain, nausea/vomiting, dyspnea, delirium, and psychological distress
Palliative Care Consult

• Address any acute issue including:
  – Symptomatology
  – Emotional distress
  – Discharge Planning
  – Family meetings
  – Clarification of Goals of Care in conjunction with oncologist
What do top hospitals have in common? Not as much as you think.

By Sarah Kliff, Published: October 31, 2012 at 2:29 pm  E-mail the writer

Johns Hopkins Hospital in Baltimore and Mt. Sinai Hospital in New York are among the nation’s elite hospitals. But when it comes to how they practice medicine, the doctors at the two institutions are very, very different.

At Johns Hopkins, nearly half of patients enroll in hospice in the last six months of life. That number stands at one-quarter at Mt. Sinai. At Hopkins, one-third of patient deaths will occur in the hospital (others are likely at home or in hospice). At Mt. Sinai, 44 percent of patient deaths happen in a hospital bed.
## Results

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Observation Group N=51</th>
<th>Intervention Group N=68</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care consultation rate</td>
<td>19 (39)</td>
<td>52 (80)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>30-day readmission rate, N (%)</td>
<td>17(35)</td>
<td>13(18)</td>
<td>0.04</td>
</tr>
<tr>
<td>Hospice referral, N (%)</td>
<td>7 (14)</td>
<td>17 (26)</td>
<td>0.03</td>
</tr>
<tr>
<td>Length of stay, mean ± SD, days</td>
<td>11 ± 12</td>
<td>14 ± 14</td>
<td>0.15</td>
</tr>
<tr>
<td>Disposition, N (%)</td>
<td></td>
<td></td>
<td>0.004</td>
</tr>
<tr>
<td>Home without services</td>
<td>25(52)</td>
<td>16 (25)</td>
<td></td>
</tr>
<tr>
<td>Home with services</td>
<td>9 (19)</td>
<td>21 (32)</td>
<td></td>
</tr>
<tr>
<td>Home with hospice</td>
<td>4 (8)</td>
<td>10 (15)</td>
<td></td>
</tr>
<tr>
<td>Sub-acute rehab</td>
<td>6 (13)</td>
<td>2 (3)</td>
<td></td>
</tr>
<tr>
<td>Inpatient hospice</td>
<td>3 (6)</td>
<td>7 (11)</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy after discharge, N(%)</td>
<td></td>
<td></td>
<td>0.03</td>
</tr>
<tr>
<td>Yes</td>
<td>21 (44)</td>
<td>12 (18)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>27 (56)</td>
<td>53 (82)</td>
<td></td>
</tr>
</tbody>
</table>
We compared UHC indexes averaged over 1-year prior to the intervention to the 3-month pilot.

This dataset includes all patients on the solid tumor service, among which 80% met eligibility criteria.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Observation Group</th>
<th>Intervention Group</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Day Readmission Rate</td>
<td>22 %</td>
<td>15 %</td>
<td>0.05</td>
</tr>
<tr>
<td>Mortality Index</td>
<td>1.35</td>
<td>0.59</td>
<td>0.03</td>
</tr>
<tr>
<td>Length of Stay Index</td>
<td>1.23</td>
<td>1.25</td>
<td>0.43</td>
</tr>
</tbody>
</table>
SUSTAINABILITY

• Based on success of the pilot, Mount Sinai made this the standard of care for all patients meeting criteria
• Hospital funded an extra palliative care team
• Impact of length on stay, hospice utilization and oncology service mortality is lasting
NEXT STEPS

• While the standardized criteria improved inpatient measures, impact on overall care was limited by the fact that the patients were already hospitalized and near the end-of-life.

• PCORI grant: *Improving Advanced Cancer Patient-Centered Care by Enabling Goals of Care Discussions*

• Multi-site randomized trial pairing oncologists in the intervention group with Palliative Care doctors trained to teach communication in joint Goals of Care meetings with the oncologists’ own patients.

• Three Practice Settings: Academic (Mount Sinai), City (Kings County) Community (Yale Care Centers and Mount Sinai—BI)

• Analysis will look at whether the patients of the intervention oncologists have increased perception their GOC were addressed.
EMERGENCY DEPARTMENT UTILIZATION AND HOSPITAL ADMISSION RATES

• 5 months period: 391 oncology patients presented to the ED and 90% of these were admitted
• Highest admission rates from GI and Thoracic disease teams
• 62% of patients arrived at the ED during the hours of 9:00AM-5:00PM.
• Mean length of stay (LOS) was 6.74 days.
• Average daily cost $1,886 per day
• $12,712 for an average hospitalization.
Estimate: 50% of admissions were preventable

- Other: 22%
- Dehydration/Electrolyte Disturbances: 10%
- Disease Exacerbation/Failure to Thrive: 10%
- Fever, Neutropenia, sepsis: 12%
- Altered Mental Status: 13%
- Pneumonia/Dyspnea: 14%
- Abdominal Pain: 10%
VIRTUAL URGENT CARE CLINIC: INTEGRATE URGENT PATIENTS INTO EXISTING CLINIC SCHEDULE

- Same day Advanced Practice RN/PA visits
- Infusion chairs and pharmacy services for administration of hydration and urgent medications
- Palliative care consultation for urgent symptom management
- No additional staffing resources
- Would work by cultural change
- Education targeted: Patients, Caregivers, Clinical Secretaries, Practice Nurses, Oncology Fellows, APPs/MD.
RESULTS: FIRST 9 WEEKS

• The number of patients who presented to the ED was reduced by 32%
• Number of patients admitted from the ED was reduced by 36%
• Of the patients who presented for urgent care visits, only 21% were admitted over the next 24 hours.
• Approximately 75% were stabilized in the ambulatory setting and not admitted.
6-Month Follow Up

• Number of patients presenting to ED returned to baseline
• What happened?
• GI and Thoracic APPs reported it was too difficult to accommodate urgent patients in their busy practice.
• Virtual Urgent Care was not sustainable
• Need a dedicated urgent care with oncology/palliative care providers and infusion services
CHANGE ON A NATIONAL SCALE
ACA PROVIDES IMPETUS FOR CHANGE

• Previously exempt cancer hospitals are required to report cancer-specific and other quality metrics via the new (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.

• In short succession, it is expected that these metrics will be rolled-out to non PPS-exempt institutions, like Yale/NSLIJ.
CMS ENDORSED METRICS FOR PCHQR

• Combination chemotherapy is considered or administered within 4 months (120 days) for women with ER negative breast cancer

• Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year for women with ER+ breast cancer

• Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients Stage III colon cancer.
QOPI PRACTICES THAT REPORT THESE CANCER SPECIFIC MEASURES ARE IN THE 98TH PERCENTILE.

THESE ARE NOT QUALITY MEASURES BUT MINIMUM STANDARDS OF CARE.
The Center for Medicare and Medicaid Innovation describes a cancer model that will align evidence-based guidelines with financial incentives, likely through episode-based bundled payments.

Multiple Payors are already trialing Value Based Payment Models.
Oncology Care Model

CENTER FOR MEDICARE AND MEDICAID INNOVATION
OCM tests institutional commitment to prioritizing high-value care

- Only way to improve VALUE is to increase quality or reduce cost
- OCM may be our only chance to engage in value reform while still collecting fee-for-service
  - Increases QUALITY through performance-based payments
  - CMS pays us for reducing COST
  - Performance-based model is based on increasing hospital margin

Source: Michael Porter Value Equation
OCM is a **value-based program** that maintains FFS payments, while also rewarding quality improvement.
OCM

- Medicare patients enrolled at time chemotherapy is initiated for 6 month episodes (multiple possible)
- Built on fee-for-service (FFS) payment for all care
- For the duration of the OCM, the model will not change the FFS payment structure
• We collect an additional $160 per patient per month for 6 month episodes (multiple possible) for all Medicare beneficiaries who receive chemotherapy
If we bill less than our historical episodes AND meet quality benchmarks, we are eligible to earn the difference -4%.

We have many targets for savings particularly in end-of-life care and utilization of ED/ inpatient services.
There are 8 metrics associated with performance-based payments

1. # of ED visits per patient/episode
2. # of hospital admissions per patient/episode
3. % of patients admitted to hospice for <3 days (higher is worse)
4. % of patients who go to the ED ≥ 1 time in the last 30d of life
5. % of patients with pain intensity quantified and a plan of care
6. Patient experience survey score (modified CAHPS)
7. % of patients evaluated for patient reported outcomes (face-to-face)
8. Percent of patients with psychosocial screening (min. 1 per episode)
Total Cost of Care for Medicare Patients Treated at Smilow by 6 month Episodes

• Spending increases dramatically as patients move through episodes (as disease progresses) and doubles when an episode ends in death.

• Is higher than other hospitals in CT and comparable to Academic Medical Centers

• Is much higher when patients present to the ED (reflecting inpatient costs)

• Consistent with national trends showing overutilization of aggressive interventions at the end-of-life.
Fundamental Infrastructure Required to Transform Care

• Formal Urgent Care Program to reduce ED utilization and hospital admissions
• Clinical Pathways
• Expanded Palliative Care
  – Ambulatory Palliative Care Program
  – Inpatient Palliative Care for All patients with metastatic solid tumors and relapsed hematologic malignancy
• OCM Patient Care Managers
• OCM Program Manage
• Financial Counselors
TO MOVE INTO HIGH VALUE CANCER-CARE WE NEED TO ANSWER:

1. How can we move beyond measuring what is measurable and start measuring what matters?

2. How do move from process measures to outcome measures?
   - Was chemotherapy offered?
   - Did the chemotherapy improve the patients survival or quality of life?

3. How do we measure shared-decision making?
   - Did the patient understand the goals of treatment?

4. How do we put the patient experience at the center of the value equation?