

The Road to VBC for a Small Community Oncology Practice

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Our practice, Pontchartrain Cancer Center (PCC), is part of a dwindling breed. We are a community-based, 2-location, private clinic in southeast Louisiana that sees 4200 patients annually and employs 1 physician and 3 nurse practitioners. We have been able to weather the storms of sequestration, declining reimbursements, and increased regulatory requirements. Our team takes pride in delivering personalized care to our patients in a warm, home-like setting. Several years ago, we were faced with the same dilemma most community-based independent practices have dealt with: reinvent the practice or join a hospital.

We decided to reinvent, but we didn't have a clear vision of what sort of a practice we would have to become. How would we compete with services the hospitals and large cancer centers offer that we, as a private practice, did not get reimbursed for? What new services would strengthen our bottom line and help offset the cost of some of the new programs that would be most beneficial to our patients? How would we deal with the other programs we simply could not afford? And lastly, would any of our payers be interested in working with a small oncology practice to develop value-based care (VBC) oncology models? If we did not adapt and evolve, we would be left behind.

The PCC team met and brainstormed about our situation. An immediate decision was made to create internal treatment, symptom management, and triage pathways; start a clinical trials program, in-house pharmacy, and Hot Lab for the administration of radiopharmaceuticals; and develop practice-based programs centered around VBC. We went with the thought process of implementing programs and workflows that would help us achieve our long-term goals of improved VBC and, eventually, VBC payer contracts.

While remaining committed to delivering the best clinical outcomes when choosing the appropriate drugs for

an individual patient's treatment regimen, we set about the task of developing standardization within the practice. This process helped deepen the understanding of drug value, not just cost. Biosimilars have played a huge role in our organization's formulary and pathway decisions by allowing us to provide high-quality drugs at a lower cost. This outcome is magnified when considering patients who are in a cost-share model to be able to afford their therapy.

Most VBC models seek to reduce emergency department (ED) use and hospitalization by shifting care to the less-costly community oncology setting. One way of doing this is by implementing symptom management and triage pathways. In creating these pathways and adapting our workflows, we were able to address changing therapies, deal with nutrition and hydration issues, and even prescribe preventive antibiotics. As a result, we noticed increased practice efficiency because we were all "on the same page" and increased patient care satisfaction because our providers were able to address many of the issues within the practice without needing to use the ED.

In 2016, we launched our clinical trials program. We now have 4 members on our research staff and 20 open phase 2, 3, and 4 trials. The research staff members screen all new patients for possible trial participation. They also work with our local physicians, as well as oncologists from other practices, to keep them abreast of our research program and when new trials become available.

In that same year we also opened our in-house pharmacy. By adding a medically integrated dispensary, oncology clinics can provide a full range of treatment options at a single site. We soon began to experience the benefits of this decision through improved patient satisfaction, improved patient care/oral adherence, increased clinic efficiencies, and a viable opportunity in our goal of VBC. When drugs are dispensed

from oncology clinics, the practice's clinical staff can address any issues or concerns, including adherence and adverse effects, resulting in a holistic view of the patient's care. If a clinician needs to adjust a medication or dosage, it can be done at the office in real time rather than through a back-and-forth with a mail order or external pharmacy that has limited knowledge of the complexities of oncology care. It also allows our physicians to dispense "short-fill" prescriptions (when allowed by the payer) while we assess patient compliance and tolerance. One of the fundamental tenets of VBC is shared decision-making and care coordination. By utilizing our medically integrated dispensary, we are better able to achieve our goal of care coordination by factoring in comorbidities and medication reconciliation, which increases adherence, resulting in better patient care.

The addition of these 2 revenue-generating initiatives, along with the new staff required to run them, allowed us the breathing room to implement other VBC workflows and non-revenue-generating programs that we believe have tremendous value to patients and their families.

We then tackled additional value-based programs such as advanced care planning, survivorship care, transitional care management, patient/caregiver education, depression screening, smoking cessation, nutrition, financial counseling, and patient navigation. Advanced care planning, survivorship care, transitional care management, patient/caregiver education, and smoking cessation are now part of the advanced practice provider (APP) workflows. Depression screenings and the nutrition risk assessment tool are handled by the medical assistants during triage and communicated to the providers, as needed. Our organization developed a list of mental health providers, which includes accepted insurance/cash prices, location, hours of operation, and area of expertise (eg, cancer patient, caregiver, children of cancer patient) and is updated every 6 months. We also have agreements with local hospitals so our patients may utilize their nutrition programs.

Transitional care management has been very useful in helping us prevent hospital readmissions. Our APPs work attentively to identify moderate- and high-risk patients to bring back to the clinic soon after their discharge. It has also increased continuity of care among the hospital, clinic, and patient, which has led to better patient outcomes.

During patient education visits, the patient now receives a simple 3-ring binder with a monthly calendar in front, followed by tabs that we customize for the patient (eg, medications, adverse effects, symptom management, glossary of terms). They also receive a list with phone numbers and contact names for each department within our practice. We further customize the binder with a list of the patient's team of

doctors and support staff and more contact information. We go over regimens, medications, adverse effects, and any other written materials that are necessary. We update the binder at every visit to include follow-up appointments with us and other appointments we have made for the patient (eg, laboratory tests, radiology, other physicians). There is also a Q&A section for patients and caregivers to write down nonurgent questions between visits. We encourage patients to bring this working document to appointments with everyone on their care team and to have those health care workers add to it as well. We realize that this may not be enough, given that the average person's health literacy is lower than optimal. It may be necessary to take the extra time and set up another appointment or provide additional or different written materials—and that is OK. Patients with cancer often come to us when they are most vulnerable, and the team felt it imperative to invoke the adage, "Treat others as you would want to be treated." Interestingly, since implementing this program, we have seen a decrease in "extra" calls to the practice for questions that are answered in the binder.

We had always felt that a cross-trained team is the best team. Rather than hire more staff for these nonreimbursable services, we made the decision to share the additional workload among existing employees. Our financial assistance team currently handles all referrals for patient assistance, including financial, transportation, and other local needs. In researching the roles of patient navigators, we encountered 2 areas of concern: First, how many patients can 1 navigator help? Second, most of the research we could find showed only modest benefit to the patient. Consequently, we decided to let families handle the job of patient navigation—with support from the existing PCC staff. As anyone with a serious illness has experienced, the emotional impact of receiving bad news decreases our ability to receive new information. When we thought about how we could bridge this situation and best serve the patient, we decided the role of patient navigator was best played by a family member or close friend, serving as a second set of ears to help patients recall what was said during the visit. We encourage patients to bring a family member or close friend to all visits.

This team approach to our new programs paid dividends. It allowed us to control the message and the expense of care. Although we have all taken on more work to meet these needs, patient and PCC staff satisfaction has gone up due to the strengthening of the patient/family relationship with virtually every member of the PCC staff.

Over the last several years we have successfully participated in the Merit-based Incentive Payment System and utilized our electronic health record and practice data analytics to track our quality and cost performance as well as patient survey

outcomes. Within the past 18 months, we have used this information to successfully negotiate our first VBC contract and we plan to participate in another by end of 2020. There are more than 40 alternative payment models either currently or coming down the pipeline. Each model differs in the type of risk to be assumed by providers, the level of care coordination, and the emphasis on cost and quality measures. In the past 5 years, our organization has undergone a large degree of change to achieve our goals of practice transformation and VBC. We reconstructed our entire operating model and systems in real time. From the daily practice of our clinicians to the shape of our workforce, from learning how to use our data to understanding the myriad of measures applied to performance, from the expanding network of professional relationships to managing the increased burden of risk and

investment, everything has changed, and it will continue to evolve while we continue to deliver high-quality care for the patients we serve.

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