Vermont Oncology Pilot (VOP) GMCB Presentation

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VOP Pilot Final Meeting Agenda

- Review VOP objectives

- Describe the VOP model as implemented

- Highlight Brandeis implementation evaluation findings

- View and discuss quality improvement data results

- Discuss next steps

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Review of VOP Objectives

GOALS:

- Improve the quality of cancer care for patients in the St. Johnsbury area by providing resources and support to providers to better coordinate and improve health care services to patients diagnosed with cancer
  - Pilot Duration June 2012-March 31, 2016

- Improve communications between and among clinical care team members about the clinical diagnosis, prognosis and plan of care
  - ❖ Team members to include: the PCP, oncologist, continuing care manager, nursing staff and palliative care team members

- Ensure early and appropriate referral for palliative care services

- Reduce unnecessary utilization and cost of care for cancer patients

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VOP Pilot Participants

Pilot Participants:

- Five primary care practices in the NVRH service area designated as PCMHs
- Norris Cotton Cancer Center of Dartmouth Hitchcock Medical Center
- Three private health insurers and Medicaid

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VOP Pilot: Patient Enrollment

- **Step 1:** Norris Cotton social worker identified patients at the time of cancer diagnosis. Patients were considered part of the VOP regardless of what insurance provider they had, or whether their insurer was participating in the VOP.

- **Step 2:** Norris Cotton social worker contacts the nurse chronic care coordinator at the patient's PCMH to inform them of the diagnosis and add them to the VOP roster.

- **Step 3:** Norris Cotton social worker and PCMH chronic care coordinator independently reach out to the patient to communicate their availability for support including: problem-solving on psychosocial issues, support with transitions in care and referrals to behavioral health services and a variety of social services, etc.

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VOP Pilot: Pilot Activities

Enhanced communication protocols

- PCPs access the medical record data from NCCC (available pre-VOP)
- PCP notes go to NCCC (new to VOP); this was done primarily via faxing
- Increased ad-hoc communication between oncologists and PCPs

Enhanced palliative care referral protocols

- New access to palliative care services (new to community, not tied specifically to VOP)

Payment Model

- $40 PPPM to PCP practices and $40 PPPM to NCCC on top of existing arrangements

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Evaluation Design Considerations

- VOP Steering Committee initially proposed collecting a robust set of metrics on beneficiaries in the pilot including: timely staging, palliative care referrals, chemotherapy protocols, care plan completion, hospice enrollment, advanced directive completion, emotional well-being, repeat imaging, ED visits and patient satisfaction.

- Most of the recommended measures were from EHRs, and from Quality Oncology Practice Initiative (QOPI). A few of the recommended measures were claims-based utilization metrics.

  - ❖ Not able to get QOPI measure specs (proprietary)
  - ❖ EHR clinical measures and practice systems in the St. Johnsbury area are not necessarily connected and/or of uniform type
  - ❖ Any EHR measure collection would therefore involve chart pulls at multiple locations; heavy administrative burden of collection thus dictated selecting a very small number
  - ❖ Data source available to the project evaluators (VHCURES) does not contain timely Medicare data, and a large number of VOP participants are Medicare beneficiaries
  - ❖ Whether or not a patient is deceased is not clear in the claims data; this hampers trying to pull a comparison group out of claims for Medicaid and Commercial participants via matching on patient characteristics, and BCBS did not have the bandwidth to pull a comparison group roster.

- Evaluation design with sufficient rigor to draw conclusions about program impact should include some form of random assignment and/or comparison group, along with multi-variate analyses over time assessing for any confounding elements

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VOP Evaluation Design

- Small sample sizes overall, lack of EHR connectedness, difficulties in constructing comparison groups, and lack of access to timely Medicare data made an impact study unfeasible.

- Brandeis University completed a qualitative implementation study.

    Sources include: document and report review, 3-day site visit with 18 interviews: 4 Chronic Care Coordinators, 4 Primary Care Physicians, 2 Administrators, 2 Oncologists, 1 Social Worker, 2 Palliative Care Physicians, 2 IT Specialists, 2 Vermont policy leaders

- Single point in time (end of project) chart pulls for qualitative improvement purposes on the following measures:

    ❖ Documentation of advanced directives in the medical record
    ❖ Hospice enrollment
    ❖ Palliative care consultation
    ❖ ICU Utilization in Last 30 Days of Life
    ❖ ER Utilization in Last 30 Days of Life

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Description of VOP Patients; n= 132
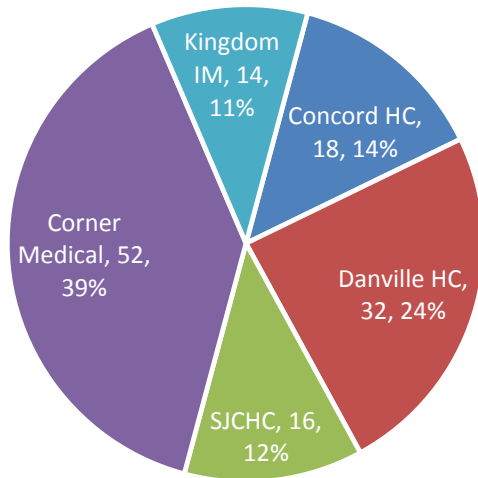
Average Age & Range
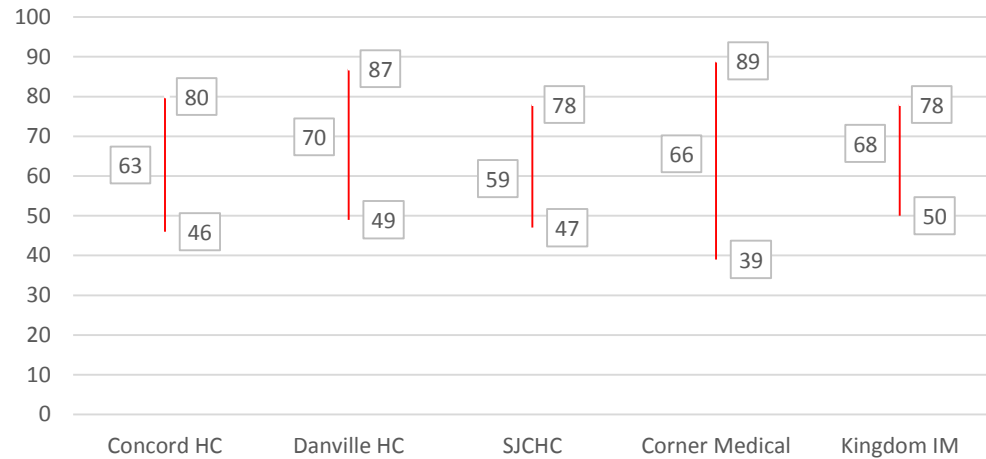
Type of Cancer	Number of Patients
Other Types <5 cases	47
Breast	25
Lung	22
Colon	8
Lymph	8
Larynx	5

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Brandeis: How the VOP changed over time

- Changes in Patient Selection/Panelization

- Payment Model

- Care Coordination: Building on Existing Systems

- Communication: Methods of Sharing Information

- Communication: The Content of Information Shared

- Palliative Care: Parallel and Complementary Efforts

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Brandeis: Lessons for Replication

- Technical solutions to communication problems are time-consuming and difficult to achieve.

- Boundary spanners are an adequate substitute for technology in some instances.

- Leveraging of existing community resources makes for quicker and more sustainable programs.

- A new community standard of care

- Payment models and incentives did not influence clinical behavior.

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Brandeis: Recommendations

- Demonstrations should be used as opportunities for learning.

- The content of shared information must be considered before its format. What information is actually being shared is more important than how it is shared.

- Build on local strengths. Select innovations whose local strengthens are widely shared. This increases replicability.

- Widen definitions of "incentives". Treat stakeholder motivations as an empirical question.

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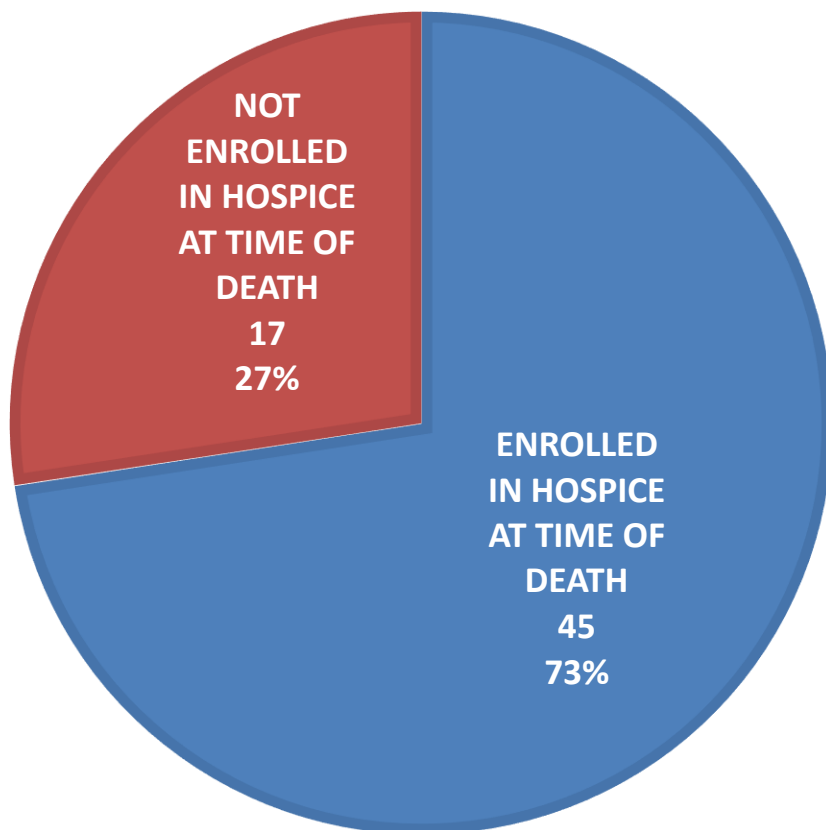
VOP Quality Improvement Metrics

- Documentation of advanced directive in the medical record

- Hospice enrollment

- Palliative care consultation

- ICU Utilization in Last 30 Days of Life

- ER Utilization in Last 30 Days of Life

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DOCUMENTATION of ADVANCED DIRECTIVE IN THE EHR? N=132
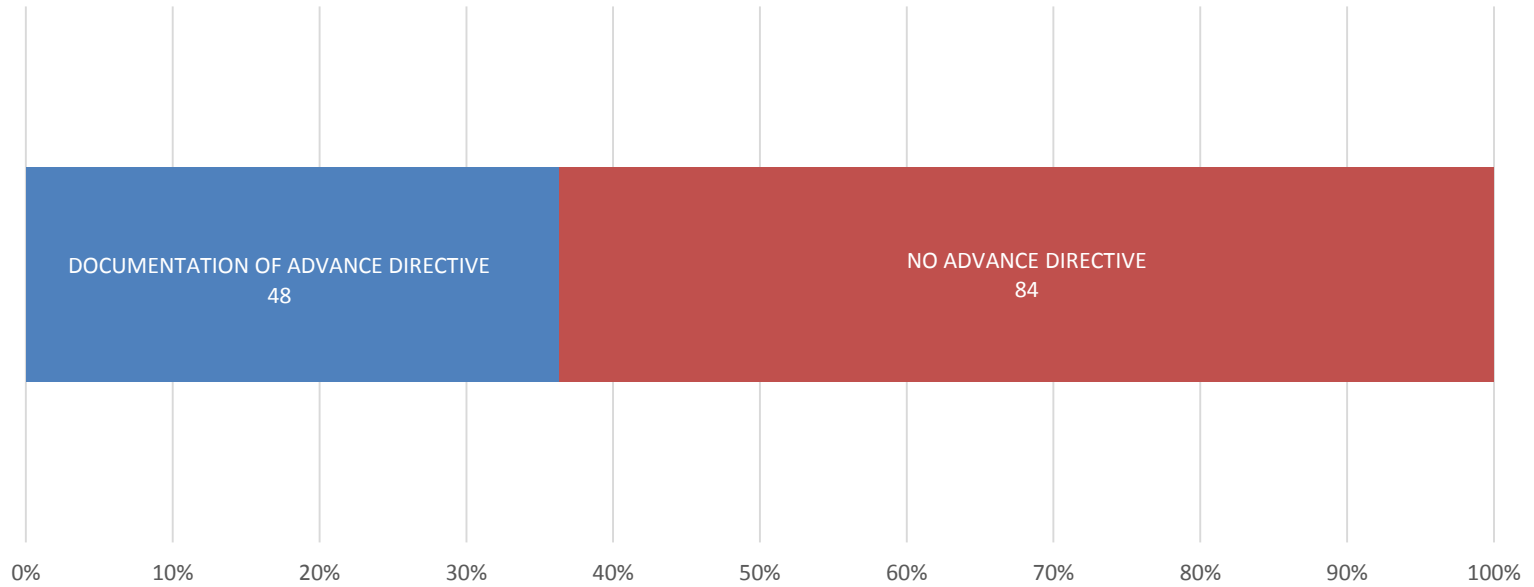
ENROLLED IN HOSPICE AT TIME OF DEATH?
N=62

NOT ENROLLED IN HOSPICE AT TIME OF DEATH
17
27%

ENROLLED IN HOSPICE AT TIME OF DEATH
45
73%

PALLIATIVE CARE CONSULTATION?
N=132

NO PALLIATIVE CARE CONSULTATION
82
62%

EVIDENCE OF AT LEAST ONE PALLIATIVE CARE CONSULTATION
50
38%

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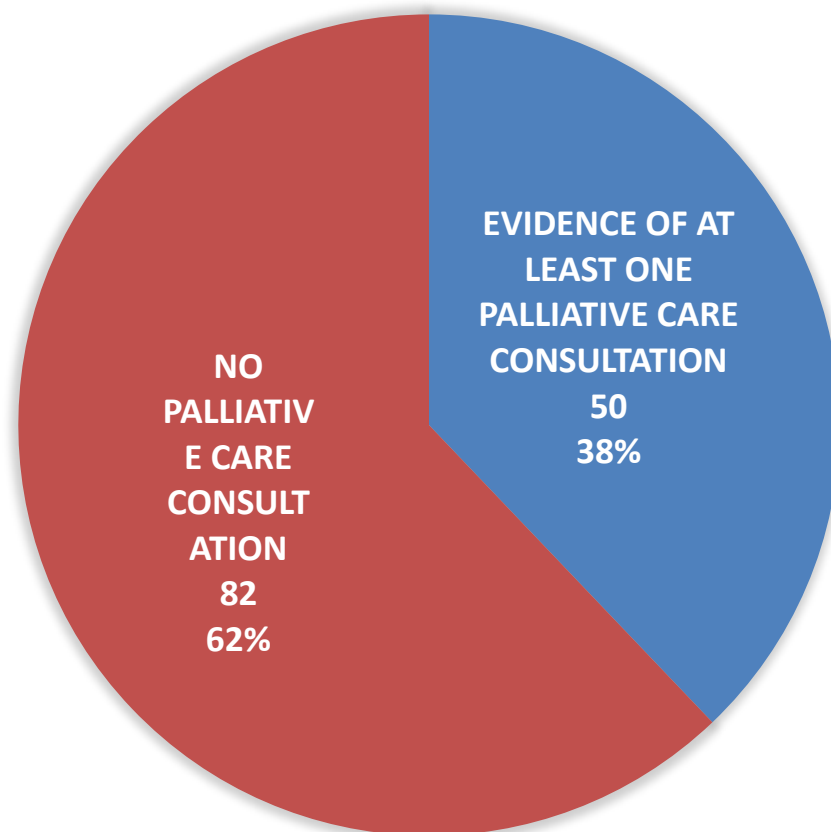
ICU UTILIZATION IN THE LAST 30 DAYS of LIFE?
N=61

No ICU Utilization Last 30 Days
55

ICU Utilization in Last 30 Days of Life; 6
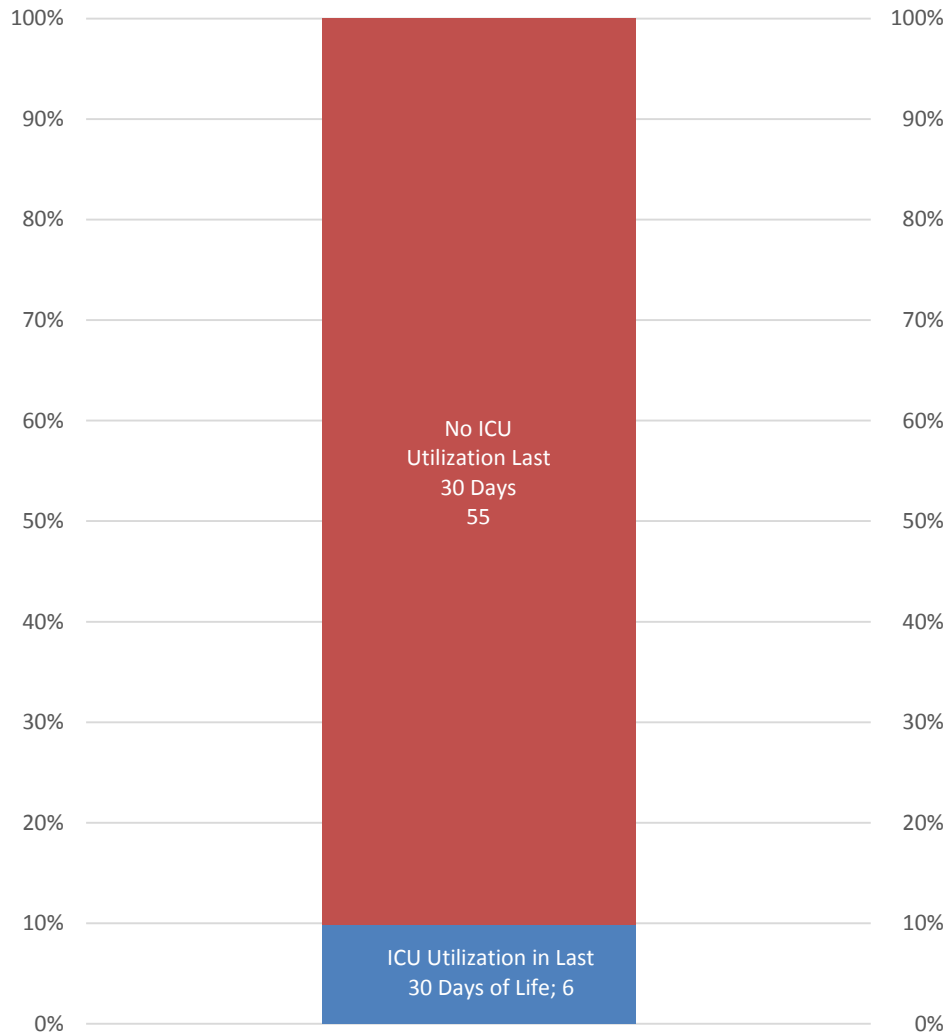
1+ ER VISITS LAST 30 DAYS of LIFE?
N=61

No ER Visits in Last 30 Days of Life
37

1+ ER Visits in Last 30 Days of Life
24

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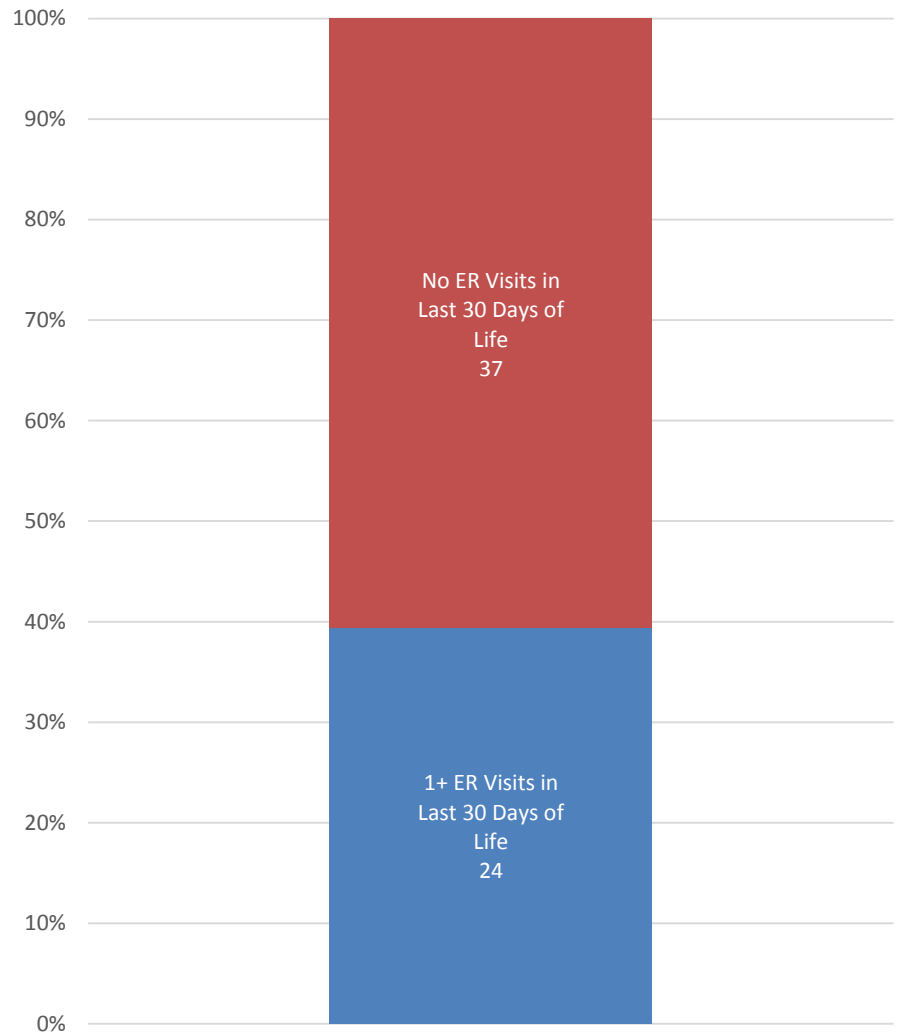
Potential Next Steps from the VOP Steering Committee
(Local to the St. Johnsbury area)

- GMCB vote to stop Payer PMPMs for beneficiaries enrolled in the VOP.

- NVRH to continue with the Transitions group and Palliative Care groups.

- Engage MDs on how care coordination supports patient-centered care, how to have conversations with patients on palliative care and hospice, differences between palliative care and hospice, etc.

  - ❖ One suggested way to do this in St. J is via encouragement of the tumor board that has been proposed by the palliative care champions in the region.

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Potential Next Steps from the VOP Steering Committee *(Statewide)*

- Webinar with other communities to share successes and challenges, and to help other communities build in similar enhanced communication protocols between PCPs and Oncologists, and increase referrals to Blueprint CHT care coordination immediately upon cancer diagnosis in specialist and PCP settings.

- Implement an ACO cancer-related pilot.

- Take steps to have NVRH (as the only community hospital in VT with board-certified palliative care doctors) mentor other community hospitals on identifying palliative care and hospice champions and building buy-in.

- Include hospice in the APM to ensure that oncology patients do not have to choose (in a black and white fashion) between hospice and care utilization.

- Take steps to increase the availability of and/or knowledge of palliative care and hospice in nursing homes in VT – to both residents and providers.

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