Gap in Care Project Evaluation

Summary of Key Findings

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Submitted to Vermont Department of Health
Comprehensive Cancer Control Program
Fall 2017

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I. INTRODUCTION

The Gap in Care Report Project involves the quality improvement (QI) staff of three Vermont payers—BCBS, MVP and Medicaid. Payers use their claims data to identify patients eligible for, but who have not had, routine breast, cervical and colorectal cancer screenings. Upon identifying patients due for recommended screening, the payer sends the list of patients (report) directly to the provider/practice. Payers and the Vermont Department of Health (VDH) Comprehensive Cancer Control (CCC) Program expressed interest in understanding how effective these practice reports are in increasing screening rates. Additionally, there was interest in learning about other strategies to increase recommended screening in primary care.

II. APPROACH

The evaluation consisted of the following methods:

- *Review of the literature* - to identify best and promising practices, practice change strategies as well as strategies to integrate public health into primary care to improve patient health through cancer screening.
- *Payer Key Informant Interviews* - to explore payer's goals for the GIC Project and if those goals have changed over time; perception of the effectiveness of the GIC report in increasing screening rates; how the report is implemented/communicated with practices; scalability of the project; and, recommendations for the Department of Health to increase screening rates.
- *Practice Survey* - to understand of the practices that receive the GIC report, how many use the report and gain a general understanding of how it is used. Survey findings were intended to inform the selection of practices for participation in key informant interviews.
- *Practice Key informant Interviews* - with practices using the GIC report to gain greater insights to how practices that receive the GIC report use and integrate it into practice systems as well as perceived effectiveness/utility of the report. An incentive of $200.00 Visa Cash Cards were provided to those practices willing to be interviewed.

III. FINDINGS

Literature Review Highlights

By and large best practices and strategies identified in the literature can be grouped into four categories[i]: 1. Provider practices and system change; 2. Policies that increase access to screening; 3. Education and awareness to increase screening; and 4. Surveillance systems and use of data. While policy is instrumental in institutionalizing systems change, policy examples in the literature fell into the macro-level of systems change work therefore were not examined (See Attachment A. Literature Review).

Payer Key Informant Interviews

MVP, Medicaid and Blue Cross/Blue Shield each participated in a 30 minute key informant interview.

- *Goals* – Payers' goals for participation in the GIC Project initiative were both pragmatic and aspirational (e.g., wanting Vermont to be in the 90th percentile on a national level). GIC reports were seen as an opportunity to help providers increase screening rates given that while many providers have great EMRs, generating meaningful and useable reports can be difficult. Payer's previous experience with quality improvement (QI) initiatives facilitated greater ease in involvement with the GIC Project. Other goals include productive collaboration with other payers across the state to strengthen modes of communication with providers to convey consistent messages that are received (listened to) by providers.

- *Reporting* - GIC reports are sent to practices either on a monthly or quarterly basis however quarterly reporting presents issues related to timing and updates.

- *Effectiveness/utility of GIC reports by practices* - based on payer communications with practices and/or data analysis, payers agreed that practices are using the GIC reports and believe the reports to be useful. However, there was clear interest in the evaluation findings to better understand the extent to which the GIC reports are used by practices.

- *Communication with practices* - communications with practices ranged from none at all to some practices providing feedback on specific reports.

- *Scalability of GIC Project* - all payers believe the initiative is scalable.

- *Further involvement in the GIC Project* - while there is interest in continued involvement in the GIC Project, not all payers have the capacity to increase their time commitment to the initiative.

- *Opportunities for improvement* - commitment by all payers with one payer commenting, the GIC initiative is about partnership. Other opportunities included the need to develop relationships with providers and the need for regular feedback from providers. Vermont Department of Health was seen as needing to play a central role in facilitating the relationship building process with providers. There was a sense that the collaboration with providers was not truly a collaboration given the nature of communication was "one direction communication" (i.e., payers to practices); a stronger collaboration would result from bidirectional communication.

Practice Survey

An online survey was developed and the survey link disseminated via email to 21 practices that receive the GIC report (See Attachment B. Practice Survey). A total of 11 individuals responded to the survey representing 10 practices. Of those 10 practices, 3 responded that they used the GIC report, 2 responded that they sometimes use it, 4 responded that they were not aware of the report and 1

responded that they do not use the report. Therefore, the 3 practices that reported using the GIC report were contacted to request an interview. Two of the 3 practices were reached and an interview was scheduled and conducted. For practices that indicated they were not aware of/using the GIC report, emails were sent requesting an interview to learn about barriers to use. None of these practices responded.

Practice Key Informant Interviews

Two practices each participated in a 45 minute key informant interview. Questions were provided to practices in advance.

- *Prior experience with QI* – both practices have participated in previous QI initiatives proving to be significant facilitators for their involvement in the GIC Project.

- *Goal setting* – Both practices have a general goal of increasing screen rates with an eye towards improvement.

- *Integration of GIC report into practice* – One practice has a designated staff person responsible for the report. The staff person goes through the list, confirms that the patient has not received the noted service, determines when/if they have an upcoming appointment and documents the service that they need. A message is communicated to the patient via patient portal and phone calls. The staff person also reviews the schedule and "tags" the patients who are due for a service. If the patient comes in for an appointment, the staff has the patient schedule the necessary screen before they leave.

  The second practice interviewed mostly uses the Medicaid report because it comes more regularly and it is a fairly short report. Breast and colorectal reports are used most frequently. If a patient is due for a screen, the patient is contacted. However, for patients who continue to appear on the GIC report, the practice has observed that the patient is most likely struggling with behavioral health issues, a barrier to care. This practice noted that BCBS had sent a very large GIC report the previous year and that they did not recall receiving one from MVP. They receive a GIC report from Medicaid every 3-4 months which they described as "short and manageable". BCBS's report was described as "too huge and burdensome". The lag time in reports was noted as challenging as some patients have already been seen by the time the report is received.

- *Monitoring patient panel* – One practice crosswalks the patient's name with its EMR and the patient flowsheet to see when they were referred out for a screen or received a screen. The practice shared that some patients refuse to be screened which will also show up in the flowchart. The second practices stated that rates are tracked via in-house reports or by using the practice profiles provided by Blue Print which benchmarks practices across the state. This practice noted the need a universal data base to capture those patients who have had a change in plans.

- *Provider Communications* – Both practices have bimonthly meetings with providers to discuss progress and areas for improvement. One practices displays data via an LCD projector during these meetings and/or provides hard copies. The other practices display graphs and charts which are updated regularly.

IV. OBSERVATIONS

- While practices reported lack of awareness of the GIC report they may not actually be receiving the reports.
- Variation of reporting schedule (i.e., when payers send reports to practices) may be adding to confusion of when reports should be expected. Consider standardizing reporting schedule. This may possibly address practice concern about lag times (i.e., patients who have already been seen by the time the report arrives).
- Size and format of the GIC report should be considered to ensure ease of use.
- Knowledge of the principles of QI and process were significant facilitators to practices use of the GIC reports.
- Further work needs to be done to build relationships with providers to ensure bidirectional communication. This may assist in ensuring providers awareness and use of the GIC reports.
- It is difficult to conclude that the GIC report has increased screening rates among practices given there is no direct correlation based on the available evaluation data.

Appendix A. Literature Review

Strategies for increasing breast, cervical and colorectal cancer screening in primary care

Highlights from the literature

INTRODUCTION

The Gap in Care Report Project involves the quality improvement (QI) staff of three Vermont payers—BCBS, MVP and Medicaid. Payers use their claims data to identify patients eligible for, but who have not had, routine breast, cervical and colorectal cancer screenings. Upon identifying patients due for recommended screening, the payer sends the list of patients directly to the provider/practice.

Payers and the Vermont Department of Health (VDH) Comprehensive Cancer Control (CCC) Program are interested in understanding how effective these practice reports are in increasing screening rates. There is also interest in learning about other strategies to increase recommended screening in primary care. In April, JIS conducted a literature review to identify best and promising practices, practice change strategies and the integration of public health into primary care as a means to improve patient health through cancer screening.

FINDINGS

By and large best practices and strategies identified in the literature can be grouped into four categories[ii]: 1. Provider practices and system change; 2. Policies that increase access to screening; 3. Education and awareness to increase screening; and 4. Surveillance systems and use of data. While policy is instrumental in institutionalizing systems change, policy examples in the literature fell into the macro-level of systems change work therefore are not presented in this summary. The following findings highlight key examples that reflect practice level strategies.

Provider practices and system changes

CDC identified the following provider practices and system changes to increase breast and cervical cancer screening [i]:

- Client reminders—Written or telephone messages advising women that they are due or overdue for screening.
- Reducing structural barriers (breast cancer only)—Reducing noneconomic burdens or obstacles that impede access to screening, such as expanding clinic hours or offering services in alternative or nonclinical settings.
- Provider assessment and feedback—Evaluation of provider performance in offering or delivering screening (assessment) and presentation of information about performance in providing services (feedback) to help improve performance.

- Provider reminder and recall systems—Information for providers that clients are due (reminder) or overdue (recall) for specific cancer screening tests; they can be generated electronically or manually.
- Establish patient navigation programs
- Create strategies that support patients to establish a medical home (colorectal cancer)

Based on a 2007 national survey, Yabroff et al assessed physician use of system strategies to increase cancer screening.[iii] Researchers identified similar system strategies to those of the CDC that were evidenced to improve cancer screenings including patient and physician screening reminders, performance reports of screening rates, electronic medical records, implementation of in-practice guidelines, and use of nurse practitioners/physician assistants. [iii] However, researchers found that few physicians used a "comprehensive set of strategies to support cancer screening"[iii], a recommendation noted by the researchers.

Researchers Arroyave, Penaranda and Lewis' article, *Organizational Change: A Way to Increase Colon, Breast and Cervical Cancer Screening in Primary Care Practices,* describes organizational change interventions. Those that demonstrate greater efficacy were diverse and involved non-physician staff. These strategies (interventions) included[iv]:

- reminding and counseling patients on the upcoming or overdue test
- providing administrative support such as appointment-scheduling
- linking patients with community resources and helping patients navigate through the health care system.
- Phone calls or face-to-face encounter instead of letters as reminders

Education

Researchers Mader et al suggested academic detailing and practice facilitation as a dual strategy for increasing screening rates.[v] Academic detailing involves trained experts providing tailored education on specific health topics and evidence-based guidance on best practices. [v] The process provides guidance to practices to better "align their work with evidence-based best practices to improve patient care and outcomes." [v]

Authors Haas et al conducted a survey of providers including physicians, nurse practitioners, certified nurse midwives, and physician assistants to assess attitudes and screening practices following changes in the USPSTF guidelines.[vi] Research findings indicated an excess use of breast cancer screening and for cervical cancer screening, providers "continued to screen women younger than age 21 if they were sexually active, and continued to offer annual screening to women in their 20s."[vi] Although providers reported that the USPSTF guidelines were "most influential in their care", reasons for deviation from the recommendations include personal disagreement with the guidelines, concerns expressed by patients about the guidelines, the use of conflicting performance measurement metrics, concerns about liability,

and lack of time to discuss the benefits and harms of screening.[vi] The survey also examined a broader set of practice characteristics and found that providers who practiced in hospital-based settings were less likely to recommend screening in excess of both guidelines. Research findings are noteworthy due to cost implications of excess screening and indicate the need for provider education on USPSTF guidelines.

Surveillance systems and use of data

Quality Improvement was referenced numerous times as a strategy for increasing screening rates in primary care. However, QI requires organizational leadership to implement this systematic approach effectively.[vii] The HRSA document reviewed noted "four essential components of an infrastructure to support quality improvement efforts, including: Quality improvement teams; Tools and resources; Organizing improvements; Building on the efforts of others by using changes that worked."[vii]

RECOMMENDATIONS

Given the findings, key informant interview questions should explore the following topic areas (with other topics added):

- Provider familiarity with the USPSTF Guidelines for breast, cervical and colorectal screening
- Utilization of quality improvement principles
- Utilization of reminder systems
- Utilization of patient navigators
- Provider assessment and feedback

SAMPLE KEY INFORMANT INTERVIEW QUESTIONS BASED ON LITERATURE REVIEW FINDINGS

- Has your practice set a goal based on the insurer's reports for number of patients/percent of identified patients screened?
- Has your practice participated in a quality improvement initiative? If so, have you utilized principles of QI to improve screening rates?
- Does your practice use client reminders? If yes, in what format, e.g., phone calls, letters, etc.
- Does your practice use patient navigators for cancer screenings?

[ii] Centers for Disease Control and Prevention. Increasing Population-based Breast and Cervical Cancer Screenings: An Action Guide to Facilitate Evidence-based Strategies. Atlanta: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2014.

[iii] Yabroff et al. Systems Strategies to Support Cancer Screening in U.S. Primary Care Practice. 2011 American Association for Cancer Research. Accessed 4.28.2017

[iv] Arroyave, AM, Penaranda, EK, Lewis, CL. Organizational Change: A Way to Increase Colon, Breast and Cervical Cancer Screening in Primary Care Practices. J Community Health (2011) 36:281–288

[v] Mader EM et al. A Practice Facilitation and Academic Detailing Intervention Can Improve Cancer Screening Rates in Primary Care Safety Net Clinics. JABFM September–October 2016 Vol. 29 No. 5

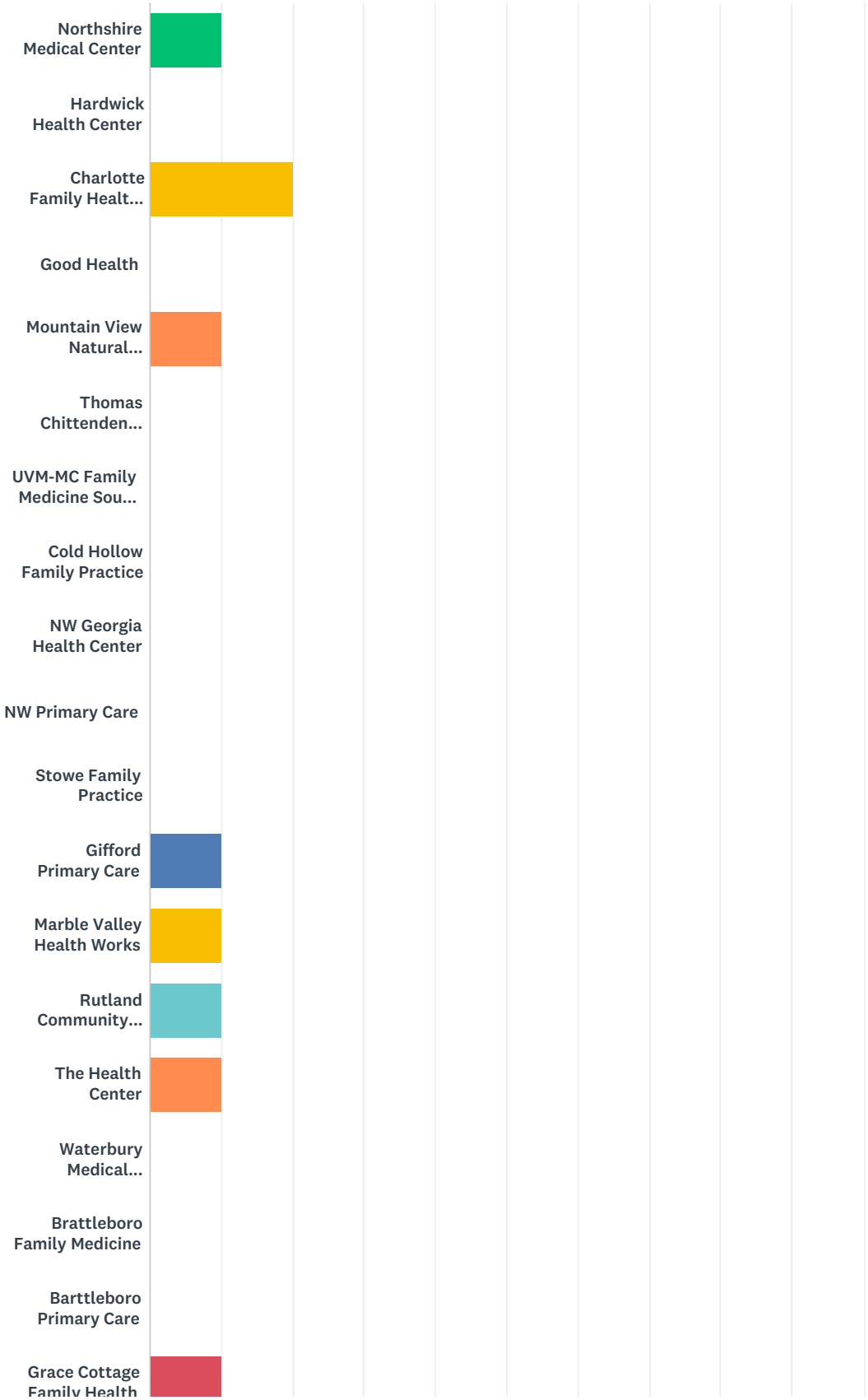
[vi] Haas et al. Provider Attitudes and Screening Practices Following Changes in Breast and Cervical Cancer Screening Guidelines. J Gen Intern Med 2015 31(1):52–9

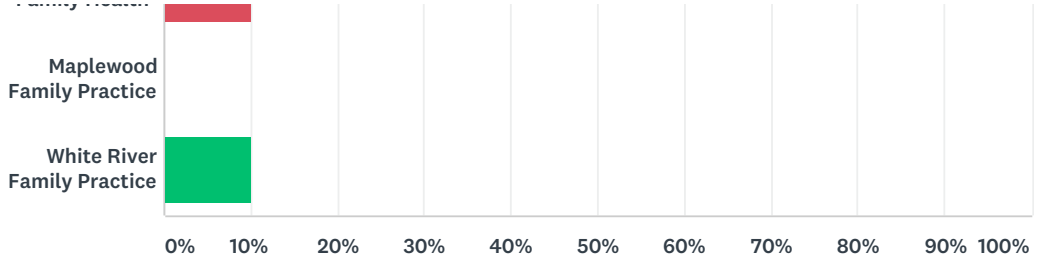
[vii] U. S. Department of Health and Human Services Health Resources and Services Administration. Cervical Cancer Screening. https://www.hrsa.gov/quality/toolbox/measures/cervicalcancer/part2.html. Accessed 4.20.2017

Appendix B. Practice Survey

Q1 Please select your practice name from the list below

Answered: 10 Skipped: 1





ANSWER CHOICES	RESPONSES	
Northshire Medical Center	10.00%	1
Hardwick Health Center	0.00%	0
Charlotte Family Health Center	20.00%	2
Good Health	0.00%	0
Mountain View Natural Medicine	10.00%	1
Thomas Chittenden Health Center	0.00%	0
UVM-MC Family Medicine South Burlington	0.00%	0
Cold Hollow Family Practice	0.00%	0
NW Georgia Health Center	0.00%	0
NW Primary Care	0.00%	0
Stowe Family Practice	0.00%	0
Gifford Primary Care	10.00%	1
Marble Valley Health Works	10.00%	1
Rutland Community Health Center	10.00%	1
The Health Center	10.00%	1
Waterbury Medical Associates	0.00%	0
Brattleboro Family Medicine	0.00%	0
Barttleboro Primary Care	0.00%	0
Grace Cottage Family Health	10.00%	1
Maplewood Family Practice	0.00%	0
White River Family Practice	10.00%	1
TOTAL		10

Q2 Please enter the name of the of the person completing this survey

Answered: 9 Skipped: 2

#	RESPONSES	DATE
1	Suzanne Jones	8/28/2017 4:06 PM
2	Elaine Swift	8/25/2017 9:33 AM

3	Debra Winslow RN MS Practice Manager	8/25/2017 8:56 AM
4	Julie Hunter	8/23/2017 11:19 AM
5	Andrea Regan	8/20/2017 11:34 AM
6	Samantha Lee, LPN	8/17/2017 2:47 AM
7	Jenna Corneille	8/10/2017 1:18 PM
8	Joanne Arey	8/9/2017 1:21 PM
9	Kristen Krause	8/9/2017 1:20 PM

Q3 Please provide the phone number of the person completing this survey

Answered: 9 Skipped: 2

#	RESPONSES	DATE
1	802-770-1805	8/28/2017 4:06 PM
2	802-365-3620	8/25/2017 9:33 AM
3	802-728-2286	8/25/2017 8:56 AM
4	802-362-4440	8/23/2017 11:19 AM
5	8024252781	8/20/2017 11:34 AM
6	425-2781	8/17/2017 2:47 AM
7	802-322-6618	8/10/2017 1:18 PM
8	802-295-6132	8/9/2017 1:21 PM
9	802-860-3366	8/9/2017 1:20 PM

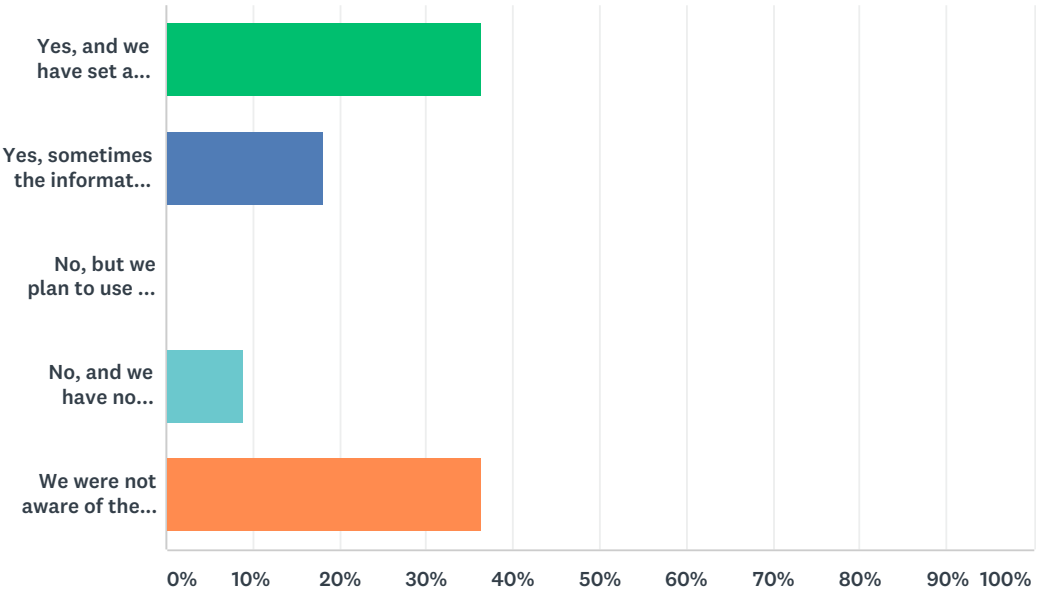
Q4 Please provide the email address of the person completing this survey

Answered: 9 Skipped: 2

#	RESPONSES	DATE
1	Suzanne.jones@mvhealthworks.com	8/28/2017 4:06 PM
2	eswift@gracecottage.org	8/25/2017 9:33 AM
3	dwinslow@giffordmed.org	8/25/2017 8:56 AM
4	Julie.hunter@svhealthcare.org	8/23/2017 11:19 AM
5	andrearegan@yahoo.com	8/20/2017 11:34 AM
6	nurseylee@gmavt.net	8/17/2017 2:47 AM
7	jcorneille@the-health-center.org	8/10/2017 1:18 PM
8	jarey@wrfpvt.com	8/9/2017 1:21 PM
9	kk@mountainviewnaturalmedicine.com	8/9/2017 1:20 PM

Q5 Does your practice use the Gap in Care Report?

Answered: 11 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, and we have set a process for how it is communicated to clinicians and other appropriate staff	36.36%	4
Yes, sometimes the information is communicated to appropriate staff	18.18%	2
No, but we plan to use it in the future	0.00%	0
No, and we have no intention of using it	9.09%	1
We were not aware of the Gap in Care Report	36.36%	4
TOTAL		11

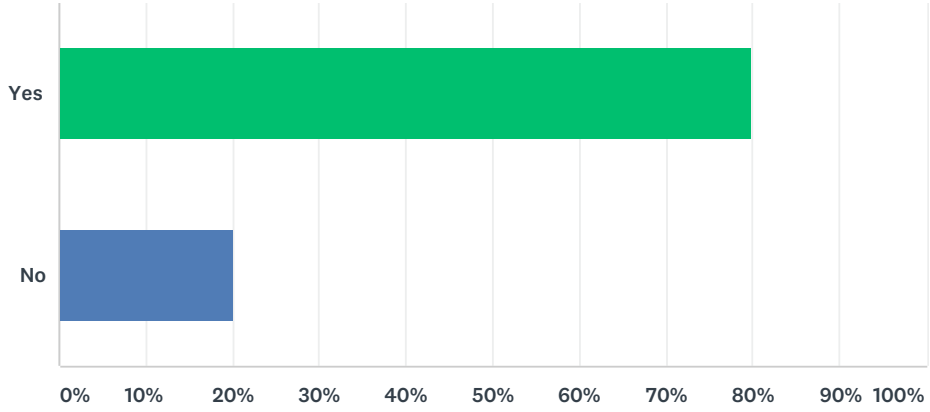
Q6 Describe the current or planned use of the Gap in Care Report at your facility

Answered: 5 Skipped: 6

#	RESPONSES	DATE
1	It is emailed to our care coordinators and they send reminders to pateints. We would be willing to do an interview--would ask that you talk to Jill Freyer.	8/20/2017 11:35 AM
2	We send a letter to the patient and set an alert in their chart	8/17/2017 2:49 AM
3	We give the report to a panel coordinator who checks the record (sometimes we find that the screening was done), and can call patients for outreach and also flag the chart that the screening is due	8/10/2017 1:22 PM
4	We have been reviewing the GAP in care reports and found them to be a duplication of work that we already do through internal processes. Additionally several patients listed on the reports are not patients of our practice.	8/10/2017 12:41 PM
5	Staff member checks to see if patient is actually non-compliant, has an upcoming apt and if no, reaches out to the patient	8/9/2017 1:22 PM

Q7 Would you be willing to participate in a 30 minute interview to help us better understand how useful the Gap in Care Report has been in increasing screening rates in your practice panel? As a small token of our appreciation for your time, each practice that participates in the 30 minute interview with receive a $200 Visa cash card for lunch.

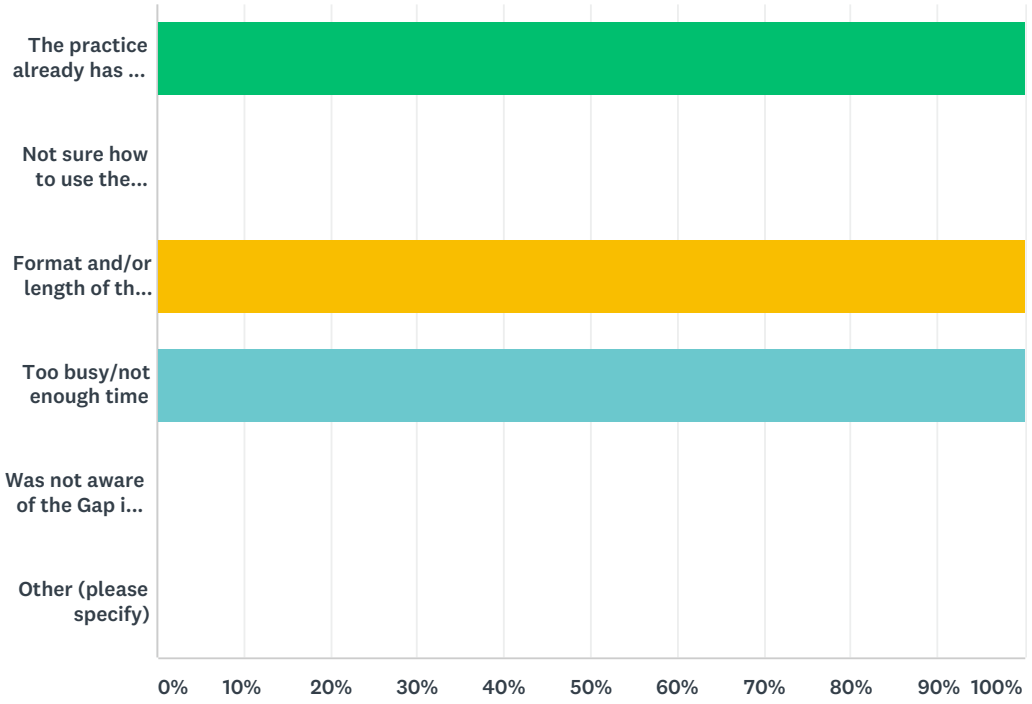
Answered: 5 Skipped: 6



ANSWER CHOICES	RESPONSES	
Yes	80.00%	4
No	20.00%	1
TOTAL		5

Q8 To understand potential barriers to practices using the Gap in Care report, please share with us why you do not plan on using the Report? (Please check all that apply)

Answered: 1 Skipped: 10



ANSWER CHOICES	RESPONSES	
The practice already has a system to identify patients in need of screening	100.00%	1
Not sure how to use the report/information in the report	0.00%	0
Format and/or length of the report is not user friendly	100.00%	1
Too busy/not enough time	100.00%	1
Was not aware of the Gap in Care report	0.00%	0
Other (please specify)	0.00%	0
Total Respondents: 1		

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q9 Please share any comments or suggestions on how the Vermont Department of Health can support you in your efforts to increase cancer screening.

Answered: 7 Skipped: 4

#	RESPONSES	DATE
1	the report has shown patients that changed insurance and actually had the test done and also showed patients that were not active in this practice	8/28/2017 4:08 PM
2	Making sure the gap report is sent to a designated person. Resources need to be available to provider outreach.	8/25/2017 9:34 AM
3	not sure	8/25/2017 8:56 AM

4	This is great! Thanks!	8/20/2017 11:35 AM
5	When a woman goes for a screening mamogram and it is abnormal, or she self reports "a lump" to the technician, the facility changes the mammogram from routine screening to diagnostic. The cost then goes against her deductible instead of being covered as routine HM. This policy needs to change. I have been told by a few women that they will no longer get their mammograms because of this.	8/10/2017 12:46 PM
6	Push payers to have a natiional database. Insurances are always changing for patients and if the patient undergoes a mastectomy, hysterectomy, etc., the gap in care may not be accurate. It's extremely time consuming to look up all of these patients and we get multiple gaps in care reports from varoius payers. Redundant work in a small practcie, or any practice, is always unfortunate. But the end result is, that we want the patients to get the care they need!	8/9/2017 1:29 PM
7	can the gap report be mailed to me? So I can look at it?	8/9/2017 1:20 PM