Culture Change

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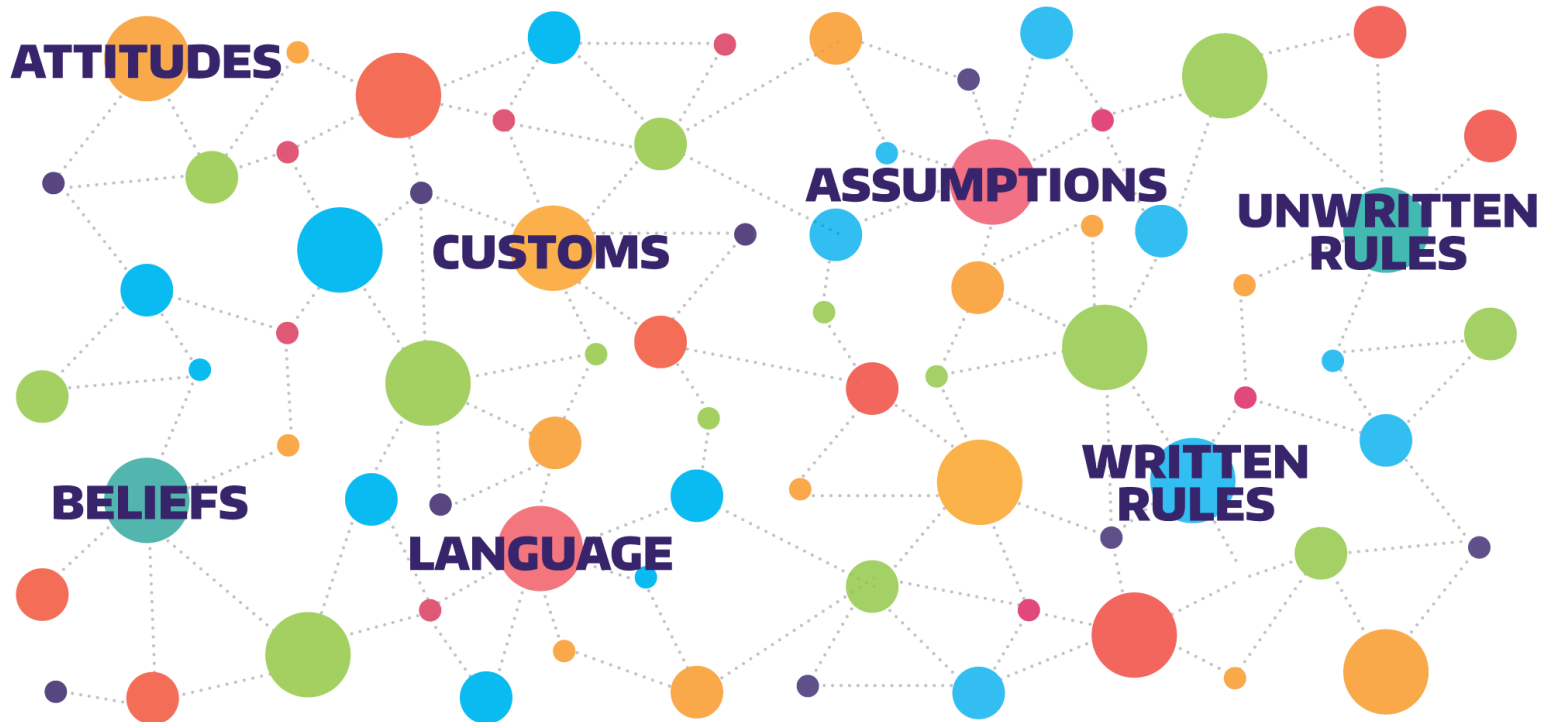SCHOOL OF PUBLIC HEALTH
UNIVERSITY *of* WASHINGTON

WHAT IS ORGANIZATIONAL CULTURE?

W

"The way things are done around here."

ATTITUDES

ASSUMPTIONS

UNWRITTEN RULES

CUSTOMS

BELIEFS

LANGUAGE

WRITTEN RULES

WHAT KIND OF CULTURE SUPPORTS PERFORMANCE IMPROVEMENT?

Learning Organization:

- Continuous learning
- Inquiry and dialogue
- Team learning
- Empowerment
- System connection
- Strategic leadership

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WHAT KIND OF CULTURE SUPPORTS PERFORMANCE IMPROVEMENT?

Psychological Safety: shared belief that the team is safe for interpersonal risk taking.
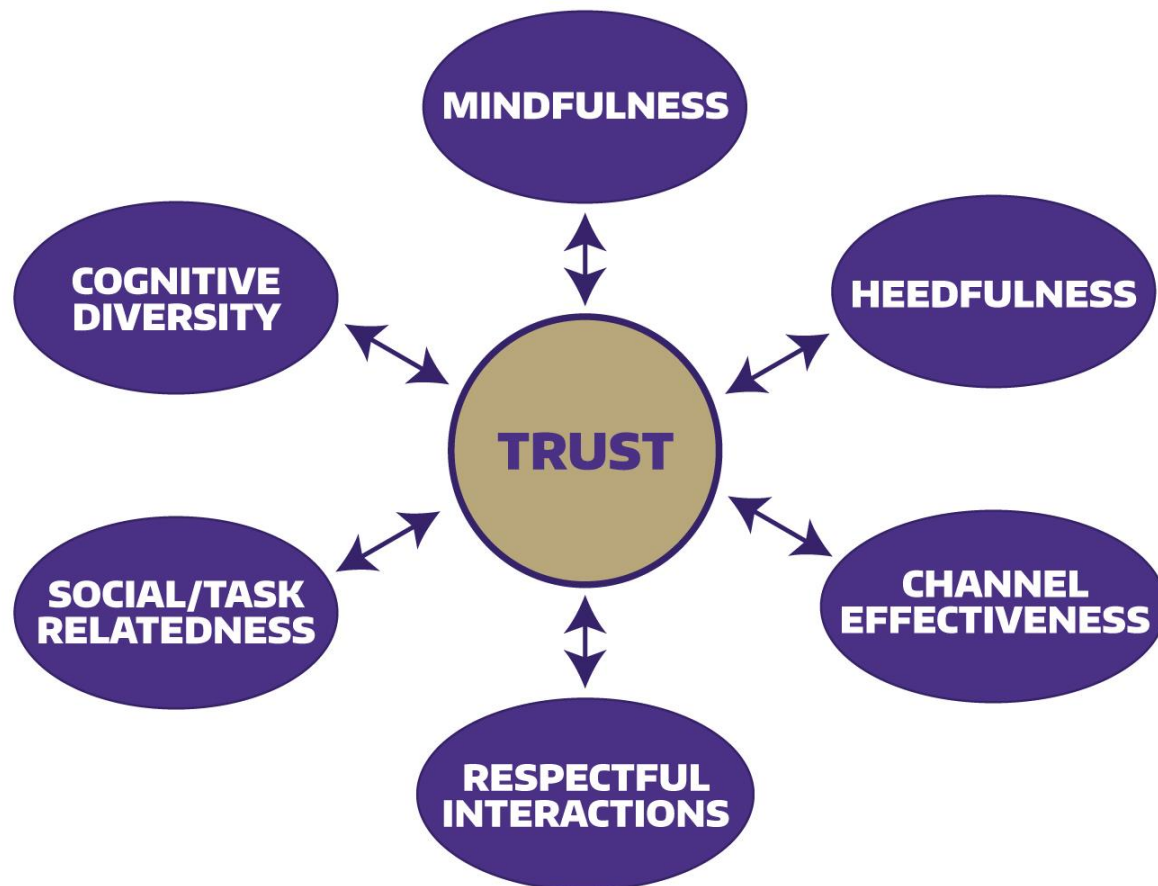
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WHAT KIND OF CULTURE SUPPORTS PERFORMANCE IMPROVEMENT?

Adaptive Reserve:

A practice's ability to make and sustain change (and to be resilient in face of change)

HOW DO YOU CHANGE CULTURE?

- Walk the talk via leadership
- Make use of rituals, stories, and artifacts
- Hire for attitudes <u>and</u> aptitudes
- Communicate the message via onboarding
- Align performance evaluation criteria
- Align reward and recognition systems
- Change behaviors → mindsets will follow

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ADAPTIVE RESERVE

➤ We regularly take time to consider ways to improve how we do things.

➤ People in our practice actively seek new ways to improve how we do things.

➤ People at all levels of this office openly talk about what is and isn't working.

➤ People are aware of how their actions affect others in this practice.

➤ Most people in this practice are willing to change how they do things in response to feedback from others.

➤ This practice encourages everyone (front office staff, clinical staff, nurses, and clinicians) to share ideas.

➤ I can rely on the other people in this practice to do their jobs well.

➤ Difficult problems are solved through face-to-face discussions in this practice.

➤ We regularly take time to reflect on how we do things.

➤ After trying something new, we take time to think about how it worked.

➤ The practice leadership makes sure that we have the time and space necessary to discuss changes to improve care.

➤ Leadership in this practice creates an environment where things can be accomplished.

➤ Practice leadership promotes an environment that is an enjoyable place to work.

➤ Leadership strongly supports practice change efforts.

➤ This practice learns from its mistakes.

➤ It is hard to get things to change in our practice.

➤ Mistakes have led to positive changes here.

➤ People in this practice have the information that they need to do their jobs well.

➤ When we experience a problem in the practice, we make a serious effort to figure out what's really going on.

➤ I have many opportunities to grow in my work.

➤ People in this practice operate as a real team.

➤ Most of the people who work in our practice seem to enjoy their work.

➤ This practice is a place of joy and hope.

Adapted from: Jaén CR, Crabtree BF, Palmer RF, Ferrer RL, Nutting PA, Miller WL, Stewart EE, Wood R, Davila M, Stange KC. Methods for evaluating practice change toward a patient-centered medical home. *Ann Fam Med.* 2010; 8 Suppl 1: S9-20; S92. doi: 10.1370/afm.1108.

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DIMENSIONS OF LEARNING ORGANIZATIONS QUESTIONNAIRE

CONTINUOUS LEARNING

- In my organization, people help each other learn.
- In my organization, people are given time to support learning.
- In my organization, people are rewarded for learning.

DIALOGUE AND INQUIRY

- In my organization, people give open and honest feedback to each other.
- In my organization, whenever people state their view, they also ask what others think.
- In my organization, people spend time building trust with each other.

TEAM LEARNING & COLLABORATION

- In my organization, teams/groups have the freedom to adapt their goals as needed.
- In my organization, teams/groups revise their thinking as a result of group discussions or information collected.
- In my organization, teams/groups are confident that the organization will act on their recommendations.

EMBEDDED SYSTEMS

- My organization creates systems to measure gaps between current and expected performance.
- My organization makes its lessons learned available to all employees.
- My organization measures the results of the time and resources spent on training.

EMPOWERMENT

- My organization recognizes people for taking initiative.
- My organization gives people control over the resources they need to accomplish their work.
- My organization supports employees who take calculated risks.

SYSTEMS CONNECTIONS

- My organization encourages people to think from a global perspective.
- My organization works together with the outside community to meet mutual needs.
- My organization encourages people to get answers from across the organization when solving problems.

STRATEGIC LEADERSHIP

- In my organization, leaders mentor and coach those they lead.
- In my organization, leaders continually look for opportunities to learn.
- In my organization, leaders ensure that the organization's actions are consistent with its values.

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TEAM LEARNING CLIMATE

PSYCHOLOGICAL SAFETY

➤ When someone makes a mistake in this team, it is often held against him or her.

➤ In this team, it is easy to discuss difficult issues and problems.

➤ In this team, people are sometimes rejected for being different.

➤ It is completely safe to take a risk on this team.

➤ It is difficult to ask other members of this team for help.

➤ Members of this team value and respect each others' contributions.

Adapted from: Edmondson, A. Psychological safety and learning behavior in work teams. *Administrative Science Quarterly*, Jun 1999; 44, 2; p350.

Practice Transformation

Sibel Blau, MD
Northwest Medical Specialties, PLLC
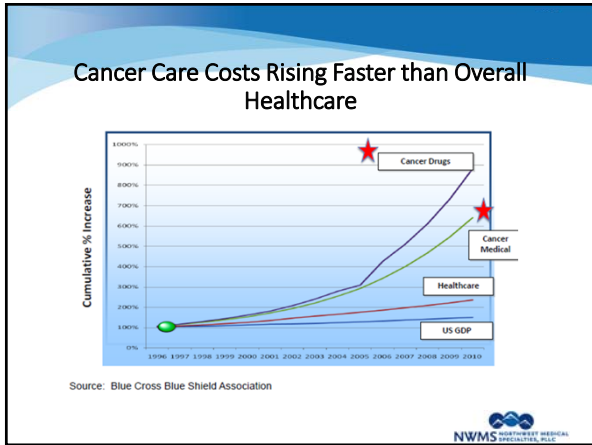**Washington State Society of Medical Oncology**
Quality Cancer Care Alliance

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Current State: **Oncology Landscape**

US healthcare is fragmented, inefficient, inaccessible and terribly expensive	To address this issue, CMS has mandated the transition from 'volume' to 'value-based care'
Cancer care targeted as one of the greatest opportunities to reduce variability in spend and outcomes	Alternative Payment Models (APMs) like CMMI's OCM are crystallizing the transformation

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Cancer Care Costs Rising Faster than Overall Healthcare

Source: Blue Cross Blue Shield Association

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Medicare **A**ccess and **CHIP** **R**eauthorization **A**ct of 2015
MACRA 2015

- Eliminates SGR Formula
- Transition from "fee for service" to Value Based Care
- Four year implementation (2019)
- Streamlines reporting programs into 1 new system: Merit Based Incentive Payment System (MIPS)
- Incentivizes involvement in Alternative Payment Models (APMs)

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Sources of Cost Savings

Source	% Cost Reduction
Drug pathways compliance	1.0% to 3.0%
Avoidable ER utilization	0.6% to 1.1%
Avoidable hospital admissions	4.0% to 7.0%
Diagnostics (imaging, lab)	0.2% to 0.5%
End-of-life care management	0.9% to 1.9%
Total potential savings	6.7% to 13.5%

About 2/3 of the savings comes from avoidable hospital events.

John D. Sprandio, MD, Consultants in Medical Oncology & Hematology. Oncology Patient Centered Medical Home ® Analysis of OPCMH savings conducted by third party actuary 2010.

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NWMS Vision for Value-Based Care

Develop a new patient-centered oncology care model focused on providing the highest quality patient care while driving down the cost of cancer care.

Create innovative solutions around quality reporting that drive practice transformation and efficiency.

Slide 1

Ongoing Value Initiatives

70%
of oncology patients in a Value Based Care program

1 of 13
NCQA OMH accredited practices

QOPI
accredited practice

PAYER PROGRAMS
ONCOLOGY CARE MODEL
aetna
PREMERA | BLUE CROSS

Slide 2

NWMS NORTHWEST MEDICAL SPECIALTIES, PLLC & aetna

Background
- Focused on <u>drug</u> and <u>acute care</u> costs vs. Washington state
- Utilizing treatment pathways
- 3 year program

Slide 3

NWMS NORTHWEST MEDICAL SPECIALTIES, PLLC & PREMERA | BLUE CROSS

Background
- Focused on <u>total cost of care</u> vs. Washington state
- One of the first VBC commercial contracts in oncology
- 3 year program initially

Slide 4

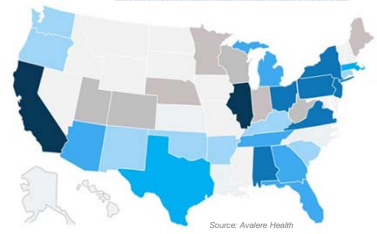### 3,200+ Participating Oncologists Nationwide

Geographical Distribution of Physician Practices Selected to Participate in OCM

Nationally:
- 190 practices
- 17 payers

Washington State:
- 3 practices

Legend:
- 0 (19 states + DC)
- 1- 2 (8 states)
- 3 – 5 (8 states)
- 6 – 9 (7 states)
- 10 -14 (6 states)
- 15+ (2 states)

Source: Avalere Health

Slide 5

OCM Basics

- **Goal:** "to utilize appropriately aligned financial incentives to enable **improved care coordination**, **appropriateness of care**, and **access to care for beneficiaries undergoing chemotherapy**. CMMI expects that these improvements will result in better care, smarter spending, and healthier people." [innovation.cms.gov/initiatives/oncology-care]
- **Eligibility:** physician practices that provide care for oncology patients undergoing chemotherapy for cancer
- **Term:** 5-year program commencing July 1, 2016 ("Start Date")

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Slide 6

Practice Redesign Activities

- Patient access 24/7 to clinician who has real time access to patient's medical record
- Attestation and use of ONC-certified EMR
- Utilize data for Continuous Quality Improvement (CQI)
- Provide core functions of patient navigation
- Document care plan in accordance with IOM
- Chemotherapy treatment consistent with nationally recognized clinical guidelines

Activities 1, 4, 5, 6 above are the OCM "Enhanced Services." Participants must attest to implementation by Oct 31, 2016

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Slide 1

☑ **ONCOLOGY CARE MODEL**

CMMI provided a very specific set of OCM requirements:

- **Who** to include
- **What** data to gather
- **When** to gather it

💡 Our Approach

- Structured OCM after our current value programs with **commercial payers**
- Employed methodology commonly used by **clinical research programs**

Slide 2

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- **6** locations through the South Puget Sound area
- **11** medical oncologists, **9** APPs
- **4,500** new Hematology-Oncology cases per year
- **1,700** of new cases are oncology (50% Medicare)

Slide 3

Value Based Care at NWMS

Expensive and time consuming

- Expanded staff
- Technology
- Analytics
- Urgent Care clinics
- Enhanced triage systems

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Slide 4

VBC requires both commitment and passion

MULTIPLE INVESTMENTS

- Expanded staff
- Technology
- Analytics
- Urgent Care clinics
- Enhanced triage systems

IMPACT ON PROVIDER TIME

- Structured data (staging, clinical data)
- Co-morbidities
- Advanced Care Planning (ACP) Visits
- Urgent Care clinics
- Enhanced triage systems

Slide 5

Our OCM study team

- Medical Oncologists
- Advanced Practice Providers
- Triage Staff
- Nurse Case Managers
- Patient Navigators
- Social Workers
- Patient Care Coordinators
- Financial Counselors

Slide 6

Value Based Care at NWMS

Think clinical trial…

Enrollment

- Set activities and timepoints
- Data collection and reporting
- Patient Care Coordinators
- Use of Clinical Trials Management software (CTMS)
- Navigating Cancer tool

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Patient Care Coordinator (PCC) Functions

This role is the "glue" of the program and keeps everyone in sync

- SCREEN NEW STARTS
- TRACK QUALITY MEASURES
- COORDINATE PATIENT CARE
- STAY ON TOP OF REGULATIONS
- TRACK & BILL MEOS PAYMENTS

Case Manager (CM) Functions

CMs are oncology-certified RNs who worked previously as infusion nurses

- CHEMO FOLLOW-UP CALLS 24 HOURS AFTER INFUSIONS
- CONDUCT POST ED FOLLOW-UP CALLS
- TRACK & MANAGE CLINICAL CARE FOR HIGH RISK PATIENTS
- CONDUCT TRIAGE FOLLOW-UP CALLS
- TRACK HOSPITAL USE AND TRENDS
- PROVIDE APPOINTMENT ASSISTANCE
- TRACK OCM / OMH PATIENT HOSPITAL UTILIZATION
- CONDUCT INFUSION VISITS FOR ASSESSMENT OF NEEDS
- PROVIDE PATIENT SYMPTOM EDUCATION AND MANAGEMENT

Care coordination check list created with our Clinical Trial Management System (CTMS)

Procedure	Complete	Notes
Verify Medicare Insurance		
Patient Portal Access Activated		
Performance Status		
Primary Cancer dx		
Patient Staging		
Patient Navigator or Case Manager Engaged		
Assessed for Clinical Trial Eligibility		
Welcome Packet/ OCM Beneficiary Letter Delivered		
Advanced Care Planning Visit		
Chemo Teach		
Treatment Plan		
Chemotherapy Consent Signed		
24 Hour Post Chemo Follow Up Call		
7 Day Post Chemo Follow Up Call		
14 Day Oral Chemo Therapy Follow Up Call		
Relapse or Progression Date Complete in EMR		
Pain Assessed		
Pain Plan Documented in EMR Note		
Medication Reconciliation (Verify Date/Time) 1 p/mo		
Review Coding and Send to Billing Department		
Comorbidity Capture: COPD ___ CHF ___ Diabetes ___ HTN ___ Renal Disease ___		
Close the Loop on Referrals		
PMPM Code Billed		
Comments:		

Claims and Reporting

OCM reporting vs. peers includes:

- End of life measures
- Total cost of care by disease
- Comparison of expense categories (Imaging, Drugs, Acute Care, Radiation)
- Acute care utilization (ED, admit, readmission)
- Outcomes (mortality, survival)

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Utilization Before OCM

Table D. Utilization Before OCM Start (not risk adjusted; 4-quarter averages, April 2015 – March 2016)

	Your practice	Median of 4-quarter averages	
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Number of ED visits not leading to admission or observation stay [per 100 beneficiaries]	14.8	14.3	15.7

CAH = critical access hospital
ED = emergency department

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Utilization before and **after** OCM

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Our OCM Progress

Table C. Expenditures (risk-adjusted 4-quarter average, October 2015 – September 2016)

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We have shown improvement in nearly every category from our baseline

▼ **25%** decrease in IP admits   ▼ **10%** decrease in ED visits

▼ **55%** decrease in readmits   ▲ **21%** improvement in hospital related care costs

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Scaling care to **all patient populations**

OCM / OMH   **Commercial Pilots**   **All Payers**

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01   **Automate reporting** and **care coordination tasks** so the care team can focus more time on managing patients and less time on admin

02   Focus on **proactive care management** through triage & remote monitoring software

03   Provide patients **with tools to engage** with their care team and in their own care

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Quality Cancer Care Alliance -QCCA

- A consortium of independent community oncology practices committed to leveraging our combined knowledge and experience to collectively improve clinical outcomes and the cancer care delivery system

- Comprised of progressive, independent community oncology practices to form an entity that can pursue national market initiatives in value based programs, research, education, contracting and purchasing

- QCCA is inclusive. QCCA works with diverse stakeholders in the cancer community that share the vision of pursuing above goals

- QCCA is for like-minded community practices

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Quality Cancer Care Alliance (QCCA)

- 21 clinics across the USA
- 250 Oncologists
- EMRs linked for benchmarking and joint development of programs
- Sharing of knowledge and best practices
- Joint payer initiatives
- Bundling Coalition

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Triage Pathways

- Clinical content written by a QCCA practice-CCBD
- Software development by Navigating Care
- Needed to transform the organization by hiring staff and changing flow
- 2 FTE triage RNs (centralized), one first responder, 2 CMs, stationary MAs

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Future

- Lower cost
- Best quality
- Keep patients at home, safe
- Hospital, outpatient organization collaboration in achieving these goals

Thank you

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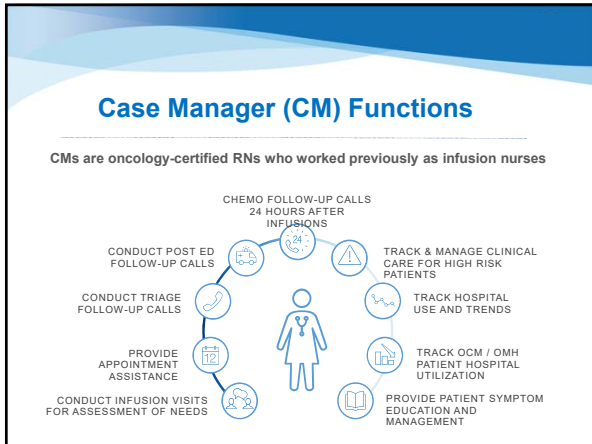
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Slide 1: Utilization Before OCM

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Slide 3: Our OCM Progress

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