ASCO Practice Leadership Series

Journey to Patient Centered Care and Developing a Health Equity & Access Strategy

Thursday, April 20, 2023, 4:00pm ET
Speakers

Ann Sweeney, MA, CCMP, CSSGB
Sr. Director Quality Programs & Process Improvement
Blue Ridge Cancer Care
Welcome!

• Please mute your phones
• Q&A session at the end
  ▪ Use the Q&A button in the bar at the bottom of your Zoom window
  ▪ Type in your question
  ▪ We will address questions in the order they are received
Blue Ridge Cancer Care
Journey to Patient Centered Care
and Developing a Health Equity & Access Strategy

Ann Sweeney
Sr. Director Quality Programs & Process Improvement
Committed to Value-based Care by joining The Oncology Care Model (OCM)

Sustained quality through physician led engagement and established infrastructure

Added additional VBC programs; increased patient-centered services

Initiated the American Society of Clinical Oncology (ASCO) Patient-Centered Cancer Care Certification (APC4) certification process

Current State: Successful in OCM & other VBC programs, ASCO APC4 Certified; preparing for participation in the Enhancing Oncology Model, exploring other VBC programs

Health Equity Strategy
VBC/Quality Programs
Driven Infrastructure
Roadmap

2016
• Nurse Navigation Team
• Quality Director

2018
• Data Coordinators
• Social Worker
• Nurse Navigation Team
• Quality Director

2022
• Health Equity Administrator
• Nurse Navigation Team+
• Social Workers+
• Pharmacy+
• APP+
• MA+
• Quality Director
• Data Coordinators

Current State = GROWTH
⭐ Health Equity Strategy & established the Health Equity Resource Administrator role
⭐ Culture & Wellness Initiatives
Institutional Overview

Blue Ridge Cancer Care offers advanced treatment technologies in a community-based setting, providing care to patients close to their homes and within their local communities.

- 9 locations throughout Southwest Virginia
  - Urban and Rural Setting
- 25 Physicians
- 19 Advanced Practice Providers

Specialties
- Medical Oncology
- Radiation Oncology
- Hematology
- Palliative Care

Services
- Clinical Trials & Research
  - Phases I, II, III, IV
- Genetic Counseling
- Nurse Navigation
- Social Work
- Nutrition Counseling
- Support Groups
Problem Statement

Between January and March 2021, an average of 54% of all new cancer patients starting IV chemotherapy at all clinic locations did not have a Nurse Navigator (NN) introduction and initial assessment (NN I/IA) completed within one month after his/her initial consult visit.

• The components we are tracking for completion: NN I/IA, Re/Education, Resources/Barriers, Psychosocial Needs.

• This variation leads to gaps in consistent care, increased frustration/burnout/inefficient use of NN time and impacts patient outcomes.
### Outcome Measure

#### Baseline Data Data Summary

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure:</strong></td>
<td>Percent of new IV chemotherapy patients that <strong>do not have</strong> the NN introduction and initial assessments (NN I/IA) <strong>within one month of initial consult.</strong></td>
</tr>
</tbody>
</table>
| **Patient population:**                        | • New IV chemotherapy patients enrolled in a VBC program between January-March 2022  
• All clinics, all cancer types, all physicians  
• Random sample pulled representing 10% (126 patients) of new IV chemotherapy patients enrolled in a VBC program |
| **Calculation methodology:**                  | Numerator = Missing NN I/IA/Data Elements completed within 1 month of initial consult  
Denominator = All patients defined in patient population |
| **Data source:**                               | Value-based Care program enrollment file, Electronic Medical Record, Navigating Care |
| **Data collection frequency:**                 | Baseline: one time data pull patient sample size from 1 quarter (Jan-March 2022) |
| **Data limitations:**                          | Self-reported data: consistency or accuracy of chart documentation |
Outcome Measure
Baseline data

Navigation Introduction/Initial Assessment Defect Rate

Weeks 1-13 - Jan - Feb - Mar 2022

Current Defect Rate
Average

54%
Aim Statement

Reduce missed Nurse Navigator introduction and initial assessment (NN I/IA) by 34% for all new patients starting IV chemotherapy at all clinic locations by December 31, 2022.

![Graph showing the defect rate for navigation introduction/initial assessment from Weeks 1-13, from January to March 2022. The current defect rate is 54%, the average is approximately 50%, and the target is 20%.]
Between January and March 2021, 54% of all new cancer patients starting IV chemotherapy at all clinic locations did not have a Nurse Navigator (NN) introduction and initial assessment (NN 1/1A) completed within one month after his/her initial consult visit.

**Problem Statement**

**Environment**
- COVID
- Frustration
- Burnout
- Lack of or variations of support for NN services
- Significantly increasing pt. volumes
- Implemented new VBC/quality programs
- Staff turnover (NN, SW, Director, all staff support NN)

**Technology (machine, methods)**
- Pt. utilization of technology, education materials
- Pt. access to technology, Pt. portal
- NN utilization, understanding of NC, G2
- NN Utilization, understanding of DC lists
- Different communication methods (G2, in person)
- NN not using consistent notes in G2/NC (4 ways to doc, moving 1)

**Policy/Procedure/Workflow (measurement, materials)**
- NN, physician/APP interpretation of priorities (survey)
- Pt volumes too high (APEX very/high/med, hospital report, Rad/Chem)
- Variation of care team huddle goals
- No defined NN program goals
- No consistent training for new NN, onboarding/orientation, timelines
- Inconsistent high risk definition
- Underscope the role; scope creep

**People**
- Pt needs
- Physician requests, needs
- No defined NN program goals (survey done)
- Inconsistent interpretation of job description
- Pt volumes are too high for consistency and effectiveness
- Variation in training of new team members
- Program/leadership allowed and supported variation (write up with Trish)
Cause and Effect Outcome

Survey Results: Variation
12 physicians, 4 NN (16)

✓ 10 variations of what NN goals should be, but common themes on top 5
✓ 8 definition on high-risk patients
✓ 75% agreed on priorities for NN team
✓ Shared results and all 16 agreed on established NN goals and priorities

48%

Increase in VBC Program enrollment July 2021 to March 2022

VBC Program Enrollment March 2022

- ASCO
- OCM
- VP

55% 39% 6%
### Process Measure – Add to FBD narrative

#### Diagnostic Data

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<td><strong>Measure:</strong></td>
<td>Missing NN documentation elements: NN I/IA, Re/Education, Resources/Barriers, Psychosocial Needs; within one month of initial consult.</td>
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</table>
| **Patient population:**                   | • New IV chemotherapy patients enrolled in a VBC program between January-March 2022  
• All clinics, all cancer types, all physicians  
• Random sample pulled representing 10% (126 patients) of new IV chemotherapy patients enrolled in a VBC program                                            |
| **Calculation methodology:**              | Count of Missing Data Elements in NN Note  
1. NN introduction and initial assessments (NN I/IA)  
2. TAP/TPF/Symptom Reeducation  
3. Resources/Barriers  
4. Psychosocial Needs                                                                 |
| **Data source:**                          | Nurse Navigator Notes                                                                                                                                                                                      |
| **Data collection frequency:**            | Baseline: one time data pull patient sample size from 1 quarter (Jan-March 2022)                                                                                                                          |
| **Data limitations:**                     | Self-reported data: consistency or accuracy of chart documentation                                                                                                                                          |
Process Measure
Diagnostic Data

Missing Elements from NN Notes

ELEMENT TYPE

COUNT

0 10 20 30 40 50 60 70 80 90 100

Resources/Barriers
NN Introduction/Initial Assessment
TAP/TPF/Symptom Reeducation
Psychosocial Needs

CUMULATIVE PERCENTAGE
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
### Priority / Pay-off Matrix

**Countermeasures**

- **High Impact / Low Easy**
  - Prioritize barriers to care assessment process
  - Redefine NN program goals
  - Create consistent documentation standards

- **High Impact / High Difficult**
  - Hire more NN
  - Improve turnover
  - Address burnout
  - Reduce quality/VBC programs

- **Low Impact / High Difficult**
  - Explore patient expectations
  - Improve team onboarding/training

- **Low Impact / Low Easy**
  - Improve team communication
  - Reduce NN patient case loads

- **Solutions that are not feasible but contribute to the problem**
  - Interventions implemented
  - Secondary interventions that will be addressed in near future
  - Larger interventions that will be explored at a practice level; beyond project scope
## Test of Change
### PDSA Plan

<table>
<thead>
<tr>
<th>Date</th>
<th>PDSA Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1-12, 2022</td>
<td>• Evaluate NN and physician expectations&lt;br&gt;• Redefine NN program goals</td>
<td>• Open discussions via meetings and surveys&lt;br&gt;• Prioritize responses based on impact to patients and VBC program requirements&lt;br&gt;• Timing of NN initial assessment and identifying barriers to care; developing a consistent approach and documentation standards&lt;br&gt;• Improved collaboration and trust; reduced frustration</td>
</tr>
<tr>
<td>September 1-21, 2022</td>
<td>• Develop a consistent method to screen for barriers of care&lt;br&gt;• Create a consistent documentation standard</td>
<td>• Implemented NCCN DT and additional note template in EMR&lt;br&gt;• Defined NCCN assessment triggers, timelines, and consistent documentation standards&lt;br&gt;• Assess all new cancer dx within 30 days of initial consult at a rate of 80% compliance to determine barriers to care&lt;br&gt;• Provide consistent quality care meeting health equity strategy standards</td>
</tr>
<tr>
<td>October 5 – present</td>
<td>• Improve team communication</td>
<td>• Communicate completion rates and assessment results weekly&lt;br&gt;• Resolve different interpretations on assessment triggers and timelines&lt;br&gt;• Conduct weekly project status meetings</td>
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</tbody>
</table>
Outcome Measure
Post Countermeasure

Blue Ridge Cancer Care
(% of Completed Nurse Navigator Initial Assessments)

P Chart: measured discrete Y/N data
Baseline = week 1-14
TOC = week 14 to week 28

- The process is under control because all data points are within the control limits; normal variation present except week 19
  - Suspected special cause variation on week 19
  - Difference in control limits = change in sample size
  - Variation improved: center line/mean shifted up and control limits are narrower
- Next Steps: confirm week 19 special cause variation, 8 data points as high as week 20
<table>
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<tr>
<th>Next Steps</th>
<th>Owner</th>
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<tr>
<td>Complete measurement period (30 days after 12/21/31) and share results with all stakeholders</td>
<td>ASCO QTP Team</td>
</tr>
<tr>
<td>Add NCCN completion rates to quality scorecard that are reviewed with teams, managers, and physicians monthly; monitor performance, address gaps, collect feedback on process and make improvements based on collective experiences and determine role responsibility; add to quality communication strategy to share performance and any changes with all stakeholders Add dates</td>
<td>Quality Team</td>
</tr>
</tbody>
</table>

**PHASE II**

<table>
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<tr>
<td>Determine NCCN reassessment criteria</td>
<td>Quality Director; Navigation and Social Worker teams, Clinical Director, Physician Champions</td>
</tr>
<tr>
<td>Improve follow-up discussions based on results</td>
<td>Navigation and Social Worker teams</td>
</tr>
<tr>
<td>Track/trend NCCN results by needs and patient demographics to determine vulnerable population</td>
<td>Quality Team</td>
</tr>
<tr>
<td>Learn how to work around gaps in community resources</td>
<td>Navigation and Social Worker teams</td>
</tr>
<tr>
<td>Continuing to strengthen community partnerships</td>
<td>Quality Director; Navigation and Social Worker teams, Clinical Director, Physician Champions</td>
</tr>
<tr>
<td>Conduct ongoing staff trainings on social determinants/health related social needs and diversity/inclusion</td>
<td>Quality Team</td>
</tr>
</tbody>
</table>
Conclusion

• What did we learn?
  ▪ Patient outcomes will improve
  ▪ Better team collaboration
  ▪ Positive feedback on NCCN tool utilization/outcomes

• Continue…
  ▪ On to phase II of the project
  ▪ To revise approach, continue to be agile
  ▪ To celebrate wins
Health Equity Strategy

**Partnership**
- Initiate the conversation
- Provide education to staff
- Establish partnerships in the community
- Consider patient experiences

**Action**
- Show organizational commitment
- Determine what is measurable
- Develop a strategy & implement the plan
- Influence public/private policy
## Health Equity Strategy & Implementation

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<td>1.</td>
<td>Identify demographic data completeness Race, ethnicity, language, gender, identification, sexual orientation; add to screening tool to ID vulnerable population and needs</td>
</tr>
<tr>
<td>2.</td>
<td>Select a SDOH/HRSN screening tool, define utilization NCCN Distress Thermomotor-Problems List 2022 (physical, emotional, social, practical, spiritual concerns)</td>
</tr>
<tr>
<td>3.</td>
<td>Establish an assessment outcome follow-up plan and timeline NCCN assessment within 30 days from initial consult, reassess after qualifying events</td>
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<tr>
<td>4.</td>
<td>Define all stakeholders; develop a communication strategy/plan Navigation, Social Work, Health Equity Resource Administrator, Care Teams</td>
</tr>
<tr>
<td>5.</td>
<td>Set measurement periods and guidelines Resource connection cycle-time; missed/canceled appt or not completed treatments; gaps in community resources</td>
</tr>
<tr>
<td>6.</td>
<td>Conduct staff training and education Diversity &amp; Inclusion (implicit bias), SDOH/HRSN training and ongoing education Health Equity Coalition &amp; Health Equity Journal Club</td>
</tr>
<tr>
<td>7.</td>
<td>Develop sustainability and continuous improvement plans Examine baseline, define phase II measurement, reevaluate expectations, process refinement, continue communication plan</td>
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Questions?
Feel free to submit questions

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• Must have at least 1 ASCO member at your practice
• Contact us at practicenet@asco.org
Next Calls

• 3rd Thursday of each month
• May 18, 4:00pm
  ▪ AI in Cancer Care – Is the Promise Real?
• Full calendar at practice.asco.org