Oncology Medical Home: Effect on cost of care

Barbara McAneny MD
CEO New Mexico Cancer Center
CEO Innovative Oncology Business Solutions

Goals of COME HOME

- 1. Prevent or control the side effects of cancer and its treatment
- 2. Allow Cancer patients to maximize their time at home, rather than spend their time getting the care
- 3. Lower the out of pocket costs to patients
- 4. Redefine quality to include the technical goal of delivering the right care and the customer service goal of respecting the time, wishes and goals of the patient

Barriers to COME HOME Goals

- 1. Lack of Payment for triage services
- 2. Lack of Payment for patient and family education
- 3. Prior authorization and co pay processes
- 4. Physician schedules
- 5. Physician and nursing fear of loss of control
- 6. Work life balance
- 7. Patients are in the habit of going to the ED

CMS/CMMI Grant

- $19.8M
- 7 practices
- Significant savings associated with Oncology Medical Home through reduced ED & IP use
- Improve quality of care through triage protocols, team care and clinical pathways
- Increase delivery of patient-centered care through after hours clinics, same day appointments, patient education and patient portal

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COME HOME Project Partners

- Innovative Oncology Business Solutions (IOBS) – managing organization formed for the purposes of administering project
- Seven community oncology practices
  - New Mexico Cancer Center
  - Center for Cancer & Blood Disorders (Ft. Worth)
  - Dayton Physician Network (OH)
  - Space Coast Oncology
  - New England Cancer Specialists
  - NW Georgia Oncology Centers
  - Austin Oncology Group
- NantHealth – HIT company creating customized quality & pathway performance dashboards using claims data and integrated EHRs
- KEW Group – integration of genetic markers into diagnostic and therapeutic pathways
- UTHSC – evaluation, cost, quality measurement expertise; using claims data for rapid-cycle feedback of cost/utilization performance

Our innovative model includes eight important components:

1. Robust use of health IT systems (EMR, PMS, lab systems, etc.)
2. An ongoing relationship with a personal oncologist to provide first contact and continuous, comprehensive care
3. Physician-led team-based care, where every member of the team works at the top of their license
4. Patient and Family orientation, with Patient Education on how a patient can best benefit from the new system
5. Integrated and coordinated care with automated real-time decision support system to provide aggressive symptom management
6. Evidence-based medicine and performance measures to assure quality and safety and generate true outcomes data
7. Enhanced access, such as late hours and same-day appointments
8. Payment models to recognize the value-add of a medical home

Differences from Primary Care

- 1. When you have cancer, Oncologists become the primary physician, and most PCPs are happy to have us do that.
- 2. We don’t have to figure out which patients will be expensive
- 3. We know how to order just the right tests and don’t panic at complications

Barriers for Patients

- 1. Don’t bother the doctor
- 2. I can’t pay the co pay
- 3. Panic
- 4. lack of understanding the “system”

What contributes to total cost of care?

- Chemotherapy and other treatments
  - Medical Oncologists have little control
  - Pass through costs
- ED Visits and **Inpatient Admissions**
  - North Carolina 2008 data[1]: 37,760 ED Visits
    - 63.2% resulted in admissions
    - Mostly for symptom control
      - GI, Pain, Neurological Symptoms, Malaise, Injury Fever
  - COME HOME Data: 32 - 53% of ED Visits result in admissions
- Medical homes have been shown to reduce inpatient admissions by 15-50%
- COME HOME Practices saw a 9.5% reduction in IP admissions in the first year of the program (from 38.28% to 34.63%)

[1]J Clin Onco 29:2683-2688

COME HOME Patient Population

26,548 unique patients through 3/31/2015

Utilization (some pts counted more than once):

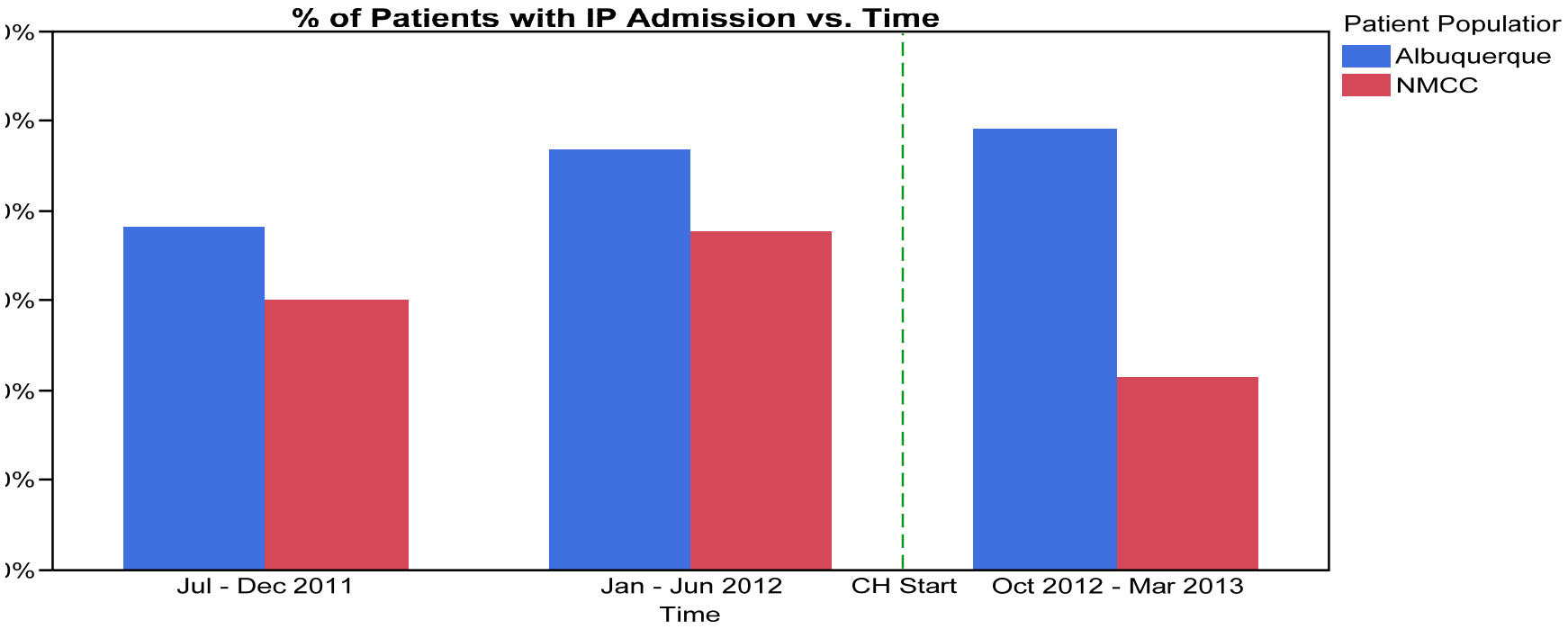
- ≥1 triage encounter: 88%
- ≥1 patient education encounter: 13%
- ≥1 same day appointment: 21%
- ≥1 clinical pathway: 3.4%

Characteristic	Percent
Female	52.3%
White	88.1%
Black	6.3%
Asian	2.2%
Native American	1.4%
Other/Unknown	2.0%
Not Hispanic	74.4%
Hispanic	12.1%
Unknown	13.5%
Commercial/Private	44.8%
Medicare FFS	23.6%
Medicare Advantage	22.6%
Other	9.0%
Breast Cancer	44.9%
Lung Cancer	17.1%
Colon Cancer	16.4%
Other	21.6%

Diagnostic and Therapeutic Pathways

- Physician generated, with academic help
- Included imaging and genomics
- Proves quality without chart abstraction
  - Document that appropriate care was not withheld
- Aggregates data on treatment regimens
  - Will allow true outcome data
  - Then true toxicity data
  - Eventually cost data
- Increases practice efficiency
- Helps determine a bundle

Percent of Patients with at least one IP Admission



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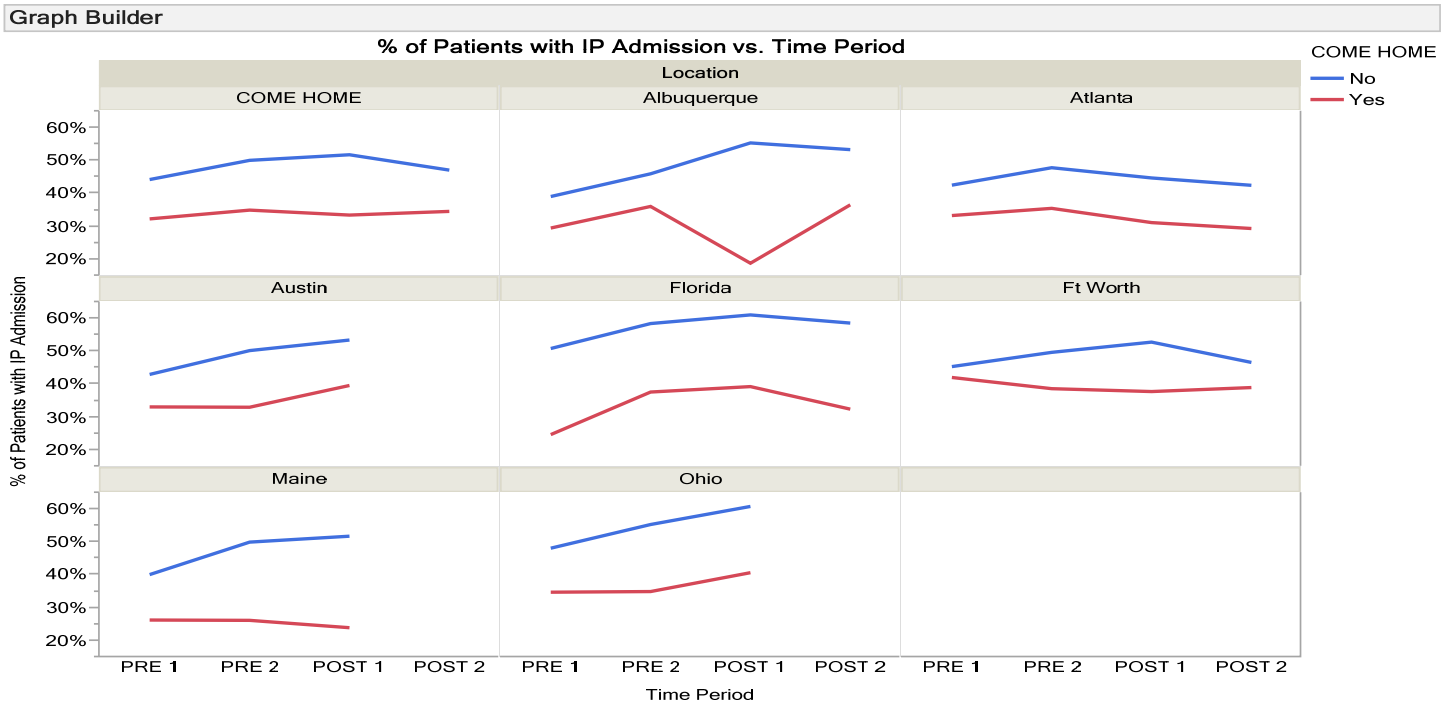
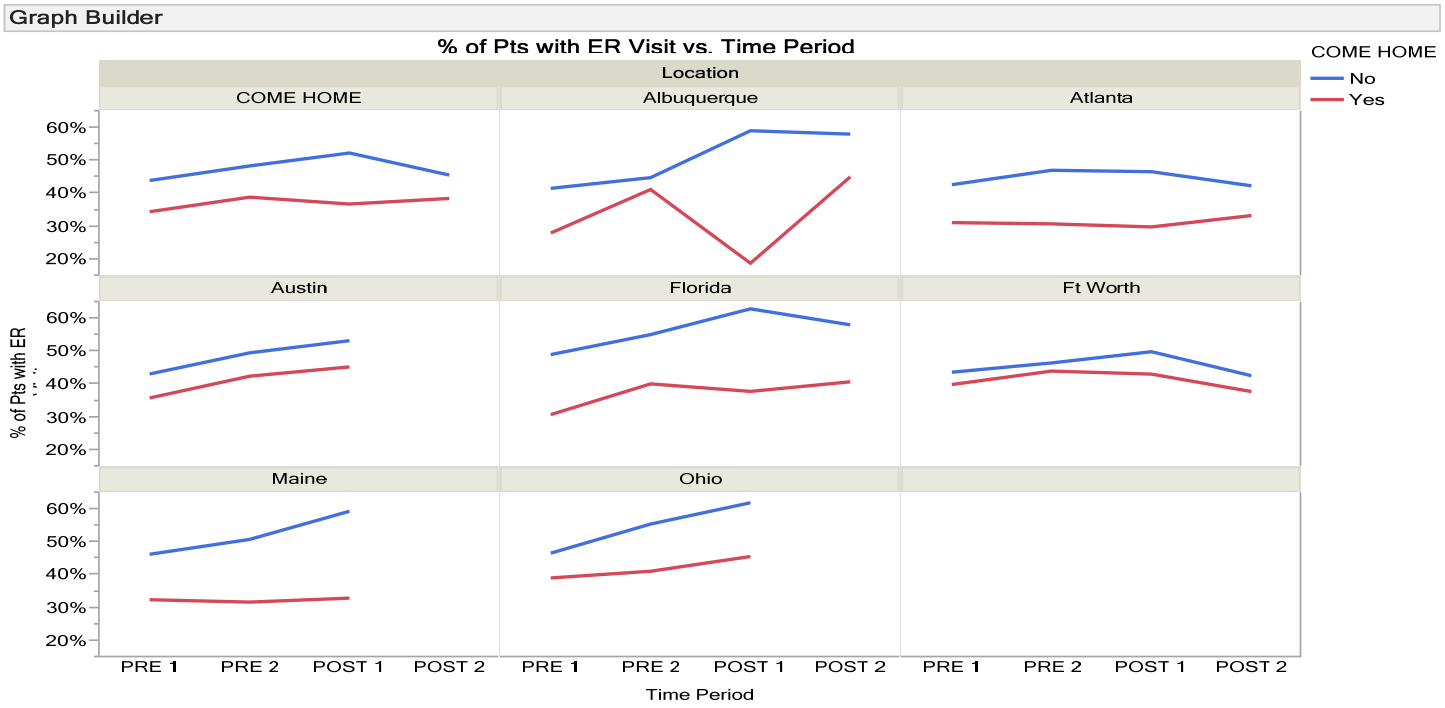
% of pts with an IP Encounter



% of pts with an ER Visit



Summary of Findings

- NMCC Post-COME HOME compared with NMCC in the Pre-COME HOME period:
  - 35.9% drop in % of patients with ED Visits
  - 43.1% drop in % of patients with IP Admissions
  - 23.8% drop in inpatient days
  - $4,784.08 (22.4%) drop in six month total cost of care
- NMCC Post-COME HOME compared with contemporaneous data from the Albuquerque MSA:
  - COME HOME patients are 50.2% as likely to have an ED Visit
  - COME HOME patients are 43.6% as likely to have an IP Admission
  - COME HOME patients spend 2.71 fewer days in the hospital
  - COME HOME patients cost Medicare $2,149.28 (11.5%) less

A Plea to Payers

- 1. Recognize that we are providing the high quality low cost service
- 2. Recognize that we have the expense side of the ledger and you have the savings
- 3. It is in your best interest to pay us enough to keep us independent rather than negotiating away our margins.