

## COMMENTARY

# The Centers for Medicare & Medicaid Services Oncology Care Model Halfway Through: Perspectives from Diverse Participants

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## Abstract

The Oncology Care Model (OCM) is a 5-year model developed and tested by the Centers for Medicare & Medicaid Services that uses an episode-based payment model triggered by the receipt of chemotherapy to test if changing payment mechanisms, in conjunction with a requirement for enhanced patient services, can generate clinical transformation that will orient practices toward more patient-centered, high-value care to reduce expenditures and preserve or enhance quality of care for beneficiaries. The model is geographically diverse with practices in 34 states and encompasses practices ranging in size from 1 to more than 400 practitioners, with a multitude of business structures. Given these varied clinical and business environments, we believe that OCM-participating practices will have different opportunities and challenges as they work toward practice transformation, but they will likely share similarities with other practices in similar clinical and business settings. This commentary shares the experiences of four diverse groups participating in OCM—three practices and one network of practices—halfway through the model's projected 5-year life cycle in the expectation that these experiences will be of value to other practices embarking toward patient-centered, high-value practice transformation.

The Centers for Medicare & Medicaid Services (CMS) Oncology Care Model (OCM) is a 5-year model (beginning in July 2016) tested under the authority of the Center for Medicare and Medicaid Innovation using an episode-based, two-part payment approach: monthly care management payments (ie, Monthly Enhanced Oncology Services [MEOS] payments) and potential retrospective performance-based payments (PBPs) based on lowering episodes' total cost of care. The latter is compared to risk-adjusted, practice-specific target amounts, as well as outcomes and performance on quality measures (1,2). Each episode is 6 months in duration and is triggered by the receipt of either oral or intravenous (IV) chemotherapy. Currently, the model includes 176 oncology practices in 34 states, with more than 6000 health-care providers and more than 20% of the Medicare

Fee-for-Service (FFS) population receiving chemotherapy for cancer (an estimated 150 000 unique beneficiaries per year) (3,4).

The model also has rigorous requirements emphasizing patient-centered, high-quality, and high-value care achieved through whole practice transformation that is achieved through providing enhanced services supported by MEOS payments (\$160 per month for each attributed episode or \$960 per 6-month episode). Patients eligible for MEOS payments include all practice-attributed patients with Medicare Part A and B coverage who are receiving IV or oral chemotherapy, or hormonal therapy for the treatment of cancer. Enhanced services and practice requirements are detailed in [Box 1](#). CMS intentionally developed these requirements to be flexible, as specific

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**Box 1.** Practice requirements and enhanced services required for Oncology Care Model beneficiaries

#### Enhanced Services

Provide Oncology Care Model (OCM) beneficiaries with 24/7 access to an appropriate clinician who has real-time access to the practice's medical record.

Provide the core functions of patient navigation to OCM beneficiaries.

Document a care plan for each OCM beneficiary that contains the 13 components in the Institute of Medicine Care Management plan (5).

Treat OCM beneficiaries with therapies that are consistent with nationally recognized clinical guidelines.

#### Other Practice Requirements

Practices must use Certified Electronic Health Record Technology.

Use data for quality improvement.

strategies for transforming care are expected to vary based on the unique business, clinical, structural, and geographic environments of participating practices.

This article includes reflections from four diverse practice groups participating in OCM, based on the experiences and changes that participation in OCM has engendered. These practices include an independently owned community oncology practice (Clearview Cancer Institute [CCI]), a hospital-based medical oncology group (Lancaster General Medical Group [LGMG]), a large academic medical center (University of Texas, Southwestern [UTSW]), and a national network of independently owned oncology practices functioning under long-term management agreements (The US Oncology Network [The Network]). The practice characteristics are summarized in [Table 1](#).

### Clearview Cancer Institute

Founded in 1985, CCI serves more than 20 northern Alabama counties, with many patients traveling substantial distances to receive care. A subset of physicians and advance practice providers (APPs) rotate to satellite clinics to better serve patients in those regions. All locations benefit from a centralized administration, a single electronic medical record (EMR) system, and billing services managed from the main office location in Huntsville, Alabama.

### Lancaster General Medical Group

LGMG is owned by Lancaster General Health, which is a member of Penn Medicine (University of Pennsylvania Health System). The Lancaster General Health cancer program serves a region of approximately 500 000 people. All aspects of care are provided by an integrated staff in one location, using a single EMR, with one organizational and leadership structure.

### University of Texas, Southwestern

All oncology providers at UTSW belong to a large multispecialty practice. The oncology practice covers two distinct sites of service. The primary site is the Simmons Comprehensive Cancer

Center (SCCC), a National Cancer Institute -designated cancer center associated with University Hospitals, and includes two satellite clinics in outlying communities. In addition, UT Southwestern Physicians is contracted to provide all professional specialty services for Parkland Health System, the safety net health system for Dallas County. Although both systems use the same EMR vendor, each system has implemented its own individualized version of the system.

### US Oncology Network–McKesson Specialty Health

The Network is a division of McKesson Specialty Health (MSH) that manages community-based oncology practices throughout the country. The Network is composed of 30 practices, 16 of which are in OCM. Practices are community-based in urban, suburban, and rural areas across 25 states. The 16 OCM-participating practices in The Network range in size from 10 to 484 physicians (median = 40). Technology binds The Network: the practices almost uniformly use the same EMR, the same data dashboard (which collates data from various sources and generates actionable reports), and a decision support tool that displays The Network's proprietary pathways.

## How Has OCM Changed Your Practice Workflow?

### Clearview Cancer Institute

CCI already had many resources required for OCM in place, including nurse navigation, social workers, medical assistants, and financial counselors. Because of reporting requirements in OCM and the need for better communication with patients, we increased our medical assistants and nurse navigation staff to improve our processes, carry out the requirements of OCM, and embrace practice transformation.

We increased nurse navigation to a 1:1 ratio for most physicians and medical assistants to 1:1 for every physician. We increased social work support to a 2:1 ratio to ensure we had the workforce to support the clinical team for the psychosocial needs of patients. We added an additional financial counselor to assist with discussions of out-of-pocket cost estimates. Prior to the addition of staff, multiple physicians shared navigators, medical assistants, and social workers, making it difficult to adequately address patient concerns and the enhanced service requirements of the model. Moving closer to a 1:1 ratio for navigators and medical assistants, and a 2:1 ratio for social workers, has allowed all team members to work to the top of their licensure and/or certification. These additions have proven to be vital to the implementation of the Institute of Medicine (IOM) care plan elements (that are a requirement of OCM) (5), triage pathways, and financial discussions, because each individual staff member now takes responsibility for specific elements of an OCM beneficiary's care.

### Lancaster General Medical Group

In our view, successful implementation of OCM required moving beyond simply "checking a box" in the EMR and instead developing a more comprehensive approach to transformation, including an improved practice workflow that allows patients, physicians, and staff to make better, more informed decisions. Our goal was to not just document that we were meeting requirements but also make the necessary changes needed to

Table 1. Characteristics of practices

Practice demographic	Clearview Cancer Institute	Lancaster General Health	UT Southwestern	The US Oncology Network
New oncology patients annually	3100	2700	7000	120 000*
Average Oncology Care Model episodes†	850	400	1600	1700 per practice‡
Health-care providers	16 medical oncologists 18 advance practice practitioners	10 medical oncologists 4 radiation oncologists 2 gynecological oncologists 4 advanced practice practitioners	50 medical oncologists 55 radiation oncologists 3 gynecological oncologists 30 genitourinary oncologists 9 palliative care physicians 54 advanced practice practitioners 16 surgical oncologists	670 medical oncologists 200 radiation oncologists*
Other health-care providers	Single specialty	Practice is part of a large multispecialty group that includes radiation oncology, surgical oncology, and primary care	Practice is part of a large faculty practice that includes a comprehensive range of primary care and specialist physicians	Surgeons, advanced practice providers
Practice ownership	Private practice	Hospital-owned practice	University faculty	Private practices, nationally coordinated
Locations	6 full-service locations and 3 satellites in urban and rural Alabama	1 full-service suburban location in central Pennsylvania	2 full-service urban locations and 2 suburban satellites in Dallas, Texas	Diverse range of locations across the country (in 25 states)
Onsite services	Freestanding cancer center with relationship with local hospitals for inpatient services	Practice integrated with community hospital; refer to university for quaternary services	Quaternary care destination with full range of services	Cancer center model with services typically including chemotherapy, radiation, surgery, supportive care
Demographics	Highly educated urban residents and a significant rural and indigent population	Predominantly Caucasian and suburban/rural	Large indigent population, high prevalence of comorbidities	Wide range spanning the United States

\*Limited to The US Oncology Network practices participating in the Oncology Care Model.

†Per semiannual performance period.

‡27 000 total episodes spread across 15 US Oncology Network participating practices (range = 200–15 000). (The commentary refers to 16 practices, but 1 practice has recently dissolved, leaving 15 US Oncology Network practices in OCM).

ensure we achieved the full benefit to patient care intended by these requirements.

The requirement for the IOM care plan, for example, did not end with the development of a new documentation template, but rather inspired a redesign of our informed consent process, with increased focus on shared decision making, advance-care planning, and improved anticancer treatment education for patients. OCM quality metrics measuring the rate at which our patients were assessed for pain or depression became opportunities to consistently screen patients to identify those at a higher risk of complications or noncompliance so that we could develop rigorous safety nets to catch those who need help. To make changes in practice workflow more permanent, we redesigned the process for beginning an office visit in our EMR so that physicians and staff are required to review or perform important care management tasks associated with OCM implementation. This “rooming tool” that we developed has been so effective at helping us consistently manage patients that our EMR vendor will be making it available nationally for all specialties.

### UT Southwestern Medical Center

OCM’s emphasis on patient engagement and improved access to ambulatory services has created the biggest impact on workflow. Although OCM impacted patient engagement and access at SCCC, its biggest effects have been at our Parkland clinic, which had difficulty dealing with same-day clinic access. The daytime telephone triage system, largely managed by an automated messaging system, directed patients to the emergency department (ED) if they needed urgent care. Although after-hours calls were answered by a central, nurse-driven triage system with access to the medical record, nurse triage scripts quickly diverted the sick oncology patient to the ED. High patient utilization of the ED and hospital were reflected in our baseline historical data from CMS.

Over the last two years, we have established a same-day clinic with infusion capabilities. Improved phone management during clinic hours, with dedicated triage nurses and updated triage scripts, were developed to guide appropriate patients to the same-day clinic rather than the ED. To reinforce the support

available, a chemotherapy orientation class with associated patient education videos was implemented, along with a systematic approach to making regular contact with patients after each chemotherapy session. Our expectation is that early patient engagement will lead to a reduction in ED visits. Because many of these capabilities exist at SCCC, the practice is pressing to better coordinate the transformation efforts across the UTSW campus, leveraging resources and knowledge gleaned from each site of service to improve care globally.

### The US Oncology Network

The Network anticipated that major changes in practices' previous workflows would be needed to implement OCM, so we conducted a pilot focused on practice transformation in early 2016 (6). Cancer centers from four practices volunteered and practiced completing components of the IOM care management plan and implementing core navigation functions, such as identifying patients who would be eligible for OCM and developing a proactive approach to symptom management. The practices began new workflows to reduce avoidable hospitalizations, such as improving patient access to the clinics via urgent-care slots rather than diverting sick patients to the ED. Identification of new workflows for OCM was essential prior to enhancing our technology platform to support those workflows.

During OCM, we have employed the lessons learned in our pre-OCM pilot; however, practice transformation is still challenging. Changing culture throughout the practices takes time; for our providers, a main influence on behavior has been sharing peer-to-peer data (and helping them understand it). For the first time, we have total cost-of-care claims data to tie to our clinical data to inform decision making.

Prior to OCM, we had a financial counseling initiative, but OCM reinforced its importance by requiring a discussion with the patient regarding estimated total out-of-pocket expenses. We have assigned personnel at each site to "own" the documentation for the treatment plans, navigation, and depression screens, as well as ensuring appropriate follow-up. We began using "huddles" for weekly meetings. These new workflows have been met with variable enthusiasm and acceptance. Continuous monitoring of progress has been critical to meeting our objectives.

### How Has (or Will) OCM Changed Your Patient Care?

#### Clearview Cancer Institute

Our greatest achievement in OCM so far has been improved communication. From the top down, communication has been the key factor in transforming patient care. Weekly and monthly feedback reports for clinical employees, paired with an active effort to improve communications between administrative and clinical staff, have increased collaboration, ensuring that the requirements of OCM are being met on a daily basis with the goal of transforming care at all clinic locations.

Clinically, we are noticing positive results because of improved communication. Before OCM, only about 2% of our patients had advance-care status documented in the EMR. Currently, more than 90% of eligible patients have this information documented. The advance-care OCM quality requirement (part of the IOM care plan) has not only encouraged us to have difficult conversations with patients but also forced us to seek

additional opportunities to serve our patients through improved palliative and end-of-life services. Clinical staff have been provided with a script for these conversations, and we have worked with a local hospice group to create an education packet regarding advance-care directives. Additionally, the implementation of our Call Us First program (7) has increased communication between patients and clinical staff by encouraging patients to contact the clinic for any need, especially before reporting to the ED. Throughout the implementation of triage pathways and the Call Us First program, CCI has noted decreasing rates of ED visits and increasing use of same-day and next-day add-on visits.

#### Lancaster General Medical Group

We have focused strongly on making meaningful changes that would be seen and felt by our patients, not just process or EMR improvements but also the behavior changes necessary for true success. For example, we have focused on using the IOM care plan and out-of-pocket cost estimates as a part of an enhanced, meaningful informed consent that routinely includes advance-care planning.

Making patients, physicians, and staff aware of the cost of care has spurred a number of projects intended to improve the value of the care provided. Our formulary committee now takes into account drug prices, restricting access to high-cost medications when less expensive alternatives exist with similar safety and effectiveness. Additionally, we have moved some treatment regimens from an inpatient to an outpatient setting to reduce the cost of care.

Implementation of advance-care planning included an improved EMR process, just-in-time reports to identify patients without a plan, and a clinic workflow resulting in more than 95% of patients having a conversation about end-of-life choices. Three focused efforts have increased the percentage of effective advance-care planning discussions that lead to shared decision making, as well as documentation of preferences and formal documents filed in the EMR: 1) providing training so that staff can achieve advance-care planning facilitation certification, 2) making palliative-care support available within the oncology clinic, and 3) providing real-time feedback on advance-care planning status when a patient is in clinic. As a result, based on OCM quarterly feedback reports, our metrics for chemotherapy at the end of life and hospital admissions at the end of life improved from 39% worse than national average to 23% better than national average.

#### UT Southwestern Medical Center

Participation in OCM was perceived as a road map for practice improvement and to prepare our oncology practice for future value-based reimbursement systems. We believed that OCM's practice transformation elements would impact care and, by formal participation, provide the accountability necessary to drive change.

The practice recognized the gap in key elements of care between SCCC and Parkland. Particularly obvious were differences in patient engagement and same-day access to services. SCCC already had key mechanisms in place to orient patients to the practice and the ability to see sick oncology patients in the clinic setting on the same day. Parkland lacked these capabilities and would benefit from the transformation efforts. Efforts to improve same-day access to the Parkland oncology clinic have

been the focus of our OCM-driven changes. Indeed, leadership at Parkland identified the key transformation activities in OCM as a framework they were interested in following whether we formally participated in the program or not. The milestones provided by participation were felt to be key in aligning both institutions to common goals.

### The US Oncology Network

OCM provides funding to enhance patient care. MEOS payments have supported new hires such as navigators, social workers, additional APPs, and even data analysts. In addition, program requirements such as completion of the IOM care management plan have driven a more comprehensive approach to meeting the needs of cancer patients. Feedback from patients about their participation in the OCM has been positive. Admittedly, there was a concern that patients would be nervous about a Medicare program that attempts to control costs, but we have seen the opposite. Because of OCM, our patients receive not only extensive instruction about their treatment and potential complications but also a plan including clinical stage, risks, and prognosis. These initiatives have generally been accepted across all 16 practices, and in the first performance period, 9 of 16 practices reduced their hospitalizations, and in the second performance period, 11 of 16 did (8,9).

Interestingly, many of our practices are providing these enhanced services to all patients, not just Medicare patients, because the perception is that OCM has improved the patient-care experience. However, providing enhanced services is time-consuming, complex, and expensive and will need to continue to be supported by payers, especially if these patient-care improvements lead to smarter spending and relative reduction in total costs.

### How Has (or Will) OCM Changed Your Use of EMRs (Successes and Challenges)

#### Clearview Cancer Institute

CCI uses an EMR with an analytics platform that houses separate dashboards and reporting functionality to support data aggregation needs for OCM. CCI was fortunate to partner with its EMR vendor as a beta site early in the development process, and this collaboration assisted us in creating more seamless processes for documentation. Because of the tools designed by our vendor, CCI has been able to streamline the processes for reviewing eligible patients for required quality metrics, resulting in a reduction in time spent reviewing and analyzing data for submission to the OCM registry.

Two challenges for the practice include difficulty in tracking oral oncolytics and integrating with other systems. Capturing Part D coverage and actual fill dates of oral oncolytics has proven to be difficult for patients whose insurance requires fills outside our specialty pharmacy. We are constantly seeking new opportunities to access these data points. Our practice management system, which houses all billing information, is unable to integrate with many systems. This has resulted in additional manual and time-consuming processes related to review of unbilled visits and MEOS eligibility, as well as a greater dependence on our billing office personnel for ensuring validity of these data points.

#### Lancaster General Medical Group

By making OCM a corporate priority contingent on dedicated information technology (IT) support, we secured the resources necessary to help us transition away from a simple document repository and toward a tool that can turn those records into meaningful data and electronic decision support.

Because of a lack of automated reporting tools from our EMR vendor, it was necessary to hire staff to manually abstract clinical data from the EMR to report results to both CMS and our practice's physicians, staff, and leadership. Attempts to automate this process have not been successful.

The benefit of this manual effort, however, is that we have more accessible information that we can use for performance improvement. Because our OCM beneficiary list is reviewed continually, we have the ability to give each provider's team a weekly dashboard on their OCM patients, pointing out which patients lack documentation for quality measures or OCM eligibility criteria. Although manually generated, these weekly reports from the EMR are our first attempt to routinely affect quality measures prospectively by attempting to provide actionable metrics prioritized for patients' upcoming clinic visits.

We are beginning to have success with our EMR in providing evidence-based care. To ensure that our care is as consistent and guideline-driven as possible, our goal has been to make our home-grown Penn Medicine pathways available as close to the point of care and clinician decision making as possible. At first, this meant providing links to the relevant pathways in our EMR, but we are now building the pathways into the EMR's ordering system, where diagnosis information now affects the selection of available treatments. As we gain experience, we add both sophistication to our EMR's decision support tool and detail to previously neglected areas in the pathway. Our tumor-specific disease teams are responsible for developing and monitoring clinical pathways.

Our pharmacy and accounting departments have put effort into developing a custom tool for individualized price estimates for patients receiving anticancer medications. This has historically been a difficult area for hospitals, but early indications show that its accuracy is suitable for routine daily use. Providing personalized price estimates to patients prior to informed consent is an important component of shared decision making and patient engagement.

#### UT Southwestern Medical Center

Practice workflow is often dictated and defined by the capabilities of the EMR, rather than the converse—indeed, every process is a compromise between what the practice envisions as an ideal workflow and the capability of the EMR. A challenge for us has been to execute similar changes in workflow across both sites of service (ie, SCCC and Parkland). Although both systems use the same brand of EMR, each institution's EMR is a separate "instance" of the program. Each institution has vigorous governance and oversight committees for EMR customization, and each institution puts a premium on internal consistency to ensure a common EMR experience for all providers in the given institution. Although this makes perfect sense to ensure patient safety and consistency, our team underestimated the effort required to tailor the systems to meet OCM metrics across both institutions. Many key activities required for transformation have been delayed as we try to align workflows with our technology, including harmonization of triage scripts, mechanisms

of nurse triage documentation, consistent use of staging and oncology history modules, the builds of effective treatment summary and survivorship documents, the implementation of a clinical pathways program, minimization of duplicate data entry, and the ability to create and maintain an internal OCM registry to allow better case management and appropriate reporting. Indeed, the efficient use of technology remains our biggest challenge and offers the potential for the greatest impact to improve patient and provider engagement and workflows in our clinics.

### The US Oncology Network

EMR adaptations have been necessary to implement OCM efficiently through the creation of standard structured fields for data collection. MSH made a substantial investment to add program-specific elements to the EMR that allow documentation of quality metrics so results can be aggregated without a fully manual effort, and further enhancements were made to an existing decision support tool.

There have been some early positive lessons combining EMR data with the CMS claims data. We have internally generated and provided reports to physicians regarding individual performance on hospital admissions, ED visits, and hospice use to facilitate continuous learning and quality improvement. Even with all these enhancements, OCM still presents challenges, such as added documentation and “extra clicks” for providers, the creation of new technology to support patient navigation, and the preparation of data to submit to CMS. The burdens of patient identification, attesting to quality metrics, and data submission for the purpose of participating in this model are all new. Technology will be key to changing the balance from added work to added benefit.

### How Has (or Will) Your Practice Leadership Managed the Change Involved in Implementing OCM?

#### Clearview Cancer Institute

We have all had to shift our thinking from a Medicare FFS to a value-based care mind-set. OCM core team members include individuals from our compliance and quality control department, operational division managers, and a physician champion, as well as external vendors for data analysis.

One of the key elements helping drive change is the claims data supplied and quarterly feedback reports supplied by CMS. It has always been challenging to benchmark ourselves against other oncology practices. Feedback reports have given administrative staff the ability to communicate findings with physicians through reports and dashboards. The response to these findings has generally been positive and has been the backbone behind the drive for practice transformation regardless of payer. We have moved away from the mind-set of how we “think” we are doing based on EMR data to a more complete picture with CMS claims data.

#### Lancaster General Medical Group

One of the first steps in managing change of this magnitude is building consensus within the entire team. For us, this process began before OCM with a multiyear effort to improve outcomes

and consistency of care in anticipation of future value-based payment contracts. Before OCM began, we held retreats with our entire clinical team focused on developing and implementing clinical pathways, advance-care planning, shared decision making, palliative care and symptom management, emergency department visits, end-of-life care, and price estimates.

The emergence of OCM validated our direction and served as a communication tool that described what we wanted to accomplish and helped achieve the necessary consensus from clinical and administrative leaders so that critical personnel and resources would be provided. The promise of IT support for EMR improvements helped secure physician buy-in. Our medical staff wanted to feel confident that practical and immediate support to implement the process changes deemed necessary would be provided.

The next aspect of change management was to devote resources and leadership to key projects and focus the attention of those teams, and the practice as a whole, on completing those projects with minimal distraction. Change management was achieved through the use of aligned goals, with individual teams working on individual components of what collectively rolled up to practice goals. Weekly reports ensured that our top-priority OCM projects wouldn't take a back seat to other issues.

Our implementation teams include not just physician and administrative leaders but also frontline staff representing nursing, APPs (generally responsible for acute patient visits), medical assistants, scheduling and clerical staff, financial counseling, IT, and data analysts. We have found the deliberate inclusion of interested OCM “end users” important to success; their feedback on the implementation of new ideas has helped both improve and accelerate the execution of our projects.

A senior hospital leadership decision was made that all patients would receive the enhanced services in the new OCM, preserving a single standard of care for all patients, regardless of payer. This decision has been key to our participation in the model and has helped us more quickly demonstrate that our changes are both effective and scalable to other payers. This has influenced our decision to more aggressively pursue alternative payment models with commercial payers. A sharp focus on the success of OCM implementation has necessarily limited other administrative work so that new projects are selected only if they support OCM. Physician and administration support of OCM allows program metrics to be used for corporate quality projects and compensation for leaders and physicians who may have part of their compensation at risk for quality measures.

#### UT Southwestern Medical Center

Leadership of the UTSW oncology practice consists of a complex matrix of clinician leaders, academic departments, and corporate administrators, reflecting the hierarchical structure of two large health systems. The oncology clinical leadership includes 12 disease-oriented teams.

Executive administrative support for OCM was largely drawn from SCCC leadership. Parkland Health System leadership was drawn primarily from the corporate suite—largely from the population health and ambulatory operations leadership—and coordinated by the oncology service line administrator.

An OCM executive committee was formed to provide oversight of the practice transformation activities at SCCC and Parkland. Both organizations support the overall goals of the project and hope to use OCM to align practice patterns across the system and help prepare for future value-based payment

models in oncology. That said, the multiple layers of leadership at the two institutions have made the timely execution of key decisions to support transformational activities a challenge. Overall, organizational priorities have changed during our years of participation in the model, affecting resources allocated to OCM activities. At Parkland, resource restrictions require the re-setting of OCM transformation timelines annually.

At UTSW, an ongoing system-wide priority is to support a rapidly growing and successful Accountable Care Organization (ACO) that is prompting care transformation across the entire organization. OCM metrics are oncology focused, as opposed to the broad metrics for the ACO. These differences limit the leverage that the organization's participation in the ACO can provide to OCM. These realities inevitably forced budgetary priorities that affect OCM implementation.

Data are critical to physician and health-system engagement with alternative payment models. A strong motivator for participating in OCM was the potential for access to claims files for our attributed patient population, providing a picture of how our practice is "viewed" by CMS and how we stack up against other oncology practices vis-a-vis quality and resource utilization. Indeed, the reports provided by CMS have been illuminating. The system had hoped to use existing ACO analysts to provide these services, but the differences in metrics and programmatic structure between OCM and the ACO was so great that additional analytic help has been necessary. Harmonizing definitions and metrics between alternative payment models would allow practices to better leverage participation in specialty models. Participation in OCM has been helpful by providing the metrics and benchmarks necessary to force change within our oncology practice.

### The US Oncology Network

One very important thing we learned in value-based care programs preceding OCM (10,11) is that physician leadership is crucial. Value-based care programs require change at the provider, administrative, and clinic levels. This must be supported by practice leadership, or it loses steam and interest. We have designated physician leaders at each of our OCM-participating sites. These physicians are responsible for driving change, particularly at the provider level. We have found the most powerful "tool" in driving change is information. OCM provides a rich supply of claims data, and The Network has a team of program analysts who generate actionable reports. It is up to the OCM physician champions at each site to share this information with their colleagues and identify opportunities for improvement. Examples include outliers in hospitalization rates, ED visits, treatment plans, quality metric documentation, and advance-care planning. OCM is a comprehensive program touching all providers in the practice, and program success can't be achieved without strong physician leadership and engagement.

OCM does, however, present challenges in determining the appropriate method for physician compensation. We have shown in some of our network practices that small changes in compensation that tie income to performance have improved pathway adherence (12). Many of our practices are considering other ways to reward value while still maintaining some degree of income tied to productivity. Aside from the individual practice leadership, The Network and MSH have developed a network-wide leadership structure for value-based care initiatives. This depends on all practices sharing data and information in a blinded fashion with each other. Our robust internal

#### Box 2. Summary of key practice changes\*

- New process to identify Oncology Care Model eligible patients
- Treatment plan incorporated into electronic medical record
- Follow-up call to select patients after treatment
- Financial counseling
- Team huddle
- Advance care planning
- Analytics using claims and practice-generated data
- Continuous learning (ie, feedback to providers and staff)
- Physician champions

\*This list is not comprehensive of all transformation and quality improvement activities implemented.

analytics and reporting team allows us to learn from all network practices in OCM and, accordingly, establish "best practice" models.

### Conclusion

Oncology care is complex, encompassing multiple medical specialties and heterogeneity in care intensity. Similarly, a broad variety of clinical, geographic, and business environments across the United States provide diverse opportunities and challenges for enhancing patient care. Consequently, we believe there is not a single path to patient-centered, high-value care. Recognizing this, CMS chose to make OCM as flexible as possible, allowing practices to discover their own paths to practice transformation. This commentary was an effort to share some of the experiences of a diverse group of OCM practices.

Several common themes emerged (Box 2) from discussions with participants, who reported that communication within a practice and with patients is vital to providing efficient, patient-centered, high-value care. Improved communication within a practice can take many forms and occur at many levels. At the most basic level, these include clinical team huddles and closer working relationships between dedicated support staff, but they also encompass improved communication between administrative and clinical staff and shared governance, specific to the practice structure, that is required to generate the administrative support, resources, and buy-in necessary for success in complex organizational structures.

Improved communication with patients required by OCM includes patient and physician discussions of treatment risks and goals through structured communications such as the IOM care plan (advance-care planning is a data element) (5), as well as quality measures that assess depression (OCM 5, NQF 0418) (13) and pain (OCM 4a, NQF 0384) (14). Also critical is timely and effective patient communication that allows for the early recognition and management of disease and treatment complications. The clinical importance of these communications has recently been demonstrated by Basch et al. (15). Interventions such as a dedicated phone triage staff with detailed clinical pathways, same-day appointments, and after-hours and weekend clinics can help prevent unnecessary ED visits and hospitalizations.

Effective EMRs have the potential to improve patient care and make workflows more efficient, but this is still a work in progress for some OCM practices, and it may require the allocation of significant financial and personnel resources. Physicians

are learning to adapt to the format of EMRs and to consistently use structured data fields that allow for the collection of relevant quality and risk adjustment data (at least until natural language processing becomes more functional)—a significant change for physicians more accustomed to including these data elements in narrative notes.

Substantial financial resources have been expended by CMS in the form of MEOS payments and by some practices from other revenue streams. The MEOS payments are intended by CMS to support the enhanced beneficiary services that are part of OCM. The specific uses of these additional financial resources have varied across practices, but in general, include supporting the personnel required to provide these enhanced services to OCM beneficiaries, spending on information technology to improve EMRs and analytical capabilities, expanding internal education and communication, and providing the administrative personnel necessary to fulfill the reporting requirements of the program.

Leadership support is critical to practice transformation regardless of practice type. This takes many forms and is dependent on the structure of the practice. Regardless of structure, however, participation in OCM and other similar value-based models is an acknowledgement of anticipated future health-system changes in the United States and a desire to gain experience in this new paradigm earlier in the process. As these practices have described, the path is sometimes challenging, but it is intended to ultimately lead to improved patient engagement and care.

## Notes

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The information presented on individual practice outcomes and metrics has not been verified by CMS or its contractors and is the sole responsibility of the practice reporting the data. The views, findings, and conclusions in this commentary are those of the authors' and do not necessarily represent the views or official policies of the Centers for Medicare & Medicaid Services. The authors wish to acknowledge the work of all practices

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