Vermont Oncology Pilot Project Annual Report

Submitted to the Vermont Oncology Pilot Project Steering Committee

Green Mountain Care Board

Table of Contents

Introduction

The Green Mountain Care Board (GMCB) formally approved the Vermont Oncology Pilot Project (VOP) in June 2012. The aim of the VOP is to improve care for patients residing in the St. Johnsbury area who have been diagnosed with cancer. Specifically, the project proposes to improve patient experience and satisfaction, reduce unnecessary utilization of services and reduce overall expenditures related to cancer care. In this project, the primary care, oncology, and palliative care providers share responsibility for assessing physical and psychosocial symptoms, establishing goals of care, and assisting with decision making. The first year of the VOP revealed notable barriers to delivery system reform, namely staff turnover, continuing confusion over the pilot's goals, and ineffective tools and strategies for Health Information Exchange (HIE) between different provider organizations. Despite the challenges to changing care delivery, the VOP has improved communication between Oncologists and PCPs and provided enhanced care services to patients.

Pilot Participants

Providers

The Vermont Oncology Pilot Project (VOP) includes participants from two primary care provider groups: Northeastern Vermont Regional Hospital (NVRH) and Northern Counties Health Care (NCHC); as well as the Norris Cotton Cancer Center (NCCC) of Dartmouth Hitchcock Medical Center (DHMC). A total of six different primary care practices participate in the pilot, four of which are owned by NCHC Federally Qualified Health Center and two of which are owned by NVRH.

Payers

Three commercial insurers, (Blue Cross Blue Shield of Vermont, Cigna HealthCare, and MVP Health Care), and Vermont Medicaid participate in the Vermont Oncology Pilot by making $40 per patient per month payments (PMPM) to both PCPs and Oncologists who are jointly managing care for participating patients.

Payment and Attribution Methodology

Requests for payment are submitted monthly to payers by the practice participants. Patients are attributed to the pilot through a similar methodology to Vermont’s Blueprint for Health Advanced Primary Care Practice Patient Centered Medical Home Demonstration. Patients are attributed by a participating insurer to one of the participating primary care practices for Blueprint PMPM payments. Patients must be currently enrolled in the VOP, and must be 18

years of age or older. For participation in the pilot, patients must have been diagnosed with cancer on or after January 1, 2010. Patients can have a diagnosis of any cancer, all stages and all cell types, with the exception of limited depth melanoma and basal cell and squamous cell cancers of the skin.

Operations

The Vermont Oncology Pilot Project is overseen by a Steering Committee that is made up of commercial payers, leadership from the three providers, staff from the GMCB Payment Reform Team, and one member of the GMCB. The Steering Committee was established in January 2012. The Steering Committee meets monthly and advises on the operations of the pilot including making recommendations on the attribution methodology and targets for panelization of patients.

Operations meetings occur monthly and include all providers involved with the VOP, including care coordinators, social workers, PCPs, Oncologists, information system managers, and quality and performance personnel. The operations meetings are also attended by the leadership from the NVRH, NCHC, and DHMC.

Weekly and Bi-weekly meetings occur with the core team responsible for coordinating communications among providers as well as with specified workgroups that have been formed to address key issues and problems.

Cycle One of the pilot began in May 2012. In this phase a micro pilot team was recruited, care team personnel were identified, a common care plan system was established, coordination and communication processes were identified, and two patients already in treatment were panelized.

Cycle Two of the pilot began in June 2012. The goal of Cycle Two was to panelize 10 additional patients and to better define the processes that had been identified in Cycle One. By December 2012, Cycle Two was complete and 10 patients had been panelized.

The VOP is now operational and patients, both in treatment and newly diagnosed, are being panelized on an ongoing basis.

VOP Year 1 Successes

The last six months of the VOP have produced significant results in terms of improving care delivery for cancer patients in the St. Johnsbury area. The Steering Committee established a target in April, 2013 for panelizing 30 patients by July 1, 2013. As of June 19, 2013, 25 patients have been enrolled in the VOP. Enrolling more patients in the pilot has allowed for care delivery changes to be operationalized. There are now enough patients going through the system to test care protocols and changes in care delivery. Important changes in care delivery include:

- PCP Care Coordinators are sending information to NCCC about patients that have gone to the ER or have been admitted to the hospital (NVRH); prior to the pilot, NCCC had no way of knowing if their patients had been seen at NVRH.
- Regular communications between NCCC and PCP practices about cancer patient care plans.
- Communications between Care Coordinators and Home Health about cancer patients and Home Health enrollees who have been seen in PCP practices.
- An established protocol for determining the Advance Directive status of cancer patients in the VOP.
- All participants are invested in the VOP and this has led to a trickledown effect on the care of cancer patients that not being seen at NCCC. Auxiliary staff that have not been directly involved in the VOP are also being included, as needed, and as the pilot grows.

The following is an example of how care delivery is changing for cancer patients being treated in the St. Johnsbury area:

St Johnsbury Community Health Center has a patient that was enrolled in the Vermont Oncology Pilot. Her case was complicated by other medical conditions, plus she was having trouble with the cost of transportation and food. She began treatment at NCCC-N and was being transported by her caregiver, a family friend. The caregiver was provided with gas cards to help with the cost of transportation which helped tremendously. NCCC-N worked with the patient to help allay some of her fears about using RCT and she was actually able to schedule with them. This patient was also having trouble with the cost of food and due to a referral to AAA she was provided with food stamps and meals on wheels. The patient and her caregiver have both advised they are very happy with the responsiveness of the team to the needs of the patient.

This patient recently had a change in care and I got a call immediately that I needed to access her chart via DHconnect. I was able to print the information for the provider to keep her updated to the patient's care as she doesn't have a follow up scheduled at the clinic here in the near future. The provider has verbalized her appreciation of being kept in the loop about the plan for the patient.

Dawn M. "Gidget" Doty, RN St. Johnsbury Community Health Center Chronic Care Coordinator.

VOP Year 1 Challenges

Two factors contributed to the uneven communication and slow progress that characterized this pilot early in its development:

1. Changes in staff and personnel caused information to be lost and/or miscommunicated.

2. The absence of a single health information technology system for sharing information between the organizations created barriers to sharing information between providers.

Changes in staff and personnel include not only position turnover, but turnover and inconsistency among the participants in weekly and monthly meetings about the operation of the pilot. The turnover of staff and initial lack of full participation in the operations meetings may have led to a lack of consensus about the goals of the pilot that persists today. Going forward, key parties involved with the pilot will be encouraged to continue to regularly meet together, as has been happening for the last several months.

Building broad consensus across all the providers in the pilot has also been a hindrance to transforming care delivery. Changes in staff and personnel have contributed to misunderstandings about the goals of the pilot. Adjustments to pilot protocol have also been made based on the experience of provider participants that are present in meetings, and these adjustments have not always been effectively communicated to those who are not present in meetings. For example, there were varying opinions regarding whether PCPs or Oncologists were responsible for identifying a patient and introducing him or her to the VOP. Arriving at a mutually agreeable solution, wherein both parties were responsible for panelizing patients, took considerable negotiation.

With many more partners now actively participating in conversations regarding the operations of the pilot, some of the processes that were initially decided upon have been adjusted to include information and address concerns from all of the newly active participants. Early participation in these conversations by all the participants in the pilot may have avoided some miscommunications about the processes.

Collaboration and care coordination through electronic systems is currently not possible because there is no technological solution that provides for different organizations to contribute to a shared patient record. Although a number of HIT tools were identified and evaluated on their potential to make communications easier, no mutually agreeable solution was available. Considerable staff time was dedicated to exploring technological solutions to aid communication across organizations, to no avail. In spite of these difficulties with communication, the providers

participating in the pilot program have established an effective way to share information from patient records through phone, fax, and one way EMR access.

Some of the key factors that may have impacted the pilot's progress are listed below. Some are steps that should have been taken before the pilot began in order to provide a better baseline for evaluation of success. Others are ongoing issues that have been identified for improvement:

- Initial analysis of possible candidates for panelization may have been inaccurate.
- No baseline data were gathered to determine current quality of care for cancer patients or margin for improvement prior to the start of the pilot.
- Changes in leadership have slowed or interrupted progress over the course of the past year.
- Provider education about the project has been inconsistent.
- Original expectations about the amount of provider participation that would be needed for the operation of the pilot were not clear and/or not adequate.
- Definition of supportive/palliative care and when palliative care should be offered to patients has been inconsistent and not fully agreed upon by the participants. This was not designed as a PCP/Oncology/End-of Life pilot project.

Establishing Baselines and Areas of Improvement Supported By Data

As mentioned in the narrative above, the VOP has been challenged by inconsistent communication. In part, this challenge was the result of inadequate data collection at the outset of the pilot. If the identified areas for improvement had been better supported with data, communication about the goals and purpose of the pilot may have been easier. Without data to provide demonstrable areas for improvement, getting buy-in into the process of improving and enhancing care may have been more difficult. Furthermore, if the goals of the pilot had been supported by more data, there may have been fewer opportunities for confusion about the pilot objectives.

Status of the Vermont Oncology Pilot as of June 19, 2013

- Pilot teams have been identified and are functioning.
- Steering Committee has been identified and is meeting monthly.
- Common Care Plan and system of communication has been designed.

- Care team personnel have been identified and are functioning in their roles.
- Coordination and communication processes have been identified and are being tested.
- All parties have agreed to the process for panelization.
- Attribution and payment methodology has been agreed upon and is functioning.
- All major payers in Vermont are participating in the pilot and are making payments to the pilot. It is not clear that an accounting of these payments is being maintained, a report has been requested by the Steering Committee, and participants are submitting information.
- As of 6/19/2013, 22 patients are currently panelized in the pilot, and a total of 25patients have participated in the pilot since it began one year ago. Three participants have passed away.
- It is expected that at least thirty patients will be panelized into the pilot by July 1, 2013 so that the evaluation of the pilot can begin.

Recommendations for Strengthening the VOP

1. Continue to include PCPs, Oncologists, practice managers, home health providers (or reliable representatives) in future communications meetings.

2. Inform providers of Steering Committee's recommendation on final panelization criteria:

   i. All cancers being treated at NCCC are eligible for pilot.

   ii. PCPs should panelize patients who have been newly diagnosed.

   iii. PCPs may recommend that Oncologists currently seeing patients in treatment panelize an individual.

   iv. If Oncologists see a newly diagnosed patient before a PCP, they should initiate panelization.

3. The GMCB should provide all parties with a written document describing the agreed upon panelization criteria and process, if approved by the operations team.

4. Agree on the definition of palliative/supportive care.

5. Agree on clinical, financial, and utilization measures by July 15, 2013, and begin to collect them for evaluation purposes by September 1, 2013.