HSCT in 2020
System Capacity Initiative

Care Delivery Model Working Group

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Within scope

- Continuum of Care
  - Referral to post-transplant care
  - Identify rate limiting steps of system
  - Expect overlap with other workgroups
  - Situational solutions may require different models:
    - Non-academic tertiary care centers
    - Academic centers
    - Cancer centers
    - Large, medium, small

Outside of scope

- Individual patient barriers
- Handoffs to other workgroups

Delays in Referral

- **Patients referred late in the disease process have**
  - poorer outcomes
  - require more intensive therapy
  - Utilize higher staff resources
  - longer lengths of stay

Delays in Referral

- Recommendations:
  - Work with professional medical organizations (ASH) to highlight optimal transplant timing.
  - Seek new methods to raise awareness and use referral timing guidelines.
  - Develop new optimal-timing awareness methods. Disease specific white papers.

Lack of HLA typing performed at diagnosis

- **High Resolution patient typing, Low Resolution family typing recommended**
  - Will assist in treatment planning if likelihood of a matched related or unrelated donor is known early in the process
  - Reduce delays in donor procurement if Preliminary Search is done early
  - Reduce likelihood of disease progression while waiting for search results

Lack of HLA typing at diagnosis

- Recommendations:
  - Build consensus regarding diseases for which typing at diagnosis recommended as therapy likely to include transplant. *(Table 1.0, CDM Executive Summary, pgs 13-14)*
  - Work with Payors regarding reimbursement
  - Educate referring physician community
  - Provide HLA testing kits to ensure correct degree of typing performed by accredited labs

Post-transplant care logistics

- **Patients seen by local care providers**
  - May not have access to most recent patient records
  - Or patient may be seen in an urgent care setting
  - Providers may have limited expertise with BMT complications
  - Prompt care for Transplant complications may not be provided
    - Increasing cost, length of stay and intensity of care when referred back to transplant center

Post-transplant care logistics

- Recommendations:
  - Develop patient/clinician post-transplant guidance materials
  - Provide patients with up to date records
  - Develop mechanism for patients & treating MDs to access applicable patient records
  - Ensure that patients can inform their local provider with contact information at TC
  - Coordinated care plan with Payors, leveraging pharmacists, etc.

Lack of caregiver support

- **Patients do not always have sufficiently skilled caregiver team**
  - Recommendations:
    - Identify alternative, full-time, non-family caregiver options.
    - Develop universal caregiver education programs, or broadly adopt existing programs.
    - Work with Payors regarding reimbursement for fees associated with non-family caregivers.

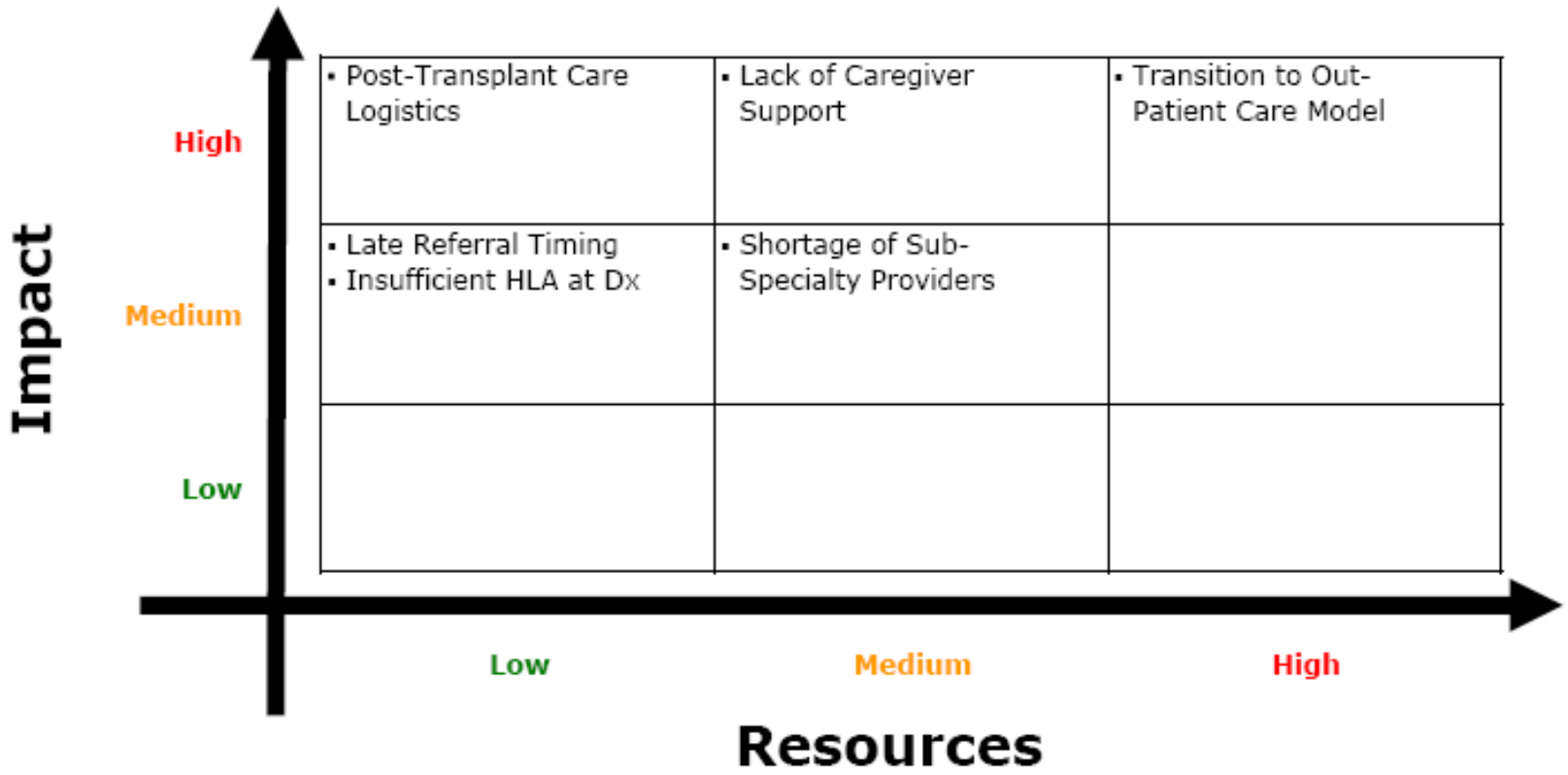
Explore outpatient care model

- **Need for outpatient care, plus local alternative housing options**
  - Recommendations:
    - Assess best practices for transitioning patients from inpatient to outpatient care.
    - Expand outpatient service model to include post-transplant monitoring via close, temporary housing for patients/families.
    - Seek reimbursement solutions for outpatient services.

Limited sub-specialty availability

- **Increased center capacity also impacts need for sub-specialists.**
  - Recommendations:
    - Develop best practices for urgent consultations with sub-specialist
    - Develop guidelines for inpatient and outpatient consultation procedures
    - Explore partnerships with sub-specialty professionals outside current network.
    - Work with Payors to ensure non-standard care-provider costs reimbursable.

Impact of Change vs. Resource Inputs



Conclusion

- What's next for years 2-3?
  - Obtain additional feedback from subject matter experts.
  - Devise implementation strategies
  - Define metrics.

Questions or Comments

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