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LOUISIANA DEPARTMENT OF HEALTH

Statewide Cancer Strategy Leadership Committee Meeting

January 19, 2018

Louisiana Cancer Research Center
1700 Tulane Avenue
Room 901 (9th floor)
New Orleans, Louisiana

Meeting Agenda

	**Introductions** Dr. Rebekah Gee, Louisiana Department of Health	**15 mins**
	**Confirm Leadership Committee Charge & Guiding Principles** Jonah Frohlich, Manatt Health Strategies	**15 mins**
	**Review Project Approach & Work Plan** Megan Ingraham, Manatt Health Strategies	**5 mins**
	**Discuss Interview Findings & Preliminary Hypotheses** Committee Members	**80 mins**
	**Review Near-Term Next Steps** Megan Ingraham, Manatt Health Strategies	**5 mins**

Leadership Committee Composition

Committee Members

- **Rebekah Gee**, Secretary, Louisiana Department of Health (co-chair)
- **Augusto Ochoa**, Professor, LSU School of Medicine (co-chair)
- **Karen DeSalvo**, Former Assistant Secretary for Health, HHS
- **Gregory Feirn**, Chief Executive Officer, Louisiana Children's Medical Center
- **Lee Hamm**, Dean, Tulane School of Medicine
- **Jennifer Malin**, Senior Medical Director, UnitedHealth Group
- **Glenn Mills**, Director, LSU, Shreveport Cancer Center
- **Steve Nelson**, Dean, LSU School of Medicine
- **Oliver Sartor**, Professor of Cancer Research, Tulane University School of Medicine
- **Greg Sonnenfeld**, Director Cancer Center, Willis-Knighton Health System
- **Todd Stevens**, Chief Executive Officer, Mary Bird Perkins Cancer Center
- **Warner Thomas**, Chief Executive Officer, Ochsner Health System
- **Ed Trapido**, Professor, LSU School of Public Health
- **Steven Udvarhelyi**, Chief Executive Officer, Blue Cross and Blue Shield of Louisiana
- **Vindell Washington**, Chief Medical Officer, Blue Cross and Blue Shield of Louisiana
- **Scott Wester**, Chief Executive Officer, Our Lady of the Lake Hospital
- **Donna Williams**, Director, Louisiana Cancer Prevention and Control
- **Jeff Williams**, Chief Executive Officer, Louisiana State Medical Society
- **Xiao-Cheng Wu**, Director, LSU Tumor Registry

Staff Support

- **Pete Croughan**, Policy Director, Louisiana Department of Health
- **Jonah Frohlich**, Managing Director, Manatt Health Strategies
- **Megan Ingraham**, Director, Manatt Health Strategies
- **Bob Rebitzer**, Managing Director, Manatt Health Strategies
- **Chris Cantrell**, Manager, Manatt Health Strategies
- **Christine Malcolm**, Consultant, Salt Creek Advisors
- **Paul von Ebers**, Consultant, Prospective Health

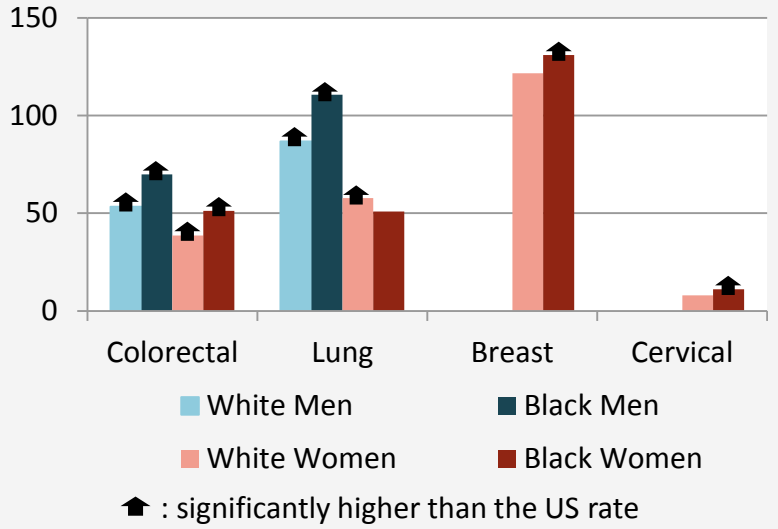
Case for Change

Leading Cancers for 2009-13

	Men		Women	
	Incidence	Mortality	Incidence	Mortality
1	Prostate	Lung	Breast	Lung
2	Lung	Prostate	Lung	Breast
3	Colorectal	Colorectal	Colorectal	Colorectal
4	Bladder	Pancreas	Uterus	Pancreas

Avg. Annual Incidence Rates for 2009-13

(per 100,000 people)



- Louisiana has the fourth highest cancer mortality rate in the nation.
- The state significantly lags behind the national average for colorectal and cervical cancer screening.
- Many patients seek care out of state.
- Persistent disparities exist across all cancers, both in terms of stage at diagnosis and mortality.
- Medicaid now covers a third of the state's population, presenting opportunities for broader cancer initiatives.

Sources: United Health Foundation, America's Annual Report Health Rankings, 2016; National Cancer Institute, State Cancer Profiles; Louisiana Comprehensive Cancer Control Plan 2017-2021, Louisiana Tumor Registry.

Leadership Committee Charge & Guiding Principles

Committee Charge

The Leadership Committee will lead the development of a statewide strategy to improve cancer outcomes in Louisiana; identifying high priority cancer conditions and interventions to enhance quality, improve access to care and contain costs.

Guiding Principles

- ***Fact-based & Transparent Dialogue:*** Committee members will engage in fact-based and hypothesis-driven dialogue, and operate in a transparent manner by sharing key decisions with the committee and stakeholders.

- ***Broad-based Decision-Making:*** The Committee will strive for consensus wherever possible; in the absence of complete agreement, decision-making authority will reside with the Committee co-chairs.

- ***Coordination & Alignment:*** Committee activities and decisions will be coordinated and aligned with other cancer initiatives in Louisiana.

Project Approach

Phase I: Develop Louisiana Cancer Strategy (Jan – May 2018)

Key Activities

- Develop Louisiana landscape analysis of cancer prevalence, mortality, delivery system, cost and outcomes.
- Assess payer-enabled, provider-driven cancer programs in other states.
- Convene Leadership Committee in March and a cancer summit in April.
- Develop a statewide cancer collaborative approach.

Outputs

- ✓ Statewide landscape analysis
- ✓ Cancer collaborative agreement components

Phase II: Establish Cancer Collaborative Agreement (Jun – Dec 2018)

Key Activities

- Draft three-year cancer collaborative agreement with milestones, requirements and payer and provider expectations.
- Convene Leadership Committee to refine and finalize agreement.
- Engage stakeholders to review agreement and secure commitments.

Outputs

- ✓ Three-year collaborative agreement
- ✓ Commitments from participating stakeholders

Phase III: Implement Statewide Cancer Strategy (Jan 2019+)

Key Activities

- Organize and engage participating payers and providers
- Initiate selected interventions

Outputs

- ✓ Launch of selected interventions

Scope of Manatt support

Preliminary Observations

We need to get to root causes of cancer issues in Louisiana.

Louisiana physicians are very independent and are not going to want anyone telling them what to do. Pay for Performance may be way to go.

Lay navigators and churches can help build community support for screenings.

Are we focused on advancing care or improving public health?

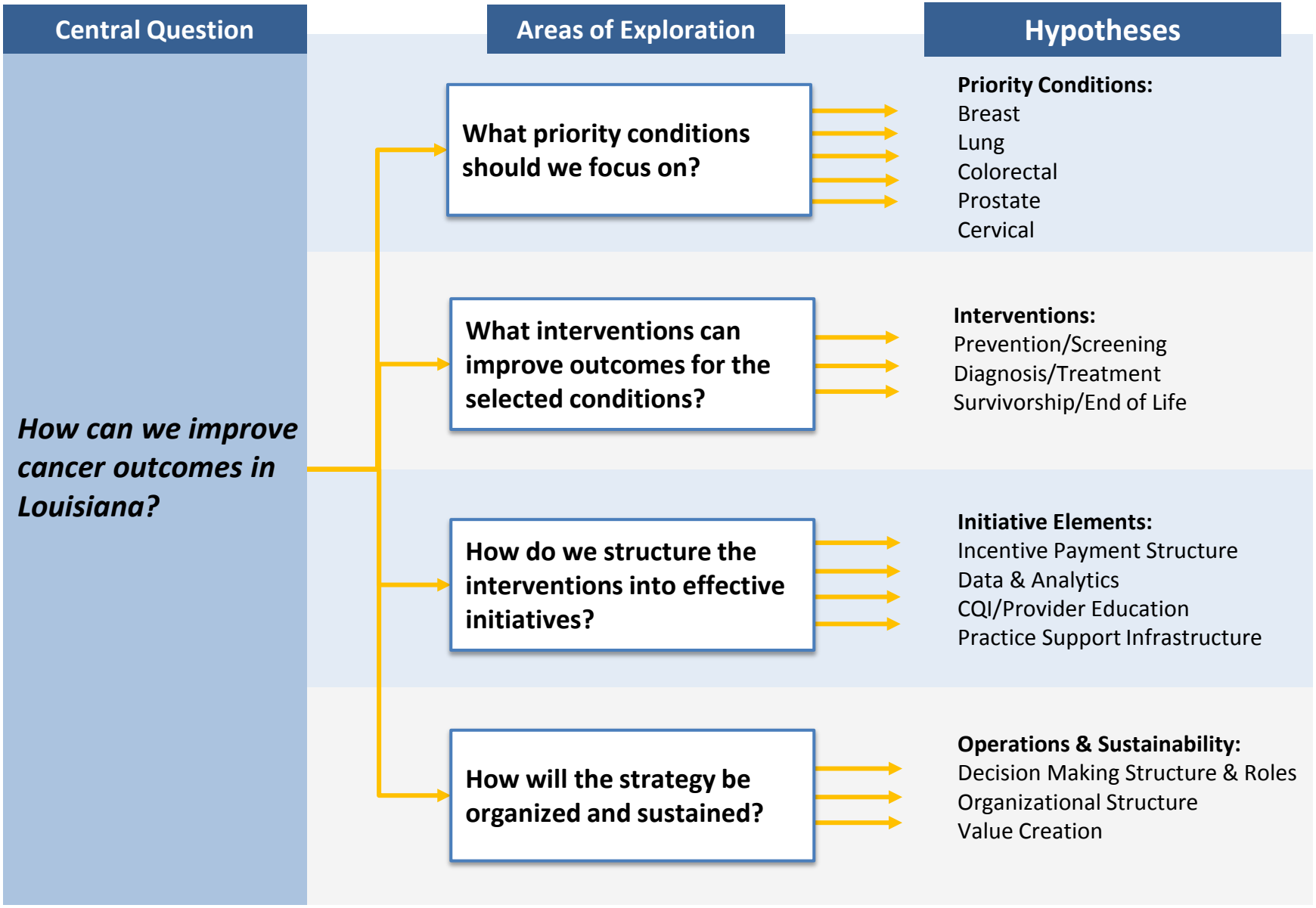
We need to initially focus on interventions that can yield measurable impact in the relative near term.

FQHCs may be a strong partner in these interventions and a potential channel for expanding clinical trials.

I'd recommend leaving prostate out of this initiative's first phase because of screening nuances.

Screening must be channeled through community and primary care settings – not via oncologists.

Louisiana Statewide Cancer Strategy Hypothesis Issue Tree



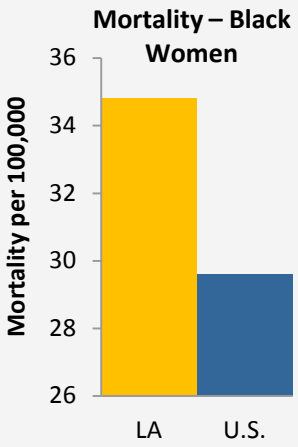
What priority conditions should we focus on?

Hypotheses

- The strategy will initially focus on no more than two priority conditions, considering: breast; lung; colorectal; prostate, and cervical cancer.
- The strategy will prioritize conditions based on: disease prevalence and incidence trends; clinical outcomes and mortality; disparities; costs, and research opportunities.

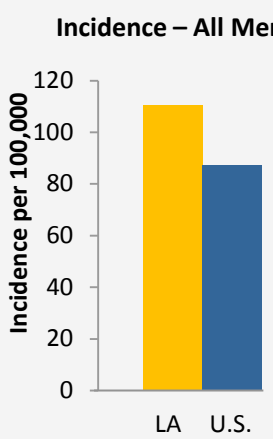
Evidence

Breast



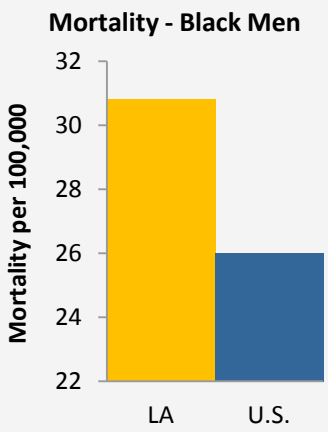
Louisiana has the highest breast cancer mortality rate in the U.S.

Lung



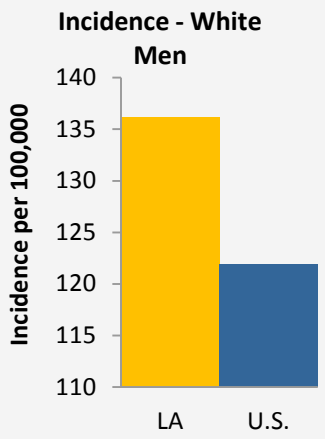
Incidence and mortality rates are significantly higher across all genders and race groups compared to national averages.

Colorectal



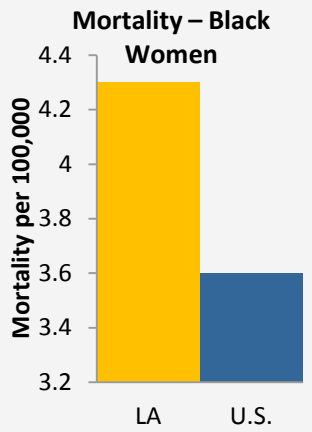
Louisiana has the 3rd worst mortality rate for colorectal cancer in the U.S.

Prostate



Incidence rates are significantly higher for white and black men

Cervical



Louisiana has the 3rd highest mortality rate for cervical cancer in the U.S.

Sources: Louisiana Comprehensive Cancer Control Plan 2017-2021, , Louisiana Tumor Registry.

What interventions can improve outcomes for the selected conditions?

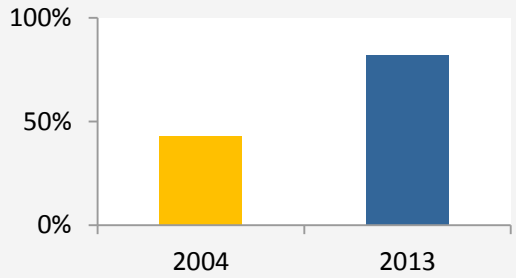
Hypotheses

- Interventions will address: prevention and screening; diagnosis and treatment; and survivorship.
- Interventions with the greatest potential for improvement in quality and outcomes, access and cost will be selected.
- Interventions will be designed to consider and directly address health disparities.
- Participating clinicians will lead design of clinical interventions, protocols and guidelines.

Evidence

Prevention/Screening

Colorectal Screening Rates



Kaiser's colorectal screening program nearly doubled screening rates.

Diagnosis/Treatment

Michigan Urological Surgery Improvement Collaborative (MUSIC) achieved:

- **50% reduction in hospitalizations related to prostate biopsies.**
- **Prostate biopsy-related infections reductions to 0.6%.**
- **Statewide decrease in utilization of both staging bone scans and CT scans.**

Survivorship

Deep South Network for Cancer Control explicitly focuses on survivorship education for African American populations and other underserved communities.

Sources: Kaiser Permanente colorectal screening program: https://www.kpihp.org/kp-policy-story-vol-4-no-1-colorectal-cancer-screening-preventing-a-deadly-disease/#sthash.dFkViQA5.dpbs; Michigan Oncology Quality Collaborative: https://moqc.org/; Deep South Network for Cancer Control: http://www3.ccc.uab.edu/community-outreach/deep-south-network-for-cancer-control/.

Opportunities across Cancer Care Continuum by Condition

<table>
<tr><th>Conditions</th><th>Prevention/ Risk Reduction</th><th>Screening</th><th>Diagnosis</th><th>Treatment</th><th>Survivorship</th><th>End of Life</th></tr>
<tr><td>Breast</td><td rowspan="5">• Obesity & exercise campaigns
• Pursue legislation to:
a. Raise cigarette taxes
b. Introduce additional sin taxes
c. Mandate teen HPV vaccinations</td><td>Build on existing State breast/ cervical screening programs</td><td>Breast health centers</td><td rowspan="4">• Pathways with prior authorization requirement for opt-outs
• Increased community-based clinical trial accruals
• Designation of centers of excellence</td><td rowspan="5">Leverage PCPs/PAs/NPs & telemedicine to lighten oncologists’ load</td><td rowspan="5">• Introduce palliative care earlier in disease process & across clinical settings
• Waive hospice requirements
• End of life conversations & training</td></tr>
<tr><td>Cervical</td><td>• Self-sampling tampons
• Avoid over-screening</td><td>• Vinegar colposcopy
• See & treat practices</td></tr>
<tr><td>Lung</td><td>• Regional screening centers
• Screening van</td><td></td></tr>
<tr><td>Colorectal</td><td colspan="2">• Two step screening and Tx: Universal access to FOBT or FIT + colonoscopy
• Mobile medical clinics
• Early screening for select populations</td></tr>
<tr><td>Prostate</td><td>• Mobile medical clinics</td><td></td><td>Shared Tx decision making (e.g., watchful waiting), biopsy timeouts</td></tr>
</table>

How do we structure the interventions into effective initiatives?

Hypotheses

Initiatives will:

- Incorporate incentive structures that reward quality and cost results
- Support "centers of excellence" models for preferred providers
- Adopt centralized and coordinated data collection, analysis and reporting

Evidence

Incentive Payments	Centers of Excellence	Data Collection, Analysis & Reporting
$58.4 million in incentive payments were awarded to providers in Blue Cross Blue Shield of Michigan's CQI efforts in 2014.	**The NCI Community Cancer Centers Program saw hospitals invest $3.74 for every NCI dollar invested.**	**Largest collection of clinical data in the world: Nearly 500,000 cases were submitted to CQI registries in 2015, equating to more than 2.1 million cases across all registries**

Sources: Michigan Oncology Quality Collaborative: https://moqc.org/; Delaware Cancer Consortium. https://www.healthydelaware.org/Consortium; Anthem treatment pathways. https://anthem.aimoncology.com/Resources.html ; PA urology collaborative: http://www.arbormetrix.com/press-releases/arbormetrix-analytics-to-power-urology-clinical-decisions-in-southeastern-pennsylvania.
Journal of Healthcare Management, 2014

How will the strategy be organized and sustained?

Hypotheses

- The strategy will:
  - Add value for patients, providers and payers
  - Have a fair and transparent decision-making structure
  - Organize and coordinate payer and provider participants

Evidence

Value Creation	Organizational Structure & Decision Making
$793 Million in statewide health care cost savings were generated from five of Michigan's Quality Collaborative initiatives between 2008 and 2013.	**Anthem/WellPoint Cancer Care Quality Program uses a 12-member Committee, comprised of NCI-accredited cancer center representatives and community oncologists to advise on the treatment pathways.**

Sources: Michigan Oncology Quality Collaborative: https://moqc.org/; Delaware Cancer Consortium. https://www.healthydelaware.org/Consortium; Anthem treatment pathways. https://anthem.aimoncology.com/Resources.html ; PA urology collaborative: http://www.arbormetrix.com/press-releases/arbormetrix-analytics-to-power-urology-clinical-decisions-in-southeastern-pennsylvania.

Near-Term Next Steps

Manatt and LDH teams to:

- Refine hypotheses based on input from Leadership Committee.
- Analyze Louisiana Tumor Registry data and reports to refine clinical priorities based on prevalence and mortality.
- Coordinate with payers on needed analysis related to cancer costs and care patterns for clinical targets to specify requirements for claims analysis.
- Complete leadership interviews with State, health systems, payers, and other stakeholders.
- Summarize findings of landscape research.
- Outline components of Statewide Cancer Strategy Agreement.

Leadership Committee to:

- Provide feedback on initial hypotheses to Manatt team (Chris Cantrell, ccantrell@manatt.com)
- Reconvene in March to:
  - Review landscape assessment findings.
  - Prioritize target conditions and interventions.
  - Review and refine components of Statewide Cancer Strategy Agreement.

Appendix

Case Study: Michigan Oncology Quality Consortium (MOQC)

Program Objectives	Promote high-quality, effective, and cost-efficient care for cancer patients.
Conditions Addressed	Lung, cervical, colorectal, endometrium, ovary, uterus, vulva and other cancer conditions.
Program Elements	▪ Tobacco Cessation Program Initiative: Promotes tobacco use screening and cessation programs in provider practices, including counseling and patient education materials. ▪ Oral Oncolytics Initiative: Promotes best practices and guidelines for oral anti-cancer medications across a variety of conditions. ▪ Gyn-Onc Initiative: Promotes strategies to improve the timeliness and quality of cancer treatment, including implementing evidence-based protocols. ▪ QOPI Data Reporting: All participating MOQC practices are required to abstract QOPI measures for quality reporting and improvement purposes.
Organizing Entity	Value Partnership Coordinating Center at the University of Michigan
Infrastructure	Coordinating Center at the University of Michigan provides staffing (7 FTEs), office space and data reporting infrastructure.
Program Participants	▪ Blue Cross Blue Shield of Michigan (BCBSM) - part of the broader Value Partnership quality improvement program. ▪ 70 medical oncology practices participate, representing 328 oncologists. ○ Notable health system participants include Henry Ford Cancer Center, University of Michigan Health System, McLaren Health Care Corp, and Oakwood Healthcare.
Financing	All of MOQC's financial support is provided by BCBSM, including staff at the Coordinating Center at the University of Michigan.
Outcomes	▪ Increased adherence to standardized oncology practice guidelines for some specialties (e.g., breast, colorectal cancer), but adherence to pain management guidelines was not as high. ▪ Dramatically improved tobacco cessation referrals in Michigan with 2,093 cancer referrals made to the Quitline in the first two years. The program provides free nicotine replacement therapy and counseling services to oncology patients. ▪ Financial incentives, such as reimbursement for data collection costs, significantly increased provider participation in the MOQC.

See the included Health Affairs article for further information on the implementation and early results of the MOQC program.

Case Study: Anthem/WellPoint Cancer Care Quality Program (multi-state)

Program Objectives	▪ Promote adoption of standardized chemotherapy pathways for 80-90% of eligible patients. ▪ Reduce cost of chemotherapy treatment for select conditions. ▪ Reduce hospitalizations resulting from side-effects from more toxic treatment regimens.
Conditions Addressed	Breast, bladder, colorectal, gastro-esophageal, head and neck, lymphoma, kidney, lung, melanoma, ovarian, pancreatic, prostate, testicular, uterine.
Program Elements	▪ Standardized Treatment Pathways: Anthem partnered with AIM Specialty Health (a subsidiary of Anthem) to provide best practices, guidelines and pathways for chemotherapy to providers. ○ 12-member Committee, comprised of NCI-accredited cancer center representatives and community oncologists, advises on the treatment pathways. ▪ Decision Support Platform: Providers use AIM's web-based platform to access decision support tools and pathways. ▪ Quality Reporting: Practices receive quarterly reports on quality measures, including ER and hospitalizations, pathway adherence, and National Quality Forum (NQF) End of Life care measures. ▪ Provider Incentives: Providers may receive enhanced reimbursement from Anthem for compliance with the pathways.
Organizing Entity	Anthem BlueCross BlueShield
Infrastructure	Web-based platform for providers to access cancer treatment pathways (called AIM Provider Portal).
Program Participants	▪ Anthem BlueCross BlueShield provides funding and leads the program. ▪ AIM Specialty Health, a subsidiary of Anthem, administers preferred treatment pathways and web portal. ▪ Provider practices may choose to participate in the pathways program. ▪ HealthCore Inc. conducts the program evaluation.
Financing	▪ Program Funding: Anthem provides funding for AIM Specialty Health's support to providers. ▪ Provider Incentives: Providers receive standard reimbursement for commercial populations and Medicare Advantage members, and may receive an enhanced $350 PMPM if they follow one of the preferred chemotherapy pathways.
Outcomes	▪ Between July and December 2014, 616 practices registered 5,538 patients in the program to participate in and receive Pathways treatments, with a mean of 8.7 patients per practice. ▪ 30% of patients had breast cancer, 15% lung, 13% colon, 10% lymphoma, and 33% other. ▪ Pathway adherence varied across cancer types: Breast (63%), Colon (72%), Non-Small Cell Lung (63%) ▪ Early evaluation found little variation in patient outcomes but significant reductions in treatment costs for providers using preferred pathways.

Case Study: Highmark Cancer Collaborative (Western Pennsylvania)

Program Objectives	▪ Improve patient safety, patient experience and clinical outcomes. ▪ Enhance quality by reducing unwarranted variations in care. ▪ Increase adoption of evidence-driven, highest standards of care. ▪ Lower total costs of care and improving patient access to high-value care.
Conditions Addressed	25 cancer types, covering 96% of cancers impacting Highmark members, including breast cancer.
Program Elements	▪ Standardized Treatment Pathways: Highmark provides clinical pathways software (NCCN-approved McKesson's Clear Value Plus) to participating oncologists. ▪ Value-Based Payments: Episode-based payment reimbursement for target conditions, with no prior authorization requirement for providers who adopt standardized pathways. ○ Highmark is developing a value-based pricing arrangement with a pharmaceutical company.
Organizing Entity	Highmark
Infrastructure	▪ Highmark serves as a convener of clinical experts to define effective cancer treatment pathways. ▪ McKesson Clear Value Plus web-based pathways software.
Program Participants	▪ Highmark provides care coverage, tracks payments, and analyzes data for care quality (including meeting with providers to discuss their performance). ▪ Allegheny Health Network (AHN) provides clinical care and expertise across 50 clinic locations (150+ oncologists). ▪ PinnacleHealth provides clinical care, with a focus on breast cancer treatment. ▪ John Hopkins Kimmel Cancer Center provides access to early phase clinical trials, physician peer-to-peer review, and other virtual support.
Financing	▪ Program Funding: Highmark funds the Collaborative's administrative costs ▪ Value-Based Payments: Episode-based reimbursement payment arrangement with participating health providers for the 25 target conditions
Outcomes	▪ Achieved 83% adherence to evidence-based treatment protocols and payment models that incent value-based care. ▪ Pathways generated 35% cost savings compared to traditional models of care. ▪ Expanded to offer clinical pathways for 25 different types of cancer, covering 96% of cancers impacting Highmark members. ▪ CMS selected Highmark Cancer Collaborative and AHN for inclusion in the Oncology Care Model.

See the included Journal of Healthcare Management article for further information on the program.

Case Study: NCI Community Cancer Centers Program (NCCCP)

Program Objectives	▪ Bring more Americans into a system of high-quality cancer care. ▪ Increase participation in clinical trials. ▪ Reduce cancer healthcare disparities. ▪ Improve information sharing among community cancer centers.
Conditions Addressed	Breast, colorectal, prostate, lung and other cancers.
Program Elements	▪ Disparities: Implement cancer outreach, screening and navigation programs targeted to underserved populations. ▪ Clinical Trials: Increase patient accruals, including underrepresented and disadvantaged populations. ▪ Quality of Care: Increase adoption of evidence-based guidelines and participation in other quality initiatives. ▪ Survivorship: Expand adoption of survivorship care plans and palliative care initiatives. ▪ Biospecimens: Identify requirements and approach for implementing NCI best practices for biospecimen resources. ▪ Health IT: Implement an EMR and tumor registry, and assess capacity to share data with NCI systems.
Organizing Entity	National Cancer Institute
Infrastructure	Participating hospitals are required to achieve and/or support the following: ▪ Accreditation from key organizations (e.g., Joint Commission, American College of Surgeons Commission on Cancer); ▪ Dedicated cancer center with medical, surgical and radiation oncology in a single location; ▪ Dedicated cancer medical staff, with at least one Physician Director; ▪ Defined plans for an EMR; ▪ At least one ongoing cancer disease specific multidisciplinary team conference; and, ▪ Planned or existing research affiliations with NCI-designated cancer centers or academic research institutions.
Program Participants	▪ Pilot program launched in 2007 with eight hospitals and has since expanded to include 30 hospitals across 22 states. ▪ Notable participants include Our Lady of the Lake Regional Medical Center and Billings Clinic.

Financing	▪ Each of the pilot sites received approximately $500,000 in NCI funding annually and were required to provide any remaining funds required to implement their initiatives.
	▪ NCI funds allocation requirements:
	  ○ Reducing health disparities (40%)
	  ○ Conducting clinical trials (20%)
	  ○ Collecting biospecimens (20%)
	  ○ Supporting health IT infrastructure (20%)

Outcomes	▪ Increased patient cancer care volumes among participating hospitals. ▪ Increased cancer physician affiliations with participating hospitals. ▪ Quality of care improved across all pilot sites, largely driven by targeted quality initiatives and nurse navigation.