Coordinating Seamless Transitions Across Care Settings

- Leveraging Data to Identify Priorities
- Coordinating Transitions with the Cancer Care Team
- Ensuring Smooth ED Transitions
- Improving Continuity of Inpatient and Outpatient Care
- Developing Collaborative Hospice Relationships
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Available Within Your Oncology Roundtable Membership

Over the past several years, the Oncology Roundtable has developed numerous resources to assist members in improving the quality and efficiency of their cancer programs. The most relevant resources are outlined here. All of these resources are available in unlimited quantities through your Oncology Roundtable membership.

Strategic Guidance for Improving Program Quality and Efficiency

Redesigning Cancer Care Delivery for the Era of Accountability
- Tactics to increase efficiency and improve the patient experience
- Process improvement methodologies
- Comprehensive symptom management
- Oral therapy management programs

Delivering Sustainable Survivorship Care
Lessons for Program Design and Implementation
- Models for delivering survivorship treatment summaries and care plans
- Practices for engaging patients in survivorship care
- Keys to financial sustainability

Strategic Road Map for Cancer Quality
Five Goals for Five Years
- Value-based quality strategy
- Updated cancer quality dashboards
- National reporting initiatives
- Clinical data collection and management

Cancer Quality Dashboard Metric Selection Tool
This tool supports the development of a customized tumor site-specific dashboard that includes definitions and benchmarks supported by clinical literature and endorsed by national quality organizations.

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Executive Summary

Smoothing transitions in preparation for coming cost accountability
Cancer patients routinely move across settings of care, navigating a complex and fragmented health care system. Poor coordination can lead to lower quality care, reduced patient and provider satisfaction, and unnecessary costs. Yet few cancer programs have invested in cross-continuum coordination.

Improved cross-continuum coordination is essential to prepare for approaching cost accountability measures. To date, cancer providers largely have been sheltered from payment reforms such as readmissions penalties. However, they will not be able to stay out of the crosshairs indefinitely.

Looking inward to reveal transition opportunities and engage patients, providers
Improving care transitions first requires a look inward at the cancer program’s processes to understand potential problems. A robust understanding of the organization’s transition challenges enables strategic prioritization of coordination efforts and thoughtful use of limited resources.

Once leaders understand what problems exist, one avenue to address those problems is by engaging patients and providers—those at the center of care provision—in ensuring seamless care transitions. Simply educating patients about various sites of care can improve many transitions. Furthermore, working with independent oncologists to develop a shared understanding of patient flow and care coordination responsibilities has outsized benefits.

Developing collaborative relationships across the care continuum
Creating a seamless patient experience also requires reaching out to other sites of care and engaging them in coordination efforts. Cancer patients frequently require care provided by the emergency department, hospital inpatient unit, and hospice. Strategies for working with these care settings, such as establishing two-way communication channels, developing cross-site protocols, and cultivating a transitions-oriented culture, help these settings manage the needs of cancer patients. These strategies also benefit the cancer program as well.

This study serves as a comprehensive guide for cancer programs seeking to smooth transitions for their patients, both to improve patient care and to reduce costs in preparation for payment reforms. It includes 21 practices to improve coordination of patient care across the continuum. As you work toward this goal, we sincerely hope that you will call upon us to facilitate discussions with your team, offer consultative guidance, or provide any other needed support. As always, we close with appreciation for the opportunity to serve you.
The Oncology Roundtable would like to express its deep gratitude to the individuals and organizations that shared their insights, analysis, and time with us. The research team would especially like to recognize the following individuals for being particularly generous with their time and expertise.

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Essay: Examining the Coordination Imperative
Clear Assignment of Responsibility Often Absent

Cancer patients are often at their most vulnerable when they move across settings of care. While the nature of each care transition varies—whether for a planned inpatient stay or an unplanned emergency department visit—the circumstances are often similar. Patients are frequently in pain, interacting with unfamiliar providers, and struggling to understand changing treatment plans.

In one survey, nearly three-quarters of physicians reported that care in their communities is not well coordinated. The unfortunate truth is that when no one is responsible for coordinating care transitions, the burden falls to patients, and their families, to fill the gaps. This does not always go well, even when institutions are organized around coordination.

For example, at one well-reputed integrated health system, a lung-cancer patient went to the emergency department 49 times within a year. During that same period, he was admitted to the hospital 9 times. And none of his providers realized this was happening.

Burden of Coordinating Transitions Falls to Patients

Physicians Reporting Whether Care Is Coordinated in Their Community

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Percentage of Oncology Roundtable Members Who Learn of Cancer Patient ED Visits from the Following Sources

- Patient/Family/Caregiver: 79%
- Oncologist: 70%
- ED Clinician: 53%
- Cancer Center Navigator: 50%
- Manual ED Record Review: 24%
- Electronic Automated Alert: 19%

The Dirty Little Secret

“Nobody is responsible for coordinating care. That’s the dirty little secret about health care.”

Lucian Leape, MD
Harvard School of Public Health

1) Respondents were asked to identify how often (Often, Sometimes, Seldom, or Never) they learned of ED visits, inpatient admissions from a list of sources. This chart includes those respondents who selected “Sometimes” or “Often” the given source.

Transitions, Problems Occur Frequently

Although weekly ED visits are an extreme example, cancer patients may be transitioning between care settings more often than the cancer care team realizes. Reviewing national data, we found that a cancer program with 500 infusion patients annually can expect their chemotherapy patients to make 465 trips to the ED and be admitted nearly 200 times.

Furthermore, problems with these transitions are not uncommon. A recent Oncology Roundtable membership survey found that 62% of cancer program leaders reported experiencing problems sometimes or often with transitions between the ED and cancer center. In addition, 48% of leaders reported experiencing problems with transitions to and from hospital inpatient units.

Systemic Processes Needed to Smooth Numerous Transitions

Estimated Transitions for a Cancer Center with 500 Chemotherapy Patients Annually

- **465** Estimated chemo-related ED visits each year
- **189** Estimated unplanned, chemo-related hospital admissions each year

ED Transition Challenges

- **62%** Survey respondents who reported problems with transitions between the ED and cancer center

Inpatient Transition Challenges

- **48%** Survey respondents who reported problems with patient transitions to and from hospital inpatient units

Poorly Coordinated Transitions Have Wide-Ranging Effects

When transitions break down, effects can range from provider dissatisfaction to serious medical errors. The cost of wasted resources, complications, and readmissions stretches well into the billions of dollars. Given that cancer care makes up more than 5% of national health care spending, cancer care likely constitutes a substantial portion of these totals.

**Decreased Provider Satisfaction**

“Right now, it’s hard to go home feeling good at the end of the day when you’re worried about patients whom you discharged off to who knows where.”

*Dr. Susan Nedza*

*Emergency Medicine Physician*

**Lower Quality of Care**

80% Estimated percentage of serious medical errors involving miscommunication during handoffs between providers

**Wasted Resources**

$25B–$45B Amount of wasteful spending in 2011 resulting from inadequate coordination, including inadequate management of care transitions

Doubling Down on EHR, Navigation Will Not Solve the Problem

EMR Challenges Go Beyond Installation, Meaningful Use

- Inpatient, outpatient modules often differ; providers not trained on, don’t use the other setting’s module
- Records are only as good as the information that providers input
- Interoperable EMR systems still a long way off for some sites of care

Coordinating Care Transitions Only One Component of Navigators’ Role

- 50% of survey respondents reported that navigators had eight or more responsibilities
- Navigators served 150 patients each year, on average

Resource in Brief: Maximizing the Value of Patient Navigation

Lessons for Optimizing Program Performance

- Explore 10 lessons for defining and implementing the navigator role in order to reflect your organization’s unique needs and maximize returns
- Available at: advisory.com/Research/Oncology-Roundtable/Studies/2011/Maximizing-the-Value-of-Patient-Navigation

There Is No Silver Bullet

Oncology Roundtable interviews revealed that many cancer program leaders expect investments in electronic health record (EHR) systems and navigation to improve coordination. However, interviews with leaders in programs that have already implemented these solutions indicated that these measures alone do not solve the problem.

Even cancer programs in integrated health systems with robust EHRs say they struggle to access and share patient information. For instance, inpatient and outpatient EHR modules often differ, leaving providers unable to access information from other sites of care. Furthermore, the inclusion of chemotherapy orders in health system-wide EHRs is still the exception rather than the rule.

As for navigation, program leadership must acknowledge that coordination problems are too big for one person to solve. The problem is better solved through changing processes and systems.
As health care providers assume more accountability for costs and quality, cross-site coordination will be critical for success.

To date, providers and payers have tended to focus their care transformation efforts on disease management and cardiovascular services. However, with the continuous pressure to find new cost savings, health systems will eventually turn their attention to cancer care.

**Payers Ratcheting Up Cost Accountability**

**Improved Cross-Site Coordination Essential Under Accountable Care**

**Reforms Aimed at Driving Cross-Site Coordination**

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1) Admissions for medical treatment of cancer are currently excluded in the calculation of CMS hospital-wide readmissions rates.

2) Accountable care organizations.

Source: Oncology Roundtable interviews and analysis.
Multiple efforts are under way to measure the quality of cancer care coordination. For example, the National Quality Forum recently published a report recommending performance measures for CMS's 1 PPS-Exempt Cancer Hospital Quality Reporting Program. This report emphasized that measuring the quality of coordination across all cancer providers should be a top priority for payers, providers, and quality reporting initiatives.

To that end, the Cancer CAHPS 2 survey is testing new measures of care coordination for patients to use in evaluating their cancer providers.

Furthermore, CMS has begun the process of evaluating new quality measures, including measures of avoidable admissions and emergency department visits among patients receiving outpatient chemotherapy. While there is still much work to be done, it’s likely only a matter of time before care coordination metrics are rolled out more broadly.


1) Centers for Medicare and Medicaid Services.  
Coordinating Seamless Transitions Across Care Settings

This study is designed to provide tactical ideas for smoothing transitions to prepare for payment reform and improve care for cancer patients.

The first chapter guides program leaders through identifying, understanding, and prioritizing among problems with cross-site coordination.

Chapter 2 provides examples of how cancer programs have engaged their patients and independent oncologists as allies in improving transitions across care settings.

Finally, the last three chapters provide specific strategies that cancer programs have used successfully to smooth transitions between the cancer program and three settings where patients frequently receive care: the emergency department (chapter 3), hospital inpatient units (chapter 4), and hospices (chapter 5).

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Leveraging Data to Identify Priorities

Practice #1: High-Level Problem Identification
Practice #2: Underlying Problem Assessment
Practice #3: Strategically Prioritized Follow-Up
Program Leaders Often Unaware of Extent of Problem

Is Improving Transitions Across Settings of Care Currently a Priority for You?

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Three Anecdotal Perspectives on Care Transition Problems

1. **What Problems?**
   One-third of leaders haven’t seen or been exposed to any care transitions problems.

2. **We Might Have Some Problems…**
   One-third of leaders aren’t sure if the problems they’ve heard of are systemic or just one-time complications.

3. **Yes, Houston, We Have a Problem.**
   One-third of leaders have identified that they have systemic problems and are working to understand and address them.

Source: 2013 Oncology Roundtable Seamless Coordination Across the Continuum Quick Poll; Oncology Roundtable interviews and analysis.
Getting to the Point

The Oncology Roundtable has identified three specific practices to help members understand and then tackle the transition problems facing their organizations.

To begin, identify transition problems by gathering readily available, high-level data.

Once these problems are identified, the next step is to dive deep to assess the underlying sources.

Finally, prioritize problems according to their prevalence and impact on patient care to determine where best to focus initial improvement efforts.

As these three steps build on each other, most cancer programs will want to start with the first practice. But some who have begun to assess their transitions already may be able to start with practice two or three.

Identifying Care Transition Challenges, Prioritizing Response

Practices to Strategically Identify, Prioritize Care Transitions Problems

1. High-Level Problem Identification
2. Underlying Problem Assessment
3. Strategically Prioritized Follow-Up

Oncology Transitions Assessment Toolkit Available on advisory.com

- Step-by-step workbook-style toolkit designed to walk members through identifying and assessing care transitions problems, and strategically prioritizing follow-up steps
- Access the toolkit at: www.advisory.com/Research/Oncology-Roundtable/Studies/2013/Coordinating-Seamless-Transitions-Across-Care-Settings

Source: Oncology Roundtable interviews and analysis.
Practice #1: High-Level Problem Identification

Uncovering Transition Problems

The first step toward identifying and prioritizing among transition problems is to develop a well-rounded view of patients’ transitions.

While it may be tempting to rely heavily on one source of information, such as patient complaints, this does not provide a complete view of the problem.

Informal conversations with staff, clinicians, and patients can help leaders begin to uncover problems. Seeking out leaders from other care settings for similar conversations can also be revealing. Finally, quantitative data, such as from billing records or payers, can provide an unbiased perspective.

When thinking about which sources to include in this high-level problem identification step, it’s useful to think about benefits and challenges of the various data types. For example, quantitative data can shed light on an issue by demonstrating the magnitude of a problem, but qualitative data may be necessary for understanding why the problem is occurring.

Strategic Conversations and Data Reveal Challenges

Key Information Sources, Topics

- **Cancer Center Staff, Clinicians**
  - Frequency of unsuccessful transitions
  - Timely information exchange
  - Common patient, provider complaints

- **Patients and Caregivers**
  - Patient complaints
  - Unmet needs or delays in care following a transition
  - Detailed explanations of patient satisfaction survey responses

- **Leaders from Other Care Settings**
  - Staff knowledge about caring for cancer patients
  - Timely receipt of patient information
  - Number of cancer center patients receiving care

- **Billing Records, Payer Data**
  - Number of cancer center patients receiving care at each external site
  - Comparison with other cancer programs on transitions metrics (e.g., readmissions)

Problem Identification Tools Available on advisory.com

- Discussion guides for qualitative interviews with staff, clinicians, and patients
- Step-by-step guidance on how to request, analyze, and report on billing data

Source: Oncology Roundtable interviews and analysis.
Examining the Source of Transition Challenges

Once a potential problem area is identified, deeper investigation will ensure a focus on the right potential solutions. These in-depth investigations can take on a variety of forms.

This publication presents three innovative methods Oncology Roundtable members have used to assess their transition problems: a multi-stakeholder gap analysis, a patient data deep dive, and cross-site shadowing.

Appropriate Strategy Depends on Available Resources, Expertise

Strategies to Investigate Problem Areas

- **Multi-stakeholder Gap Analysis**: Representatives of all involved stakeholder groups interviewed to learn where problems exist.

- **Patient Data Deep Dive**: Program leaders review patient records to illustrate the full story behind quantitative data.

- **Cross-Site Shadowing**: Clinical staff shadow their counterparts in another care setting to see care differences firsthand.

Source: Oncology Roundtable interviews and analysis.
The cancer program at UT Southwestern conducted a gap analysis to gain a comprehensive understanding of problems with patient transitions between the inpatient and outpatient settings. Before launching the analysis, program leaders already knew that this particular transition was a problem based on information from patients and providers. Program leaders tasked an outpatient social worker with conducting the analysis. Her first step was to interview patients after discharge to learn about their overall transition experience and how prepared they were for discharge. Following the patient interviews, the social worker also interviewed inpatient and outpatient clinical and case management staff members. These staff interviews complemented the patient experiences by adding clinical and case management perspectives. The social worker found that one key to her success in generating buy-in across multiple departments was her focus on improving patient safety, a concern shared by all stakeholders.

**Interviewing Multiple Stakeholders Provides Comprehensive Perspective**

**Gap Analysis Process at UT Southwestern**

- **Interviews, analysis conducted by cancer center social worker**
  - Interviews with inpatient and outpatient nurses, social workers, and case managers identified provider issues, gaps in care

- **Patient Interviews**
  - Post-discharge telephone interviews with 60 cancer patients about care experiences, discharge process

- **Staff Interviews**
  - Analysis identified patient, provider challenges across settings, potential to generate broader benefits

**Implementation Tips**

- Emphasizing common concerns, such as patient safety, helps unite stakeholders
- Selecting an interviewer from among existing staff allows the interviewer to better identify appropriate staff to interview, ask the right questions
- Incorporate questions from Press Ganey surveys in patient interviews, along with additional questions targeted at areas of greatest patient complaints

**Case in Brief: UT Southwestern University Hospitals**

- Two-hospital academic medical center based in Dallas, Texas; includes the NCI-designated Simmons Cancer Center
- Factors prompting the cancer center to conduct a gap analysis of its inpatient and outpatient care included:
  - Declining patient satisfaction
  - Post-discharge service failures
  - Cancer program goal to create a more patient-centered experience
  - Lack of proactive discharge planning

Source: Sayles S, et al., “Patient and Family Focused Transitional Care,” Oncology Issues, July-August 2012: 26-29; UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Taking Feedback to Heart

Analysis Findings Drive Program Goals

Findings from patient and staff interviews revealed where patient care and provider communication were breaking down. Based on these findings, the cancer program developed a transitional care program to better serve patient needs. Ultimately, a final report summarizing the results was a powerful tool for compelling senior health system leaders to allocate additional resources for the new program.

Patient Interview Findings
- Reactive discharge planning, inconsistent follow-up appointment scheduling
- Lack of communication, collaboration between care providers
- No supportive counseling during inpatient stay
- Little inpatient education about care plan, disease process

Staff Interview Findings
- Outpatient providers not informed of discharge plan or changes in patient status
- Patients’ psychological, emotional needs not adequately evaluated or addressed
- Patients’ medications not preauthorized prior to discharge, leading to unfilled prescriptions

Transitional Care Program Goals
1. Support patients and their families through transitions across settings
2. Improve communication, collaboration across sites
3. Communicate patient data accurately and in a timely manner between settings
4. Address all needs of patients and families, including social, emotional, and spiritual needs

Initially, Aurora Health Care wanted to understand how many of the system’s cancer patients were going to the ED. Cancer program leaders collected billing data for all chemo patients who visited EDs within their system. Program leaders soon realized that there were many more visits than they had anticipated.

Program leaders then sought to learn why patients were coming to the ED. For this deeper analysis, they focused on a subset of these visits by looking at data only for patients who visited the ED at Aurora’s tertiary care center. This resulted in collecting both billing data and medical records for 300 chemo patients.

Program leaders analyzed the data in many different ways to identify which patients were visiting the ED, when, and why. Because billing data diagnosis codes were often inconsistent and ambiguous, they manually abstracted patients’ medical records to verify their chief complaints when presenting at the ED. This process was aided by an internal medicine resident willing to lend his clinical expertise to the project.

**ED Data Reveals Improvement Opportunities**

**Aurora Health Care’s Review of ED Patient Records**

**Collected Patient Records**

- Worked with decision support to get ED visit data from billing records
- Included all visits within 60 days of outpatient chemo infusion; 1,600 visits identified across the system

**Medical Record Review**

- Approximately 20% of total ED visits, 300 in total, within tertiary center
- Manually abstracted all tertiary center ED visits to verify chief complaint

**Analyzed Data**

- Analyzed 300 ED visits from tertiary center
- Analysis included:
  - Tumor site
  - ED visit time of day
  - ED visit day of week
  - Time from chemo infusion to ED visit
  - Chief complaint (pain, fever, and infection were most common reasons for ED visits)

**Case in Brief: Aurora Health Care**

- 15-hospital, not-for-profit health system serving communities throughout eastern Wisconsin and northern Illinois
- Cancer program analyzed ED visit data as a first step toward reducing ED visits, hospital admissions for chemotherapy patients
- Billing data was obtained from the decision support department for all patient ED visits within 60 days of an outpatient chemotherapy infusion; analysis determined overall number of ED visits, visit distribution across days of the week, time from infusion to ED visit, common complaints
- An internal medicine resident and oncology system service line leader reviewed medical records for a sample of approximately 300 patients to identify underlying reason for ED visit
- Cancer program leaders used results of this analysis to guide identification of opportunities for improvement

Source: Aurora Health Care, Milwaukee, WI; Paragkumar R, et al., “Opportunities for Better Management of Cancer in Patients Receiving Chemotherapy at Aurora Health Care (AHC), a Large Integrated Health System in Eastern Wisconsin,” J Clin Oncol 30, 2012 (suppl 34, abstr 110); Oncology Roundtable interviews and analysis.
### Targeting Resources to Identified Opportunities

The deep-dive analysis resulted in a robust understanding of patient ED visits, which Aurora’s leaders were able to use to target resources to implement changes and improve transitions for patients. For example, because many patients were visiting the ED within one week of a chemotherapy infusion, the cancer center added better support for patients during this critical time.

### Results from Aurora Health Care’s ED Visit Analysis

<table>
<thead>
<tr>
<th>Time from Chemo Infusion to ED</th>
<th>Tumor Site</th>
<th>Timely Access, Common Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-third of patients were visiting the ED within one week of their chemo infusion</td>
<td>40% of ED visits were patients with thoracic or GI cancers</td>
<td>Many patients visiting ED during clinic office hours; most frequent reasons for ED visit included infection, pain</td>
</tr>
<tr>
<td>Provide more extensive education and support to patients during the week after chemo infusion</td>
<td>Nurse navigators target education and symptom management to thoracic and GI patients</td>
<td>Equipped oncologist offices with IV antibiotics, narcotics to better address infection and pain</td>
</tr>
</tbody>
</table>

**Source:** Aurora Health Care, Milwaukee, WI; Paragkumar R, et al., “Opportunities for Better Management of Cancer in Patients Receiving Chemotherapy at Aurora Health Care (AHC), a Large Integrated Health System in Eastern Wisconsin,” J Clin Oncol, 30, 2012 (suppl 34; abstr 110); Oncology Roundtable interviews and analysis.
Method #3: Cross-Site Shadowing

A Day in the Life

At the University of Minnesota Physicians Cancer Care at Fairview, the cancer program was one of three pilot sites within a larger system-wide performance initiative focused on improving care coordination.

The initiative was led by the performance improvement department, which recruited a team of inpatient and outpatient oncology providers and staff to participate. The team met weekly.

As part of a current state analysis, team members shadowed their colleagues in other parts of the hospital for two brief sessions. For example, an infusion center nurse shadowed a nurse on the inpatient floor. Their experiences were shared within the broader team, which helped identify opportunities for improving patient transitions.

An unexpected benefit of the observations was that providers could also better prepare patients for transitions to different care settings.

Revealing Transition Opportunities Through Inter-site Observations

Cross-Site Shadowing at University of Minnesota Physicians Cancer Care at Fairview

System Initiative Launched
• Performance Improvement-led initiative included focus on cancer care coordination
• Inpatient/outpatient team met weekly; team included nurses, physicians, transitions coordinators
• Periodic updates given to physicians, senior leaders

Current State Analysis
• Select inpatient, outpatient staff shadowed their counterparts in two 45-minute sessions
• Findings and experiences shared in subsequent group meeting

Shadowing Results
• Increased cross-site understanding of processes, patient experience
• Strengthened relationships with staff in other settings
• Identified improvement opportunities such as patient education, discharge instructions

Case in Brief: University of Minnesota Physicians Cancer Care at Fairview
• 10-hospital academic health system based in Minneapolis, Minnesota
• The cancer center, along with its largest hospital and affiliated medical group, recently launched a performance improvement project to review how patients are managed across the continuum
• To assess current care coordination processes, group members shadowed colleagues in other departments
• Based in part on their shadowing efforts, the project group identified five areas of opportunity to improve patients’ care transitions: care coordinators, patient education, discharge instructions, rounding, and risk stratification

Source: University of Minnesota Physicians Cancer Care at Fairview, Minneapolis, MN. Oncology Roundtable interviews and analysis.
Focus Initial Efforts on Highest-Impact Areas

Prioritization Factors for Consideration

- **Volume of Impacted Patients**
  - Overall number of patients experiencing each problem
  - Relative volume of high-risk patients

- **Severity of Problem**
  - Patient safety concerns
  - Patient, provider satisfaction concerns

- **Potential Cost Savings**
  - Resource utilization concerns
  - Preparation for value-based payment reforms

- **Linkages with Broader Initiatives**
  - Alignment with institution- or system-level priorities
  - Congruence with other cancer program initiatives

- **Ability to Inflect Change**
  - Source of control for areas needing improvement
  - Potential to have a measurable impact on problem

Source: Oncology Roundtable interviews and analysis.
One factor deserving special mention is high-risk patients. Often, cancer patients are categorically considered to be at high risk. However, given limited resources, cancer programs may see the largest impact by focusing on those patients within the cancer population who are at highest risk for poor transitions. For example, certain cancer types or comorbidities can place cancer patients at a higher risk for transition failures or readmissions. Psychosocial risk factors such as social support networks and ability to follow a treatment plan should also be considered.

Identifying Patients Most Affected by Poor Transitions

Factors That May Indicate Patient at Risk for Transition Failures, Readmission

Clinical Risk Factors

- Cancer types:
  - Lung
  - Head and neck
  - GI
  - Lymphoma
- Multiple comorbidities, especially insulin-controlled diabetes
- Chemotherapy patients, especially those on oral or platinum-based regimens
- Patients taking high-dose narcotics

Psychosocial Risk Factors

- Inadequate social support
- Living alone
- Difficulty following treatment plan
- Limited caregiver ability to meet patient needs
- Interpreter needed
- Financial or insurance concerns

Source: Oncology Roundtable interviews and analysis.
Leveraging Data to Identify Priorities

Although improving care transitions is a priority for most cancer center leaders, they often lack a robust understanding of transition problems within their organizations. Such understanding is essential for cancer programs seeking to implement high-impact improvements with limited resources.

1. Identify problems by gathering high-level data
   Gathering readily available information about the quality of care transitions through strategic conversations and key metrics provides a well-rounded view of transition problems within the cancer program.

2. Assess the underlying sources of transition problems
   Targeted assessment of problems helps identify their causes. Assessment methods include interviews with a variety of stakeholders, a detailed review of patient records, or shadowing staff in other care settings to see care differences firsthand.

3. Strategically prioritize follow-up efforts
   Prioritizing initial efforts to focus on improving the highest-impact care transitions can result in best use of limited resources.
Chapter 2

Coordinating Transitions with the Cancer Care Team
Part I – Engaging Patients

Practice #4: Pre-transition Patient Education
Practice #5: Strategically Timed Discharge Information
A Complex Care Journey for Patients

In today’s complex health care environment, patients are often overwhelmed by the sheer number of different care sites they visit during their cancer treatment.

Adding to the complexity, many of these sites have little connection with each other. This means patients are typically the hub for information exchange between the many sites of care.

Cancer Patients’ Current Care Experience

Source: Oncology Roundtable interviews and analysis.
Frequently Relying on Patients to Relay Information

In a 2013 Oncology Roundtable survey, 77% of respondents reported learning of ED visits and inpatient admissions from patients and caregivers “sometimes” or “often.”

In fact, patients and families were the most commonly used mechanism to learn of ED visits, and the second most common for admissions.

This reliance on patients to communicate information across sites of care is ill-advised for multiple reasons. For instance, patients in the ED and inpatient units are experiencing acute issues and might not be well enough to communicate or absorb information. And since patients aren’t typically clinically trained, their ability to relay complete medical information is limited especially in light of the complicated nature of medical jargon.

Although in an ideal world we would not rely on patients to coordinate their care across sites, in reality, since patients will travel to these sites, it is important to prepare them for these transitions.

But Patients Ill-Equipped to Manage Transitions

Challenges of Relying on Patients to Relay Information Across Sites

- ED patients experiencing acute issues
- Inpatients likely least stable; highest acuity
- Most patients not clinically trained
- Medical jargon difficult to understand, easy to confuse
- Some patients do not want deeper engagement

Reliance on Patient, Family, Caregiver Reports

77% Percentage of respondents who hear of ED visits and admissions from patients, families, and caregivers “sometimes” or “often”
Equipping Patients in Advance

One organization striving to do just this is the Simmons Cancer Center at UT Southwestern. All newly diagnosed cancer patients are given what they call a Journey Book. This binder includes information on their specific cancer, available support services, and community resources.

Although such patient information books are increasingly common at cancer programs throughout the country, what is unique about the Journey Book is that it also includes information on transitions. For instance, one section notifies patients that they might need care in the ED at some point. It then describes what patients should expect there. This advance notification likely helps decrease patient anxiety and confusion if they do seek treatment at the ED.

Embedding Transitions Information in Patient Education

Simmons Cancer Center’s Patient Journey Book

- Three-ring binder of information provided to all patients
- Information on diagnosis, support services included
- One-page document notifies patients they might need care in the ED, and what to expect in that setting

Case in Brief: UT Southwestern University Hospitals

- Five-hospital health system based in Dallas, Texas; includes the NCI-designated Simmons Cancer Center
- All newly diagnosed patients given a “Journey Book” to educate them about their cancer, available support services, and community resources
- Book also includes information on what patients should expect in the ED

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Other organizations put tools in patients’ hands to help them advocate for themselves in other sites of care.

Obelisk Health System, a pseudonym, gives all patients identification cards that include their name and medical record number. These cards help ensure unity of medical records across sites of care within the system, while protecting patient privacy.

Although all patients are given cards, only cancer patients are given red cards. Medical oncology patients are instructed in their pre-chemotherapy education to present the card to all providers they see in the health system, thus ensuring that providers identify them immediately as oncology patients and manage them accordingly.

**Case in Brief: Obelisk Health System**

- Ten-hospital health system based in the North
- Health system uses various color-coded patient cards to identify patients; only the cancer service line uses a red card
- Red cards given to cancer patients during their pre-chemotherapy education sessions; patients instructed to present it to all providers within the health system
- Cards have proven particularly helpful with appropriate ED triage

Source: Oncology Roundtable interviews and analysis.

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1) Pseudonym.
Transporting Detailed Clinical Information

Cancer programs can also empower patients to carry more complete treatment information with them at all times. The Gibbs Cancer Center has for many years used what it calls a Patient Treatment Record. This passport-sized document incorporates information for both patients and providers.

Patient information includes cancer center contact information and guidance on what symptoms should prompt concern. Provider information includes a summary of the patient’s diagnosis, details on treatment cycles, and ongoing documentation of blood count, weight, pain, and fatigue.

Patients are given their record at the beginning of their treatment, and are instructed to ask all treating oncologists to update it.

Patients have shared that they find the record particularly useful while traveling. With the record on hand, they don’t have to worry about provider confusion if they need to seek care out of town.

Pocket-Sized Patient Treatment Record Travels with the Patient

Patient Treatment Record at Gibbs Cancer Center and Research Institute

Patient Treatment Record Details

Information for Patients

• Important cancer center contact information
• List of symptoms/conditions that would prompt the patient to call the cancer center (fever, severe pain, bleeding, etc.)

Information for Providers

• Patient name, diagnosis, medical record number
• Chemotherapy treatment record, number of cycles
• Allergies
• Documentation of blood count, weight, pain, fatigue

Case in Brief: Gibbs Cancer Center and Research Institute

• Cancer center and research institute located in Spartanburg, South Carolina; part of the two-hospital Spartanburg Regional Healthcare System
• Cancer center developed pocket-sized patient treatment record that includes information for patients and providers in different sites of care
• Treatment record provides patients with key information during transitions to other providers, facilities

Source: Gibbs Cancer Center and Research Institute, Spartanburg, SC. Oncology Roundtable interviews and analysis.
If educating patients before transitions is important and helpful, educating patients at the right time is equally so. One particularly challenging time for patients to absorb information and transition between sites of care is at the point of discharge from an inpatient stay.

Typically, patients are given a wealth of information just prior to discharge, ranging from what test results are pending, to when and how they should exercise, to recommended self-care. Unsurprisingly, this information can be overwhelming.

Discharge isn’t necessarily the best time to engage patients in significant education. Many of the common problems patients experience after discharge relate to information retention.

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**Oncology Roundtable Resource**

“Strategically Timed Pre-treatment Education for Cancer Patients” in *Delivering on the Promise of Patient-Centered Care*

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**Traditional Post-discharge Patient Problems**

- Difficulties with activities of daily living
- Emotional problems
- Knowledge deficit
- Insufficient help
- Uncertainty and anxiety
- Informational needs

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Source: Mistlaen P and Poot E, “Telephone Follow-Up, Initiative by a Hospital-Based Health Professional, for Postdischarge Problems in Patients Discharged from Hospital to Home,” Cochrane Collaboration. 2008, 3: 1; Oncology Roundtable Interviews and analysis.
Cancer program leaders can consider working with inpatient staff to develop alternative approaches to discharge education.

One organization that adjusted its approach is Fox Chase Cancer Center. It now provides all patient education materials at least one day prior to discharge. Patients thereby have time to review the information and ask questions of the inpatient care team.

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**Fox Chase Cancer Center**

*Pre-discharge education*

- **Discharge**
- **Patient education materials given one day before discharge**

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**Key Benefits**

- Patient has time to review instructions, ask questions before leaving the hospital
- Inpatient staff well suited to address patient questions
- Does not require significant workflow redesign

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**Case in Brief: Fox Chase Cancer Center**

- 100-bed cancer hospital based in Philadelphia, Pennsylvania
- All admitted patients are given educational materials, including post-discharge self-care instructions, one day prior to discharge; patients have the opportunity to review materials, ask questions as needed
- All patients admitted to a medical service also have a telephone visit within 48 hours of discharge and an on-site visit within seven days

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Source: Fox Chase Cancer Center, Philadelphia, PA; Oncology Roundtable interviews and analysis.
Postponing Patient Education Another Viable Option

In contrast, Scottsdale Healthcare’s cancer program has stepped in after discharge to reinforce the information relayed on the inpatient side. Cancer center advanced practice nurses call all patients within 48 hours after discharge.

The phone call focuses on pain management, understanding prescriptions, and recommended follow-up appointments. At Scottsdale, these phone calls have resulted in increased patient satisfaction and decreased readmissions.

Delayed Education Lessens Patient Confusion, Adds Service Touch

Scottsdale Healthcare
Post-discharge education

Discharge

All patients called within 48 hours post-discharge

Key Benefits

- Clinician can call at a time convenient to the patient
- Outpatient staff familiar with patients and their needs
- Patient reconnected with outpatient clinicians, staff, services

Case in Brief: Scottsdale Healthcare

- Three-hospital health system based in Phoenix, Arizona
- As part of a system goal to reduce unnecessary readmissions, cancer center examined its discharge procedures; clinicians reported challenges with creating a coordinated post-discharge care plan, service line leaders reported opportunities to improve the patient transition home
- Cancer center APRNs call all discharged patients within 48 hours to discuss pain management, discharge prescriptions, and follow-up appointments
- Initiative has resulted in increased patient satisfaction and decreased readmissions

Source: Scottsdale Healthcare, Phoenix, AZ; Oncology Roundtable interviews and analysis.
Preparing Patients for Transitions Across Settings

Clearly there are a different approaches to enhancing patients’ ability to navigate cross-site transitions. Underlying any approach, however, should be some assessment of individual patients’ preparedness for transitions. Questions such as those included here can be a part of these assessments.

After gaining an understanding of patients’ starting points, the discussion topics presented here can be introduced to patients to enhance their preparedness for any transitions.

Key Questions and Discussion Topics to Consider

Key Questions

• Do you know what each of your medications does?
• Do you know what symptoms you should monitor and watch out for?
• Do you know who to call when you are concerned about a symptom or when you have a question?
• Do you know what information you should take with you when you need care outside of the cancer center?
• Do you know how to identify yourself as a cancer patient at all sites of care, and why you should do so?

Discussion Topics

• Review settings of care for patients, including the ED and inpatient units
• Explain why patients may need to receive care in the ED or on an inpatient unit
• Review information patients should take with them during visits to the ED or inpatient unit
• Ask whether the patient has a family member, friend, or caregiver who can help provide support during care episodes outside of the cancer center

Source: Oncology Roundtable interviews and analysis.
The Oncology Roundtable also has many resources related to understanding patient needs, engaging them in their care, and building patient-centered care. These publications can be ordered on advisory.com.

Additional Oncology Roundtable Resources for Engaging Patients Across the Continuum

**Delivering on the Promise of Patient-Centered Care**
*Designing Services to Support the Whole Patient*

**Delivering Sustainable Survivorship Care**
*Lessons for Program Design and Implementation*

**Integrating Palliative Care into Oncology Practice**

**Inside the Mind of the Cancer Patient**
*Uncovering Patient Preferences to Guide Cancer Program Investment*

Source: Oncology Roundtable interviews and analysis.
Key Takeaways

Coordinating Transitions with the Cancer Care Team: Engaging Patients

Although patients currently bear a significant burden for cross-setting care coordination, cancer care providers devote little time to preparing patients for transitions. Even simple education about various sites of care can have outsized impact on transition quality.

1. Educate patients about transitions before they happen
   Patients can more effectively serve as their own advocates in other sites of care when cancer programs invest up-front time in informing patients about transitions and equipping them with information about their care.

2. Schedule education during periods of lower stress
   Cancer care providers should pay particular attention to the timing of post-discharge education, since cancer patients are often overwhelmed at this time and vulnerable to readmission.

3. Identify the key learner and engage patients, families accordingly
   Patients should not be the only targets of education; cancer programs should also seek to engage family members, friends, and caregivers as appropriate.

Source: Oncology Roundtable interviews and analysis.
Chapter 2

Coordinating Transitions with the Cancer Care Team
Part II – Engaging Independent Oncologists

Practice #6: Cross-Site Transition Mapping
Practice #7: Care Coordination Agreements
Practice #8: Ongoing Transition Quality Improvement
Coordination with Independent Oncologists Often Challenging

How often do you experience challenges with transitions to and from independent oncology offices?

- Never: 2%
- Occasionally: 16%
- Sometimes: 38%
- Seldom: 44%
- Often: 2%

Typical Coordination Challenges

- Incomplete orders
- Illegible orders
- Incomplete staging information
- Incomplete transfer of medical records

Source: Oncology Roundtable Seamless Coordination Across the Continuum Quick Poll; Oncology Roundtable interviews and analysis.

1) N/A responses removed.
There are multiple barriers to smoothing these transitions. Patient information is usually stored in different locations, with different recordkeeping systems. Cancer centers and independent oncologists have many priorities in addition to patient care transitions. What’s more, some independent practices and cancer centers are in direct competition and have little motivation to collaborate. Finally, neither side has full insight into the patient pathway. Often, there’s little clarity as to what services are provided where, when, and for what reason.

Examining the Challenges

**Barriers to Improving Care Transitions**

- **Siloed Patient Information**: Patient information typically stored within sites of care; difficult to access externally.
- **Competing Priorities**: Each facility has varied priorities and goals; transitions not necessarily prioritized.
- **Adversarial Relationships**: Independent oncology practices and cancer centers are sometimes in direct competition.
- **Lack of Transparent Patient Pathway**: Neither side has full insight into the other; many questions about what services are provided when, where.

Source: Oncology Roundtable interviews and analysis.
This section will follow the steps that one organization, Lehigh Valley Health Network, took to engage independent oncologists and overcome these care coordination challenges.

Lehigh Valley started by evaluating the status of patient transitions through completing a process map. It then collaborated with multiple independent groups to create formal care coordination protocols.

Finally, it created a standing committee focused on care protocols and transition quality improvements.
Taking Stock of Transitions

After Lehigh Valley’s cancer program leaders defined improving transitions as a priority, they tasked a nurse practitioner with mapping the flow of breast cancer patients from diagnosis through treatment.

Breast cancer was selected as a first priority because Lehigh Valley was seeking to improve care provided to underserved populations in its community, and the program had already identified challenges in navigating women with limited English proficiency through the breast cancer screening and diagnosis process.

To complete the process map, the NP interviewed all of the departments and providers involved with breast cancer care. Interviews with leaders in each area took just 20 to 30 minutes. Her goals were to understand processes, identify responsibilities, and pinpoint communication breakdowns.

After completing the process map, some cross-site coordination responsibilities were reallocated to be more fairly balanced between staff members.

Process Mapping Defines Responsibilities

### Process Mapping at Lehigh Valley Health Network

- **Transitions Prioritization**
  - Cancer program leaders identify transitions as a priority

- **Flow Mapping**
  - Roles and responsibilities identified; gaps and process problems defined

- **Task Reallocation**
  - Transition-related tasks more clearly defined and fairly allocated

- **Education**
  - System-wide meeting presents findings, ideal patient flow

### Implementation Tips

- Task a long-standing staff member to lead process mapping
- Involve all providers across the continuum
- Cultivate a champion in each department
- Emphasize a focus on the patient as a unifying force

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1) Nurse practitioner.

Source: Lehigh Valley Health Network, Allentown, PA; Oncology Roundtable interviews and analysis.
Overcoming Assumptions

Process mapping also revealed that providers and staff were making inaccurate assumptions about how patients were treated in other sites of care.

To overcome these misperceptions, Lehigh Valley presented the process map findings in a cross-site meeting. At least one staff member from each relevant site of care attended the meeting, which was held over lunch in lieu of a typical department meeting.

The NP led a patient flow skit, walking a hypothetical patient through each step of diagnosis and treatment. Staff and providers from various sites of care explained their roles at the relevant times. The financial counseling presentation was particularly informative because it underscored the difficulties both patients and the health system faced if physicians rushed patients to appointments without leaving counselors time to investigate financial options for patients.

The common understanding created by the patient flow skit has also allowed Lehigh Valley to achieve support for standardized referral forms and simplified biopsy procedures.

Inclusive Meeting Educates on Patient Pathway

Cross-Site Presentation of Typical Patient Flow

1. Cross-System Gathering
   - Attended by at least one representative of each department related to cancer care
   - Held over lunch, rather than a typical department meeting

2. Patient Flow Skit
   - Facilitated by the NP who interviewed all departments, created patient flow map
   - Staff and providers presented about their role at the relevant time

3. Flow Changes Implemented
   - Improved understanding of ideal patient flow
   - Creation of standardized forms to smooth referrals
   - Breast biopsy procedures simplified

Case in Brief: Lehigh Valley Health Network

- Four-hospital health system based in Allentown, Pennsylvania; system also includes community health centers, a health plan, and primary care and specialty physicians
- After oncology service line leaders identified improved cross-site transitions as a priority, they tasked an NP with mapping the patient flow from diagnosis through treatment
- The NP spoke with leaders and staff of all departments related to cancer care to understand processes, identify roles and responsibilities, and pinpoint typical breakdowns
- In response to the mapping exercise, department leaders reallocated certain coordination responsibilities to improve workflows and avoid undue burdens
- NP led a cross-site meeting to present ideal patient flow; meeting provided vital information to all attendees about roles and responsibilities throughout the system

Source: Lehigh Valley Health Network, Allentown, PA; Oncology Roundtable interviews and analysis.
To formalize the responsibilities outlined in the process map, Lehigh Valley cancer program leaders engaged with independent practices to create a breast care cooperative agreement.

This agreement outlines collaborative care principles, defines timelines for screenings, diagnostics, and referrals, and describes required clinical information transfer. It also describes navigator responsibilities and includes a map of typical patient flow. Together, these elements support improved communication.

As a key to their success, Lehigh Valley emphasized the importance of having providers from various sites of care involved in the creation of the agreements. By including everyone from the beginning, Lehigh Valley ensured that no one felt imposed upon or excluded.

Breast Care Agreement Formalizes Responsibilities

Breast Care Cooperative Care Agreement at Lehigh Valley

A complete version of the Cooperative Care Agreement is available online.

Case in Brief: Lehigh Valley Health Network

- Four-hospital health system based in Allentown, Pennsylvania; system also includes community health centers, a health plan, and primary care and specialty physicians
- Using findings from patient flow mapping, created a cooperative care agreement signed by network primary care practice, hematology oncology practice, breast health services, and surgical oncology practice

Source: Lehigh Valley Health Network, Allentown, PA; Oncology Roundtable interviews and analysis.
Lehigh Valley then kept its collaboration with physicians going by creating a committee to address policies, procedures, and transitions. In its early phases, the committee included physician practice and infusion center representatives. Among other initiatives, this group has refined Lehigh Valley’s approach to patient education and created several joint clinical practice guidelines.

In addition to these specific accomplishments, the group meetings have also generally improved relationships across sites. For instance, people now feel they know who to contact when they have questions.

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**Practice #8: Ongoing Transition Quality Improvement**

**Don’t Be Satisfied with ‘Good Enough’**

**Lehigh Valley Health Network’s Quality Circle Committee**

- **Committee Overview**
  - Meets monthly for 1.5 hours
  - Addresses issues including policies, procedures, and transitions
  - Members include physician practice and infusion center representatives

- **Select Results**
  - Inclusion of patient education into prospective care plans
  - Creation of dedicated nurse appointments for patient education
  - Several joint clinical practice guidelines supporting standardization and communication across sites

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**Who You Gonna Call?**

“The committee has helped to overcome an “us vs. them” mentality that was previously common. It’s helped us to develop relationships across sites—everyone now knows who to call when they have an issue.”

Pat Shearburn

Quality Clinical Nurse Specialist, Lehigh Valley Health Network

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**Case in Brief: Lehigh Valley Health Network**

- Four-hospital health system based in Allentown, Pennsylvania; system also includes community health centers, a health plan, and primary care and specialty physicians
- Inconsistencies in referrals to the infusion center prompted the creation of a Quality Circle Committee, which gathered representatives from independent practices and the infusion center to discuss issues related to processes, procedures, and transitions

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Source: Lehigh Valley Health Network, Allentown, PA; Oncology Roundtable interviews and analysis.
Operating a Transitions Improvement Committee

Regular Meetings Provide Surprising Benefits

Cancer program leaders interested in developing this type of committee can draw upon some of the implementation tips included here. Of particular importance is the recommendation to select an initial project that will serve to build rapport and momentum in the committee. Selecting a modest initial project is also advisable because even the act of gathering together as a group to address coordination issues is helpful in itself. Creating familiarity and mutual understanding among staff and clinicians in different areas is valuable.

Committee Implementation Tips

- Recruit a passionate leader to facilitate committee meetings
- Use a focus on the patient as a unifying force
- Ensure nurse participation by securing management support
- Develop objective measures of progress
- Start with an “easy win” project:
  - Low risk
  - Staff not attached to current process
- Select early projects that focus on cross-site challenges so no one feels targeted
- Commit to transparent reporting

Meeting Is Worth the Effort

“Care transitions issues stem from not understanding the bigger picture and not realizing that one small change in workflow impacts everything else. Sitting down regularly as a group has been helpful in itself.”

Pat Shearburn
Quality Clinical Nurse Specialist,
Lehigh Valley Health Network

Additional Oncology Roundtable Resources for Driving Oncology Physician Alignment

Achieving Sustainable Hospital-Physician Alignment in Oncology
Twelve best practices to elevate physician leadership effectiveness and structure partnership models to increase engagement

Toward True Shared Governance
To help oncology administrators design an oncology service line structure that better aligns physicians’ and hospitals’ incentives, this study examines a range of organizational and physician alignment models.
Coordinating Transitions with the Cancer Care Team: Engaging Independent Oncologists

Independent oncologists and hospital-based cancer programs are partners in the provision of cancer care, but varying processes and priorities present challenges to communication and coordination. It is vital to ensure seamless transitions between these two sites of care.

1. Develop a shared understanding of patient flow
   A lack of insight into the operations of other settings of care can cause transition breakdowns. Mapping the typical patient flow, identifying misunderstandings, and communicating these findings helps set shared cross-site expectations about information transfer and transition responsibilities.

2. Formalize care coordination responsibilities
   After establishing a shared understanding of patient flow, cancer centers can formalize coordination commitments by collaborating with independent oncologists to create care coordination protocols.

3. Commit to continuous quality improvement
   Establishing a forum for independent oncology practices and cancer center representatives to address coordination issues can improve patient transitions on an ongoing basis.

Source: Oncology Roundtable interviews and analysis.
Ensuring Smooth ED Transitions

Practice #9: Systematic ED Visit Alert
Practice #10: Oncology Training for ED Staff
Practice #11: Oncology ED Transition Protocols
While the oncology community has long focused on reducing cancer patient visits to the emergency department, the fact remains that cancer patients visit the ED frequently. In fact, 56% of Medicare chemotherapy patients visit the ED at least once, with many visiting the ED multiple times over the course of their treatment. While cancer care providers are well aware of the cost and resource utilization impact of ED visits, it is also important for providers to examine the significant quality and patient safety implications as well.


1) Within six months of an outpatient chemo infusion treatment; 2011 data.
In fact, data from a study looking at time from triage to antibiotic administration for neutropenic patients found that patients waited up to five hours before receiving antibiotics, with the longest wait time being almost 23 hours.

Equally troubling is that patients are not only receiving sub par care, they often leave the ED confused about the care they received or unsure about their follow-up steps. At the core, many of these issues stem from ED providers’ lack of oncology expertise and inadequate communication.

For the most part, this is understandable, as each department within the health system has its own set of priorities. Given how often cancer patients seek care in the ED, however, and the significant repercussions if things go wrong, cancer centers should seek to align more closely with the ED.
At the most basic level, cancer care providers can support the ED by simply alerting them when a cancer patient is on their way. This simple process allows ED clinicians to triage and treat patients appropriately.

Gundersen Health System in Wisconsin developed a button within their EMR system to alert clinicians that the patient they are treating is a cancer patient. This button, aptly named the FYI button, provides clinicians with just enough information to triage the patient or call the oncologist for a consult.

This system, although seemingly simple, has outsized benefits for both the patient and the ED clinician.

**EMR Alert Informs ED Clinicians of Patient’s Diagnosis, Treatment**

**Gundersen EMR “FYI” Button**
- Homegrown EMR “FYI” button alerts ED clinicians when a cancer patient visits the ED
- Includes alerts that the patient is on active therapy or if patient is receiving palliative treatment

**Case in Brief: Gundersen Health System**
- Integrated health system based in La Crosse, Wisconsin
- Developed function within existing EMR to alert ED clinicians of patient’s cancer diagnosis, including patients receiving active chemotherapy treatment, palliative care

Source: Gundersen Health System, La Crosse, WI; Oncology Roundtable interviews and analysis.
Providing a Heads Up

On this page we have listed other tactics that members may use to achieve similar results. Each tactic has advantages and disadvantages, but ultimately serves the same purpose.

Since electronic solutions may not be feasible for all, clinician-to-clinician communication can be an option.

Equipping patients with resources that help identify them as cancer patients, as discussed in the previous chapter, is another alternative.

Variety of Approaches to Proactive Communication

<table>
<thead>
<tr>
<th>Tactic Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Alert</td>
<td>Homegrown EMR “FYI” button alerts ED clinicians that patient is a cancer patient. Includes alerts that the patient is on active therapy or is receiving palliative treatment.</td>
<td>Ensures all cancer patients within the health system are flagged for ED clinicians.</td>
</tr>
<tr>
<td>Clinician-to-Clinician Communication</td>
<td>Protocol requires that cancer center clinician calls ED nurse or physician manager to alert them of a patient visit and share any additional relevant clinical information.</td>
<td>Live handoff ensures relevant clinical, psychosocial information can be relayed.</td>
</tr>
<tr>
<td>Patient Information Card</td>
<td>Patient presents record or hospital card that identifies them as a cancer patient and provides relevant clinical detail.</td>
<td>Low-cost, low-resource alert system.</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
Engaging ED Physicians to Improve Triage

Beyond just alerts, ED clinicians often are not well trained to care for cancer patients. ED clinicians are busy, and it’s often hard to get their time or attention. One organization, Cork Hospital and Health System, a pseudonym, got the attention of ED clinicians by highlighting the problems cancer patients faced in their ED. Cancer program leaders did this by reviewing patient charts and measuring the door-to-antibiotic administration time for neutropenic patients. The cancer program leaders found that many of their patients were waiting, on average, three hours to receive medication. They used this data, and a few worst-case scenarios, to engage the ED. The initial chart review then served as the starting point for further collaboration and education.

Worst-Case Scenarios Demonstrate Need for Improvement

Chart Audits Process Reveals Delays in Care at Cork Hospital and Health System\(^1\)

1. Chart Audits
   - Cancer service line administrator reviews patient charts
   - Identifies neutropenic patients visiting ED

2. Time to Antibiotic Administration
   - Through retrospective chart reviews, calculated time from ED visit to antibiotic administration
   - Average wait time was three hours

3. ED Education
   - Chart reviews serve as first step for physician engagement
   - Cancer center medical director provides education on caring for neutropenic patients

Case in Brief: Cork Hospital and Health System

- Five-hospital health system based in the East
- Oncology medical director reviewed charts of neutropenic patients visiting the ED
- Chart audits reveal significant time lags from time to presentation in the ED to time to antibiotic administration
- Oncology medical director uses data to engage ED clinicians and improve care for cancer patients in the ED

\(^1\) Pseudonym.

Source: Oncology Roundtable interviews and analysis.
Beyond just highlighting the need for targeted care, another option is to provide more general education on managing cancer patients.

Regions Hospital in Minnesota embedded a cancer-specific training module in their ED residents’ training curriculum. The session is taught two to four times a year by the oncology medical director and other members of the medical staff. The training covers common chemotherapy-related symptoms such as neutropenia. In addition to the direct educational benefit of these sessions, they have also encouraged further informal collaboration between the cancer program and the ED.

Cancer Care Education Embedded into ED Resident Training

Regions Hospital Oncology-Directed ED Education

Cancer care education session embedded into ED resident training curriculum

Education sessions taught two to four times a year by oncology medical director, other medical oncologists

Education sessions encourage informal collaboration between ED and cancer center

Sample Curriculum Topics

1. Febrile neutropenia
2. Thrombotic thrombocytopenic purpura
3. Hypocalcemia
4. Overview of common chemotherapy-related symptoms and side effects

Case in Brief: Regions Hospital

- 450-bed hospital in St. Paul, Minnesota; part of the five-hospital HealthPartners Family of Care
- Cancer center developed ED resident training curriculum to educate ED clinicians about cancer patient management
- Training provided two to four times per year
- Cancer care protocols developed by oncologists included in ED EMR system
- Education sessions have encouraged close informal relationships between the ED and cancer center

Source: Regions Hospital, St. Paul, MN; Oncology Roundtable interviews and analysis.
Keeping Cancer Patient Needs Top-of-Mind

Recognizing that many cancer patients were seeking care in the ED, the cancer center medical director at Vidalia Medical Center, a pseudonym, sought to meet more regularly with ED clinicians. The oncologists were then invited to participate in the ED’s monthly meetings, providing a short presentation on cancer care and cancer program developments.

Though this practice is a relatively simple idea, the ongoing collaboration ensures that cancer patient needs are top of mind for ED clinicians and that the ED is continually updated.

Further, embedding the cancer center agenda into the ED’s existing meetings shows the cancer center is committed to improving transitions and is willing to support the ED.

Case in Brief: Vidalia Medical Center

- 200-bed hospital located in the West
- Twice a year, oncologists attend ED clinicians’ standing monthly meeting
- Oncologists typically present on a topic (usually a light, short presentation) and ED physicians have the opportunity to ask questions at the end
- In their last meeting with the ED physicians the oncologists presented on neuro-oncology including:
  - How to triage, treat patients with neurological cancers
  - What types of patients/cases to keep within the system and what cases to refer out to the AMC

ED Education at Vidalia Medical Center

1. Cancer center medical director meets with ED physician leader
   - Discuss opportunities for collaboration

2. Oncologists invited to participate in 2 of the 12 monthly ED meetings
   - Provide short presentation on cancer care, offer opportunity for ED physicians to ask questions

3. Typical agenda items include:
   - Updates on new policies
   - Communication between the ED and cancer center
   - Treatment guidelines for neuro-oncology patients

Source: Oncology Roundtable interviews and analysis.

1) Pseudonym.
Inevitably the ED and the cancer center have different priorities and processes that contribute to gaps in care coordination.

In fact, a recent study found that the drastically different workflows of ED physicians and primary care physicians were a barrier to coordination. There may also be similar barriers between the ED and cancer center.

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Specific Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limitations of telephone</td>
<td>Time consuming, requires providers to participate at same time, causing interruptions and disrupting workflows</td>
</tr>
<tr>
<td>Limitations of fax, email, and text messages</td>
<td>Little opportunity for back-and-forth communication; may be difficult to tell if messages are received</td>
</tr>
<tr>
<td>Limitations of electronic medical records</td>
<td>Information may not be organized for easy access or synthesis from multiple sources and medical records may be incomplete</td>
</tr>
<tr>
<td>Lack of time and reimbursement</td>
<td>Communication and coordination take time away from competing priorities, such as maintaining financial viability of practices or managing high volumes of patients</td>
</tr>
<tr>
<td>Limited role of cross-covering providers</td>
<td>Less personal familiarity with patients and with patients’ primary physician practice</td>
</tr>
<tr>
<td>Changing interpersonal relationships</td>
<td>Providers have fewer opportunities for communication and feedback on care coordination, they may be less aware of services their counterparts can offer patients</td>
</tr>
<tr>
<td>Risk and liability concerns</td>
<td>Each provider has different relationships with patients and different assumptions regarding risk and liability concerns</td>
</tr>
</tbody>
</table>

Study in Brief: Coordination Between Emergency and Primary Care Physicians

- Center for Studying Health System Change researchers conducted 42 telephone interviews between April and October 2010 with 21 pairs of emergency department and primary care physicians in 12 communities across the United States.
- Emergency department and primary care physicians were case-matched to hospitals so the perspective of both specialties working with the same hospital could be represented.
Empowering the ED to Manage Cancer Patients

The final component of ensuring smooth transitions to the ED is aligning workflows and developing shared protocols between the cancer center and the ED. This is one of the functions of Lehigh Valley Health Network’s Oncology Quality Circle Committee.

After the committee noticed inconsistencies in antibiotic administration for neutropenic patients, they invited representatives from the ED to join the group to develop protocols for managing these patients.

The advantage of this practice is that it accounts for the ED’s unpredictable resources. For example, the ED cannot control whether inpatient beds will be available when patients need to be admitted. The resulting triage guidelines support the management of patients in a variety of resource scenarios.

These triage guidelines are available on the health system’s shared network and have significantly improved time to antibiotic administration.

Case in Brief: Lehigh Valley Health Network

- Four-hospital health system based in Allentown, Pennsylvania; system also includes community health centers, a health plan, and primary care and specialty physicians
- Inconsistent antibiotic administration for patients with neutropenic fever prompted the quality circle committee to invite the ED to collaboratively develop tiered triage protocols and order sets for delivering antibiotics to patients with neutropenia
- Triage protocols and order sets available on computer desktops in the ED

1) Inpatient.

Source: Lehigh Valley Health Network, Allentown, PA; Oncology Roundtable interviews and analysis.
The final case study in this section comes from Holy Cross Health in Silver Spring, Maryland. Leaders there sought to improve care transitions to the ED for all cancer patients.

The initiative began as a way for the cancer center to engage independent medical oncology groups, but it soon expanded to a service-line-wide initiative. ED physicians, medical oncologists, hospitalists, and inpatient nursing staff all contributed to developing the protocols. Because each constituency had its own set of goals and priorities, it was vital to engage them all.

Cross-Setting Committee Helps Align Priorities

Providers, Priorities Combined to Create ED Transitions Protocols at Holy Cross Health

<table>
<thead>
<tr>
<th>ED Physicians</th>
<th>Independent Medical Oncologists</th>
<th>Hospitalists</th>
<th>Inpatient Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To understand how and where to triage cancer patients</td>
<td>• To ensure high-quality care for cancer patients visiting the ED</td>
<td>• To ensure they are receiving relevant patient clinical information during admission</td>
<td>• To expedite cancer patient admission process</td>
</tr>
<tr>
<td></td>
<td>• To be notified when cancer patients visited the ED or were admitted</td>
<td></td>
<td>• To optimize the use of inpatient beds</td>
</tr>
</tbody>
</table>

Case in Brief: Holy Cross Health

• 400-bed hospital based in Silver Spring, Maryland; part of 59-hospital Trinity Health System
• To ensure coordinated care for cancer patients visiting the emergency department, cancer service line leader convened group of physicians including ED physicians, hospitalists, and independent medical oncologists
• Group developed set of standardized oncology patient ED and inpatient admission protocols through mapping of patient pathway
• Protocols available through shared drive and are used to standardize clinician-to-clinician communication during patient transitions between oncologist office, emergency department, and inpatient unit

Source: Holy Cross Health, Silver Spring, MD; Oncology Roundtable interviews and analysis.
Collective Process Ensures Buy-In

The protocols themselves went through multiple iterations. First, two medical oncologists from the independent group drafted the protocols. Next, the ED and inpatient units revised them to ensure consistency.

Then, inpatient nursing reviewed the draft to ensure that the guidelines addressed inpatient resource utilization. Finally, the revised document was distributed to staff in the ED, hospital, and oncologist offices.

The final document includes a fully mapped patient pathway from initial ED referral to an inpatient admission. It also outlines communication expectations for all parties involved and clinical criteria for direct admissions.

Holy Cross Health’s patient pathway and protocols are available in the online appendix.
Key Takeaways

Ensuring Smooth ED Transitions

Although the ED is not the best place for cancer patients, they often seek care there. This situation means that closer alignment between ED clinicians and the cancer center is imperative. Equipping the ED to better manage the needs of our cancer patients ensures better quality of care and responsible use of resources.

1. **Proactively alert the ED of cancer patient visit**
   Alerting ED clinicians about a cancer patient visit can allow time for ED clinicians to treat or triage patients appropriately.

2. **Provide oncology-specific training to the ED**
   Supporting the ED through training and education empowers the ED to triage patients to the appropriate care setting and meet cancer patient needs.

3. **Collaborate to develop ED patient protocols**
   Care coordination issues often stem from varied priorities and workflows across settings. Creating shared protocols ensures that care is coordinated and all parties are kept in the loop.

Source: Oncology Roundtable interviews and analysis.
Chapter 4

Improving Continuity of Inpatient and Outpatient Care

Practice #12: Systematic Admission Alert
Practice #13: Principled Admission Process
Practice #14: Oncology Rounds Staffing Models
Practice #15: Codified Post-discharge Follow-Up
Practice #16: Inter-site Relationship Building
Practice #17: Dedicated Transitional Care Team
Inpatient and Outpatient Care Siloed

Given the number of cancer patients who receive inpatient care in the course of their treatments, coordinating with inpatient units is another priority for cancer program leaders.

An Oncology Roundtable survey found significant challenges with this coordination: 51% of respondents experience problems with transitions between outpatient and inpatient care “sometimes” or “often.” Qualitative data shared by members during the research process also highlighted coordination difficulties.

For instance, one cancer center director invited her inpatient counterpart to participate in conversations with Oncology Roundtable researchers. Twenty minutes into dissecting the challenges of transitioning cancer patients between the inpatient and outpatient setting, the inpatient director broke in and said, “I didn’t even know there were any challenges!” Unfortunately, this comment was not unique.

The good news is that both sides are motivated to improve transitions.

---

Extent of Problem Not Always Understood

Percentage of Members Indicating Inpatient Transitions Challenges

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often, Sometimes</td>
<td>51%</td>
</tr>
<tr>
<td>Seldom, Never</td>
<td>49%</td>
</tr>
</tbody>
</table>

Lack of Communication Common

“We’ve been talking about challenges coordinating between the inpatient and outpatient units for the past 20 minutes, and I have to say, I didn’t even know there were any challenges!”

Director, Inpatient Unit
Hospital in the North

Struggling with the Basics

“The inpatient unit used to call the primary oncologist to notify them of patient discharges and discuss follow-up care. They stopped due to some changes to their discharge protocols. It’s been a struggle.”

Oncology Service Line Director
Cancer Program in the East

Source: 2013 Oncology Roundtable Seamless Coordination Across the Continuum Quick Poll, Oncology Roundtable interviews and analysis.
Taking a Closer Look at Transition Challenges

Inpatient units and cancer centers both experience problems when transitions are poorly executed.

Without advance communication from the cancer center, inpatient units are left unprepared for admissions or are unable to access patients’ care plans. Without a proactive inpatient approach, outpatient cancer centers may struggle to access inpatient treatment records and are often unaware when patients are unexpectedly admitted. Both sites could use resources more effectively if coordination was better.

This chapter presents six strategies to smooth inpatient-outpatient transitions.

Poor Coordination Has Multiple Negative Impacts

Challenges Related to Poorly Executed Transitions

<table>
<thead>
<tr>
<th>Inpatient Unit</th>
<th>Cancer Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unprepared for inpatient admissions</td>
<td>• Unaware of unplanned inpatient admissions</td>
</tr>
<tr>
<td>• Unfamiliar with patient, caregivers, so discharge not tailored</td>
<td>• Unclear whether care plan should be updated</td>
</tr>
<tr>
<td>• Unable to access outpatient treatment information</td>
<td>• Unable to access inpatient treatment information</td>
</tr>
<tr>
<td>• Ad hoc communication requires significant clinician, staff time</td>
<td></td>
</tr>
<tr>
<td>• Redundant tests, procedures, and tasks likely completed</td>
<td></td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
Identifying a Path Forward

The first two practices in this chapter illustrate methods to learn of unexpected admissions and to effectively communicate about planned admissions. Practices 14 and 15 describe approaches for supporting patients during the inpatient stay and the post-discharge period.

Practice 16 moves beyond a specific focus on the patient flow to address the larger issue of cross-site understanding. Finally, the last practice examines a model in which staff are dedicated specifically to inpatient-outpatient transitions.

Practices for Improving Inpatient Transitions

Practice #12: Systematic Admission Alert
Practice #13: Principled Admission Process
Practice #14: Oncology Rounds Staffing Models
Practice #15: Codified Post-discharge Follow-Up
Practice #16: Inter-site Relationship Building
Practice #17: Dedicated Transitional Care Team

Level of Impact on Transitions

Resource Intensity, Difficulty

Source: Oncology Roundtable interviews and analysis.
Unexpected Admissions a Common Challenge…

Unexpected admissions are problematic for a number of reasons. First, care provided during these admissions is not typically coordinated with outpatient care, often resulting in unnecessary tests and treatments as well as patient confusion. Second, without coordination during the inpatient stay, outpatient providers are often left playing catch-up after discharge. Third, lack of proactive communication may lead to missed outpatient appointments, which negatively impact cancer center efficiencies.

For instance, while not exclusively related to inpatient stays, Akron General estimated that its 15% to 20% cancer center no-show rate translated to $18,000 per month in lost revenue.

Fortunately, a variety of methods can help the cancer center to stay apprised of inpatient admissions.

…With Potentially Significant Financial Impact

Impact of Unexpected Admissions

- Patients concerned about care continuity
- Little coordination of inpatient and outpatient care
- Missed outpatient appointments cause cancer program inefficiencies

$18,000

Monthly lost revenue for Akron General’s cancer center due to a 15%-20% no-show rate

Source: Magaw, T. “Providers AIm to Cut Missed Appointments.” Modern Healthcare, November 12, 2012; Oncology Roundtable interviews and analysis.
Active Inpatient Tracking Serves to Smooth Cancer Center Operations

Inpatient Records Review at MedStar

General and tumor-site-specific RN navigators lead care coordination

Nurse navigators review hospital’s admission, discharge, and transfer records daily

Infusion center staff and primary oncologists notified, appointments cancelled as needed

Screens Used to Identify Cancer Patients

- Name recognition through personal relationship with navigator
- Oncologist as admitting physician
- Assignment of patient to an oncology bed

Case in Brief: MedStar Health

- Ten-hospital health system, based in the Baltimore-Washington, DC region
- To consistently identify unexpectedly admitted medical oncology patients, MedStar tasked its nurse navigators with reviewing inpatient admission records
- Navigators notify the infusion center and primary oncologists of a patient’s admission; infusion center cancels unnecessary appointments and physicians have the opportunity to use cancelled appointment time more efficiently

MedStar Health in the Baltimore-Washington region conducts manual reviews of inpatient records. RN\(^1\) navigators examine admission, discharge, and transfer updates from MedStar’s four area hospitals daily.

The navigators identify cancer patients through name recognition due to personal relationships, an oncologist admitting physician, or assignment of patients to an oncology bed. When the navigators pinpoint an unexpected admission, they notify the primary oncologist as well as staff at any sites where the patient has upcoming appointments.

These record reviews only take 15 to 30 minutes each day per navigator, and they reap multiple benefits, including increased infusion center efficiency and improved oncologist workflow.

In addition to MedStar’s manual approach, there are also automated methods to identify unexpected cancer patient admissions.

\(^{1}\) Registered nurse.
Method #2: Automated Admission Alert

With the help of its IT department, Lehigh Valley added two algorithms to its EMR to flag admitted cancer patients. In radiation oncology, a report is automatically created and printed when a patient in active treatment is admitted or discharged. Clerical staff pick up the print outs and notify clinicians and treatment staff.

In medical oncology, infusion appointments are pre-registered four days in advance. When a patient is admitted during this window, an alert is automatically sent to the infusion center manager.

These alerts enable Lehigh Valley to proactively coordinate its patients’ care, resulting in benefits including decreased infusion center no-show rates and recaptured capacity.

Case in Brief: Lehigh Valley Health Network

- Four-hospital health system based in Allentown, Pennsylvania; system also includes community health centers, a health plan, and primary care and specialty physicians
- Cancer program leaders worked with the IT department to create EMR rules to enhance inpatient and outpatient communication for medical and radiation oncology patients
- Alert enabled the infusion center to shift from reactive to proactive care coordination, decreased the infusion appointment no-show rate, allowed recapture of capacity otherwise wasted due to no-shows, improved care coordination for patients, and enhanced relationships and communication with referring physician offices

Source: Lehigh Valley Health Network, Allentown, PA; Oncology Roundtable interviews and analysis.
Clinical Assistant Responsibilities Include Cancer Center Coordination

**Ebbitt Hospital’s Inpatient Care Coordinator Role**
- Serves on inpatient care team with physicians and advanced practice providers
- Updates the outpatient care team as needed

<table>
<thead>
<tr>
<th>Inpatient Admission</th>
<th>Inpatient Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notifies newly admitted patient’s physicians of admissions</td>
<td>Cancels outpatient appointments patient is likely to miss</td>
<td>Communicates with outpatient care team as needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Schedules recommended follow-up appointments</td>
</tr>
</tbody>
</table>

**Case in Brief: Ebbitt Hospital**
- 30-hospital health system based in the North
- Clinical assistant on oncology inpatient care team serves as liaison between the inpatient unit and cancer center by reviewing admission records, notifying primary oncologists of admissions, canceling existing outpatient appointments that will be missed, and scheduling recommended follow-up appointments upon discharge
- Clinical assistants are trained and able to access the outpatient scheduling system
- Positive results include higher patient and oncologist satisfaction as well as fewer missed outpatient appointments

1: Pseudonym.
Practice #13: Principled Admission Process

Take Responsibility for Information Transfer

Cancer program leaders can also take steps to improve care team coordination prior to planned admissions. For instance, the Woodberry Cancer Center, a pseudonym, has a standardized approach to scheduled admissions. Its method ensures that relevant patient information is shared with the inpatient unit in a timely manner.

When an oncologist schedules an admission, an outpatient nurse completes the admission checklist with information such as anticipated admission date, expected length of stay, and recommended drugs.

Cancer center staff also notify the inpatient unit manager of admissions and submit chemotherapy orders to the inpatient pharmacy two days before admission.

Finally, the cancer center care team ensures that inpatient staff and clinicians know they are available to answer questions during the inpatient stay. The cancer service line leader found that simply providing a direct phone number significantly improved coordination by making inpatient and outpatient providers feel like one team.

Standardized Admission Procedures Beneficial to Inpatient Units

Woodberry Cancer Center’s Admission Process

<table>
<thead>
<tr>
<th>Admission Checklist</th>
<th>Admission Notification</th>
<th>Order Submission</th>
<th>Cancer Center Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Completed by an outpatient nurse when the oncologist requests scheduled admission</td>
<td>• Cancer center staff notifies inpatient unit manager of impending admission two days in advance</td>
<td>• Chemo orders are sent to inpatient pharmacy two days before admission</td>
<td>• Cancer program’s internal number shared with inpatient unit</td>
</tr>
<tr>
<td>• Includes anticipated admission date and LOS, primary physician and office contact person, drug and dosage</td>
<td>• A verbal handoff is completed</td>
<td>• Inpatient pharmacists reach out with any questions or concerns</td>
<td>• Inpatient nurses reach out with any questions or concerns</td>
</tr>
</tbody>
</table>

A copy of the planned admission checklist is available online at advisory.com.

Case in Brief: Woodberry Cancer Center

- Part of a multi-hospital health system based in the Midwest
- Recognizing the value of having clear procedures for planned admissions, cancer center developed a standardized approach with defined communication responsibilities
- Standardized process has resulted in faster inpatient unit and pharmacy receipt of chemo orders and avoidance of last-minute scrambling to confirm orders

Source: Oncology Roundtable interviews and analysis.

1) Pseudonym.
2) Length of stay.

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Enlist Cross-Site Expertise to Improve Transitions

Cancer centers can also work collaboratively with inpatient units to improve admissions. Regions Hospital created a cross-site team including oncologists, nurses, and pharmacists to examine its admission process. This team mapped the process, identified bed availability, and delayed chemotherapy preparation as key challenges in admissions.

After improving communication with inpatient nurses and developing more efficient workflows, average time from outpatient clinic visit to inpatient treatment initiation decreased dramatically.

The inpatient-outpatient team is now examining other areas of transition opportunity, including streamlining administrative processes.

Inpatient and Outpatient Staff Collaboratively Map Process

Overview of Cross-Site Collaboration at Regions Hospital

- Oncologists
- Inpatient and outpatient nurse managers
- Oncology clinical pharmacist, inpatient and outpatient pharmacists
- Other inpatient and outpatient care team members (as needed for projects underway)

- Mapped patient flow from arrival in outpatient clinic visit to inpatient treatment initiation
- Key challenges identified: bed availability, delayed treatment preparation

- Developed chemo initiation workflow for scheduled admissions
- Average time from outpatient clinic visit to scheduled inpatient treatment initiation decreased from six to three hours after first meeting

- Exploring feasible approaches for submitting chemo orders earlier
- Exploring streamlined administrative processes for patients and nurses

Case in Brief: Regions Hospital

- 450-bed hospital in St. Paul, Minnesota; part of the five-hospital HealthPartners Family of Care
- Developed a team of inpatient and outpatient staff to examine and improve transitions and overall quality and experience
- Team identified inefficient transition and scheduled admission workflows as key challenges; improved communication with inpatient nurses and efficient workflow development around chemo initiation procedures immediately decreased average time from admission to treatment initiation from six hours to three hours, with further improvement expected

Source: Regions Hospital, St. Paul, MN; Oncology Roundtable interviews and analysis.
Coordinating care during the inpatient stay is just as important as smoothing the admission process. One way to do so is to have cancer clinicians involved in inpatient care.

There are multiple benefits of having cancer center clinicians or staff members conduct inpatient rounds. Care teams on both the inpatient and outpatient sides report increased satisfaction when there is a point person coordinating across sites. If a clinician is rounding, oncologists can devote more time to their outpatient responsibilities.

Finally, as the quote here indicates, regular contact with the outpatient care team is reassuring to patients.

---

**Decreased Oncologist Burden Particularly Valuable**

**Care Team Satisfaction**

Inpatient and outpatient clinicians value having a point person for communicating care plans and related information across sites.

**Improved Oncologist Efficiency**

Dedicated individual for cross-site coordination creates opportunities for improved oncologist workflow.

**Coordinated Care, Discharges**

Outpatient providers are familiar with broader patient and treatment context; can guide discharge planning.

**Patient Satisfaction**

Patients often overwhelmed during inpatient stay; cancer center clinician rounds decrease anxiety.

"Some of these patients have never been admitted before. They don’t know what to expect and are overwhelmed. They are so relieved to see a familiar face walk through the door."

---

1) Advanced practice provider.

Source: Oncology Roundtable interviews and analysis.

"VP of Oncology Service Line, Cancer Program in the East"
Rounding on Patients in the Hospital

A variety of different staff members or clinicians can take on inpatient rounds.

Navigator rounds focus on patient satisfaction, discharge appropriateness, and cross-site information transfer. Tasking a navigator with rounds is a natural fit because they often have established relationships with patients.

Assigning advanced practice providers to inpatient rounds leverages their clinical expertise in oncology. They can guide care and update the patient care plan.

Finally, a dedicated oncology hospitalist relieves the most burden from fellow oncologists, increasing their satisfaction and workflows.

Clinician Expertise Brings Costs and Benefits

Degree of Resource Intensity

Degree of Clinical Influence

Navigator Rounds

Focus: Patient Satisfaction
- Decrease patient anxiety
- Ensures discharge tailored to patient, caregiver needs
- Improve information transfer

APP1 Rounds

Focus: Care Coordination
- Provide oncology-specific clinical advice
- Revise patient care plans
- Consult on ED cancer patients

Oncology Hospitalist Rounds

Focus: Clinical Expertise
- Manage inpatient care
- Liaise with primary oncologist

Source: Oncology Roundtable interviews and analysis.
Which Approach Should We Take?

Each of these roles brings different levels of clinical influence and resource intensity to the task of inpatient rounding, so each rounding model has benefits and drawbacks.

<table>
<thead>
<tr>
<th>Pros and Cons of Rounds Staffing Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
</tr>
<tr>
<td>Navigator</td>
</tr>
<tr>
<td>Advanced Practice Provider</td>
</tr>
<tr>
<td>Oncology Hospitalist</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
Cancer Patients Vulnerable Post-discharge

At the end of the inpatient stay there is another important transition to help cancer patients navigate: the movement from inpatient care back to outpatient care. The discharge process is particularly important as the period immediately after discharge is a vulnerable time for patients.

A recent study in *JAMA* indicated that discharge from an oncology service was itself a risk factor for readmission.

A common difficulty during this post-discharge period is a lack of direct communication between the inpatient and outpatient settings, leading to challenges such as coordinating care plans.

**Pre-discharge Measures of 30-Day Avoidable Readmission Risk**

- Hemoglobin at discharge
- Discharge from an oncology service
- Sodium level at discharge
- Procedure during the index admission
- Index type of admission
- Number of admissions during the last 12 months
- Length of stay

**Common Transition Challenges**

- No direct communication about inpatient care
- No direct communication about recommended appointments or procedures
- Plan of care not communicated, updated
- Patients asked to serve as inpatient-outpatient link

The pages that follow describe two approaches to smoothing the discharge process.

Oncology Hematology Care (OHC), a private oncology practice in Cincinnati, developed a standardized post-discharge patient follow-up process. Its oncologists round at multiple hospitals in the area. When an OHC patient is discharged, oncologists notify a navigator. The navigator then calls the patient and documents the conversation with a “transition of care” template developed by OHC for their EMR. The patient is also scheduled for a primary oncologist appointment within seven days.

What is striking in this approach is that OHC has taken on increased responsibility for post-discharge care to avoid information falling through the cracks.

**Case in Brief: Oncology Hematology Care (OHC)**

- 50-physician oncology and hematology practice located in Cincinnati, Ohio
- OHC created an EMR template to guide and document standardized post-discharge follow-up conversations between nurse navigators and patients
- Use of the template and consistent scheduling of patients for follow-up appointments has allowed OHC to use the new transitional care CPT codes
- Billing under the new transitional care CPT codes has allowed OHC to offset costs associated with these conversations and related follow-up appointments

---

**Method #1: Standardized Follow-Up Conversations**

### Oncology Hematology Care (OHC)

**Discharge**

Oncologists manage inpatient care at several local hospitals; notify navigator of patient discharges

**Transition of Care**

Navigator calls patient within 48 hours and completes transition of care template in EMR

**Follow-Up**

Patient scheduled for follow-up appointment with primary oncologist within seven days

**Transition of Care**

- Date admitted, discharged
- Reason for hospitalization
- Medication reconciliation
- Pain assessment
- Symptom assessment
- New care team members
- Review of discharge instructions
- Follow-up appointments scheduled
- Tests, procedures performed or scheduled
- Referrals to community resources

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**EMR Template Guides, Documents Nurse Navigator Conversations**

- Use of the template and consistent scheduling of patients for follow-up appointments has allowed OHC to use the new transitional care CPT codes
- Billing under the new transitional care CPT codes has allowed OHC to offset costs associated with these conversations and related follow-up appointments

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New Transitional Care Management Codes

To offset costs related to these increased responsibilities, OHC uses the new transitional care management CPT codes. The details of these codes are outlined here.

In a nutshell, the two codes require communication with the patient within two days post-discharge and an in-person visit within seven or fourteen days, depending on the complexity of the patient’s case.

Reimbursement is approximately $60 more than for a traditional evaluation and management visit.

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**Transitional Care Management (TCM) Codes**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Requirements</th>
<th>2013 Reimbursement/Procedure</th>
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<tbody>
<tr>
<td>99495</td>
<td>Communication with the patient or caregiver within 2 days of discharge</td>
<td>$163.88</td>
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<tr>
<td></td>
<td>Medical decision making of moderate complexity</td>
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<tr>
<td></td>
<td>Face-to-face visit within 14 days of discharge</td>
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<tr>
<td>99496</td>
<td>Communication with the patient or caregiver within 2 days of discharge</td>
<td>$230.86</td>
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<td></td>
<td>Medical decision making of high complexity</td>
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</tr>
<tr>
<td></td>
<td>Face-to-face visit within 7 days of discharge</td>
<td></td>
</tr>
</tbody>
</table>

**Transitional Care Management CPT Codes**

- Providers billing under these codes must communicate with the patient or caregiver within two business days after discharge and meet with the patient within one or two weeks, depending on the complexity of the patient’s case.
- Providers should bill only once for TCM services—at the end of the 30-day TCM period; subsequent hospital admissions during that period will not result in a new 30-day period or allow billing for another TCM service.
- Physicians, other qualified health professionals, and clinic staff under the direction of the physician or other qualified health care professional can provide services under these new CPT codes.
- Qualifying transitional care management services include one face-to-face visit with the patient in combination with non-face-to-face services such as obtaining and reviewing discharge information, pending diagnostic tests and treatments; educating patient and/or caregiver to support self-management and independent living; and identifying available community and health resources.

Method #2: Expanded Hospitalist Role

Fox Chase Cancer Center takes a similarly rigorous approach to post-discharge care. About a year ago, Fox Chase clinicians noticed that a significant number of recently discharged patients were visiting its urgent care clinic. Program leaders decided that a new support resource was needed, and they created the Transitional Care Clinic.

The clinic is designed to support recently discharged patients and is staffed by hospitalists and outpatient nurses.

There are two distinct advantages to using hospitalists in this role. First, they’re familiar with the patient and the recent inpatient care. Second, as internal medicine physicians, they’re well equipped to manage patients with comorbid conditions.

The outpatient nurses are also an asset, since they smooth the hand off to the outpatient setting and educate the hospitalists about available support services.

Hospitalists and Outpatient Nurses Support New Transitional Care Clinic

Benefits of Hospitalist Leadership
- Hospitalists familiar with patients
- Patients comfortable with hospitalist
- Internal medicine expertise

Benefits Outpatient Nurse Role
- Smooth transition to outpatient setting
- Nurses familiar with outpatient services
- Educate hospitalists on outpatient services

Case in Brief: Fox Chase Cancer Center
- 100-bed cancer center located in Philadelphia, Pennsylvania; part of the eight-hospital Temple University Health System
- Created tailored, comprehensive approach to post-discharge care after noticing a significant number of patients visiting its urgent care clinic shortly after hospital discharge; patients with greatest care needs visit the newly formed Transitional Care Clinic
- High-risk patients automatically receive a follow-up appointment within 48 hours in the clinic; high-risk patients defined as those with comorbid conditions, multiple admissions, or in-hospital medication changes

Source: Fox Chase Cancer Center, Philadelphia, PA; Oncology Roundtable interviews and analysis.
While the Transitional Care Clinic’s staffing model is interesting, what is most compelling about the clinic is how it manages patients. Patients now are categorized during their inpatient stay as at either high or low risk for readmission.

Three factors qualify patients as high-risk: multiple admissions, multiple comorbidities, or medication changes during the inpatient stay. All these high-risk patients are scheduled for appointments in the clinic.

The appointment takes place within 48 hours of discharge. After its completion, patients and their care summaries are handed off to the primary care physician or oncologist.

Post-discharge Clinic Visit Facilitates Outpatient Handoff

High-Risk Patient Management at Fox Chase

1) Transitional Care Clinic.
Cancer Center Takes Point on Low-Risk Patients

On the other hand, low-risk patients are not automatically seen in the transitional care clinic. These patients receive a phone call within 48 hours of discharge. Like at OHC, nurses use an EMR template to guide these conversations. Patients are routed in one of three ways based on their response. Those with urgent issues are referred to the urgent care clinic. Those that are stable but express multiple questions or concerns are scheduled for a TCC visit. Those that are stable with no significant questions or concerns are passed on to their primary oncologist.

Of course, Fox Chase is in a unique position as a cancer hospital. However, the lesson here for all cancer programs is that a tailored approach ensures that all patients are supported after discharge, while reserving the most resource-intensive support for the highest-risk patients.

Post-discharge Phone Call Guides Next Steps

**Fox Chase’s Tailored Post-discharge Approach**

1. **Urgent Issues**
   - Immediate urgent care visit at cancer center or ED referral
2. **Stable, Multiple Challenges**
   - Transitional Care Clinic appointment
3. **Stable, Few Challenges**
   - Handoff to PCP or oncologist

**Selection of Questions Asked**

- How is your pain?
- How is your food and liquid intake?
- What other issues are you experiencing?
- Have you made your recommended appointments?
- Do you understand your medications?

**Case in Brief: Fox Chase Cancer Center**

- 100-bed cancer center located in Philadelphia, Pennsylvania; part of the eight-hospital Temple University Health System
- Created tailored, comprehensive approach to post-discharge care after noticing a significant number of patients visiting its urgent care clinic shortly after hospital discharge
- Nurses call low-risk patients within 48 hours; give tailored short-term recommendations based on patient status
- Regardless of status, all patients admitted to a medical service scheduled for an on-site visit within seven days of discharge

Source: Fox Chase Cancer Center, Philadelphia, PA; Oncology Roundtable interviews and analysis.
Cooperatively Managing Inpatient Care

Cancer program leaders can also seek to improve patient transitions by enhancing cross-site staff and clinician relationships.

Scottsdale Healthcare’s current system-wide goals are to decrease readmissions and unnecessary inpatient utilization. To achieve these goals, the inpatient department developed interdisciplinary teams to manage high-risk patients, including cancer patients.

Each week, cancer center advanced practice nurses go to the inpatient unit for high-risk patient huddles. Other participants include nurses, social workers, and chaplains.

The group discusses treatment goals, symptom management needs, and recommended post-discharge resources. These huddles ensure that high-risk patients are supported through their inpatient stay and the discharge process.

All relevant information is documented in the EMR and communicated with attending physicians.

Cross-Site Huddles Support High-Risk Patients

Management of High-Risk Inpatients at Scottsdale Healthcare

Care Team Members
- Participants: nursing, social work, chaplains, cancer center APRNs
- Cancer center staff included because cancer patients frequently readmitted

Case Review Process
- Patient cases discussed weekly
- Topics discussed: treatment goals, symptom management needs, required post-discharge resources

Post-review Follow-Up
- Discussions documented in EMR
- Recommendations shared with attending physicians

Case in Brief: Scottsdale Healthcare
- Three-hospital health system based in Scottsdale, Arizona
- Hospital inpatient departments developed teams to manage high-risk patients in response to health system goals to decrease readmissions and unnecessary inpatient utilization
- Cancer center staff members joined teams because cancer patients were often readmitted
- Results include reduced length of stay, shorter ICU bed stays, increased patient and family satisfaction, and timely referrals to hospice, if appropriate

Source: Scottsdale Healthcare, Scottsdale, AZ; Oncology Roundtable interviews and analysis.

1) Advanced practice registered nurses.
Other organizations take a broader approach to cross-site relationship-building. Mission Hope Cancer Center staff and clinicians gather weekly to review all patients in active treatment. Outpatient staff invite their inpatient counterparts to these meetings periodically for two purposes. First, the meeting provides an avenue for communication about upcoming scheduled admissions. Second, the meeting is a venue for analysis of admission and discharge processes. Mission Hope finds that an in-person gathering allows for evaluation of care coordination challenges without the miscommunications and blame that can arise via email.

### Collaborative Meetings Improve Patient Transitions

**Periodic Cross-Site Staff Meetings at Mission Hope Cancer Center**

**Weekly Outpatient Staff Meetings**

**Targeted Invitation of Inpatient Staff**

<table>
<thead>
<tr>
<th><strong>Parties Involved</strong></th>
<th><strong>Goals</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>1 Patient case reviews</td>
</tr>
<tr>
<td>Infusion nurses</td>
<td>Briefly discuss all patients in active treatment</td>
</tr>
<tr>
<td>RN navigators</td>
<td>1 Prospective care planning</td>
</tr>
<tr>
<td>Outpatient palliative care</td>
<td>Discuss upcoming planned admissions</td>
</tr>
<tr>
<td>Research nurses</td>
<td>2 Retrospective transition evaluation</td>
</tr>
<tr>
<td>Hospice</td>
<td>Analyze transition problems to improve processes</td>
</tr>
<tr>
<td>Social workers</td>
<td></td>
</tr>
<tr>
<td>Dietitians</td>
<td></td>
</tr>
<tr>
<td>Inpatient nurses</td>
<td></td>
</tr>
<tr>
<td>Inpatient palliative care</td>
<td></td>
</tr>
</tbody>
</table>

**Case in Brief: Mission Hope Cancer Center**

- Cancer center located in Santa Maria, California; part of the 42-hospital Dignity Health system
- Outpatient cancer center staff and clinicians meet weekly to briefly discuss all patients in active treatment; inpatient staff and clinicians periodically attend these meetings to discuss upcoming patient admissions and any previous admission challenges
- In-person meetings avoid potential misunderstandings of admission challenges and increase collaborative problem solving

Source: Mission Hope Cancer Center, Santa Maria, CA; Oncology Roundtable interviews and analysis.
Recruiting Inpatient Allies

Another approach to cultivating cross-site understanding is familiarizing inpatient staff with outpatient services.

Piedmont Health’s cancer center and inpatient nursing leadership collaborated to create a retreat for inpatient staff. While the retreat was not exclusively cancer-focused, the cancer center hosted, and agenda items included an introduction to the cancer program. The retreat also included some hands-on activities—participants took a meditation relaxation course offered to patients.

Sessions were held on nurses’ days off so no staff back-filling was necessary. The inpatient unit covered overtime pay, and the cancer center hosted and provided breakfast and lunch.

Inpatient staff members left the retreat with a first hand understanding of cancer center services, and they can now make recommendations based on first hand experience to patients. Other results of the retreat include increased inpatient staff satisfaction, more consistent use of cancer center educational materials, and more nurse requests for oncology certification.

Nurse Retreat Supports Cross-Continuum Perspective

Inpatient Nursing Retreat at Piedmont Health

Select Agenda Items

- Introduction to the Piedmont Cancer Program
- Wellness Center and Cancer Program Tour
- Patient Navigators: Effective Utilization
- Radiation Therapy Tour

“After the orientation, the inpatient nurses are a salesforce for patient engagement. They don’t just focus on inpatient care and discharge; they educate patients about cancer center services.”

John Goodman
Executive Director of Oncology, Piedmont Healthcare

Case in Brief: Piedmont Healthcare

- Five-hospital health system based in Atlanta, Georgia
- Cancer center partnered with the inpatient nursing department to create an inpatient nurse and staff retreat in the cancer center
- Results include increased utilization of cancer education packets, increased nurse requests for oncology certification, patient requests to be placed on the inpatient unit that has gone through the retreat, and enhanced personalization of cancer center service recommendations

Source: Piedmont Healthcare, Atlanta, GA. Oncology Roundtable interviews and analysis.
Cross-training can go beyond a retreat to a more comprehensive model of flexible staffing. Providence Health and Services, in Renton, Washington, has both stable and flex staff. Stable staff provide consistency and serve as a resource for flex staff when they have questions or concerns.

Oncology nurses flex between an inpatient unit and outpatient infusion center depending on patient volumes. Nurses in both settings are oncology trained and utilize the same processes for procedures and chemotherapy administration.

Radiation therapists, dosimetrists, and physicists also rotate between the three Portland-area locations as needed.

In addition to improving resource utilization, flex staff members enhance cross-site continuity of care by serving as common threads between settings.

Source: Providence Health and Services, Renton, WA; Oncology Roundtable interviews and analysis.

Case in Brief: Providence Health and Services

- 32-hospital health system based in Renton, Washington
- In the Portland area cancer service line, flexible staffing allows for more efficient use of resources, improves continuity of care for patients transitioning between inpatient and outpatient care, and promotes cross-setting communication
Providing Comprehensive Transitions Support

The final tactic in this section involves dedicating resources specifically to transitions. This resource allocation is not a small commitment, however a variety of factors might prompt it.

From 2010 through 2011, the Simmons Cancer Center at UT Southwestern University Hospital experienced a decline in patient satisfaction scores, multiple discharge-related service failures, and physician concerns about care continuity.

In light of its goal to provide patient-centered care, including proactive discharge planning, cancer program leaders undertook a gap analysis to understand what challenges patients were experiencing in the inpatient-to-outpatient transition.

Drivers to Create a Transitions Team at Simmons Cancer Center

- Decline in patient satisfaction, recurring discharge-related service failures
- Concerns raised by physicians
- Success of other transitional care initiatives
- National movement toward accountable care
- Goal to create a patient-centered experience
- Reactive, not proactive, discharge planning

Case in Brief: UT Southwestern University Hospitals

- Two-hospital academic medical center based in Dallas, Texas; includes the NCI-designated Simmons Cancer Center
- Augmented inpatient oncology service by expanding the medical team to include an oncology transitional care coordinator (LCSW\(^1\)) and mid-level provider (PA); meet daily to identify issues that may prevent or interrupt care and match treatment decisions to patient and family needs and goals

1) Licensed clinical social worker.

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Understanding the Problem

This gap analysis process is described in detail in the first section of this research, but to summarize here, an oncology social worker conducted interviews with patients as well as outpatient and inpatient staff. After identifying key challenges in each group, the social worker and cancer program leaders successfully made the case to health system executives that a transitional care team was needed.

This team is tasked with improving transitions in order to reduce readmissions and expenditures, while improving quality, safety, and patient satisfaction.

Gap Analysis Reveals Areas of Opportunity

Inpatient-Outpatient Gap Analysis at UT Southwestern

**Staff Interviews**
Interviews with nurses, social workers, and case management provided complementary data on the inpatient care experience.

**Final Report**
Final report summarizing findings made the case for the creation of a transitions team.

**Patient Interviews**
Oncology social worker interviewed 60 cancer inpatients about their care experience, the discharge process.

**Data Analysis**
Issues identified included patient difficulty understanding their diagnosis and prognosis.

**Transitional Care Team**
Team goal defined and transitional care team created.

**Team Goals**
Improve transitions to reduce readmissions and expenditures while improving quality, safety, and patient satisfaction.

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
The transitional care team consists of a physician assistant (PA) and a transitional care coordinator. The PA acts as a liaison between sites of care, including integrating care plans and scheduling recommended appointments. The PA also helps the ED manage cancer patients.

The transitional care coordinator, a licensed clinical social worker, focuses more on patient-specific issues. For instance, she conducts biopsychosocial assessments, engages patients and caregivers in care planning, and calls patients within 48 hours after discharge.

Shared transition team responsibilities include daily meetings with inpatient physicians and helping to match treatment decisions to patient and family goals.
Results and Implementation Tips

Although in place for only a year, this team has achieved multiple successes.

UT Southwestern’s patient satisfaction scores have increased, physician complaints have dropped, and information is transferred more smoothly across sites. In fact, the cancer program transitions team has been so successful that it hired a second transitional care coordinator. Other departments are adopting the model as well.

Included here are some implementation tips for creating a transition team.

Results Achieved by Care Transitions Team

- **Increased Patient Satisfaction**
  Press Ganey scores increased from an average of 84 to an average of 90

- **Increased Physician Satisfaction**
  Physicians no longer reporting concerns about care continuity

- **Increased Patient-Centeredness**
  Information travels more seamlessly across sites of care; transitions team consistently advocates for the patient and family voice

- **Spread of Transitions Team Model**
  Oncology service line has hired an additional transitional care coordinator; other departments planning to add transitions teams

Implementation Tips

- Invest in a robust gap analysis to thoroughly understand problem
- Utilize published results from transitional care teams to help make the case
- Leverage gap analysis into ongoing inpatient-outpatient interactions
- Invest time in educating inpatient and outpatient staff about roles and value of a cancer-specific transitions team
- Weigh the costs and benefits of staff roles; a LCSW can conduct true bio-psychosocial assessments

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Key Takeaways

Improving Continuity of Inpatient and Outpatient Care

Although cancer centers and inpatient units are separate sites of care, they should strive to operate in concert to create a seamless patient experience.

1. **Create a mechanism to track inpatient admissions**
   Implementing a manual or automatic process to alert the cancer center of unexpected admissions helps minimize missed appointments and improve care continuity.

2. **Develop processes to support the patient through the inpatient stay**
   There are three important phases of the inpatient transition: admission, inpatient stay, and discharge. Addressing each of these in turn can avoid communication breakdowns and resulting patient and provider dissatisfaction and readmissions.

3. **Build cross-site understanding**
   Well-developed relationships between staff and clinicians from different sites of care help minimize transition challenges by increasing understanding of each other’s needs and operations.

4. **Scale your efforts**
   Significant cross-site coordination challenges might warrant dedicated transitions resources.

Source: Oncology Roundtable interviews and analysis.
Developing Collaborative Hospice Relationships

Practice #18: Internal Stakeholder Priority Assessment
Practice #19: Hospice Relationship Building
Practice #20: Hospice Capability Inventory
Practice #21: Preferred Partner Contracts
A disproportionate amount of spending occurs in the final weeks of life, and much of this care can be avoided if patients are engaged in proactive conversations about their prognosis and goals of care.

Enrollment in hospice has a substantial impact on patient’s quality of life and costs at the end of life. The first graph presented here presents a recent study in *Health Affairs* that showed cost savings for Medicare patients over a variety of different hospice lengths of stay. In many cases, these cost savings increased with longer lengths of stay.

But costs aside, this is the right thing to do for our patients. Timely referral to hospice means better quality of life, longer survival, and more control for patients in their final weeks. However, we all know that despite the best intentions, this transition does not occur as smoothly as we’d like.

### Providing Significant Cost, Quality Benefits

#### Cost Savings Across Various Lengths of Stay

- **Incremental Savings in Medicare Expenditures, by Various Lengths of Hospice Enrollment Before Death**
  - **1-7 days**: $2,700
  - **8-14 days**: $5,000
  - **15-30 days**: $6,400
  - **53-105 days**: $2,500

- **Mean Survival for Lung Cancer Patients**
  - Days
  - Usual-Care Patients: 240
  - Hospice Patients: 279

- **Mean Survival for Pancreatic Cancer Patients**
  - Days
  - Usual-Care Patients: 189
  - Hospice Patients: 210

Transitions to hospice are difficult for nearly all stakeholders involved. Patients and families often do not have timely discussions about end-of-life planning and are usually unsure of what to expect during this transition.

This is also a difficult transition for oncologists. They worry that admitting their patients to hospice is tantamount to “giving up” on them.

And at the other end of the spectrum, hospices too experience difficulties, largely due to an inefficient and complicated referral process.

Patients, Providers All Experiencing Challenges

**Patients**
- Do not have timely end-of-life planning discussions
- Are unaware of end-of-life treatment options
- Do not know what to expect during transition to hospice

**Oncologists**
- Feel they will lose control of patient’s treatment
- Lack of guidelines for hospice referrals
- Driven by goal of patient cure
- Unaware of hospice services and capabilities

**Hospice**
- Do not receive timely patient referrals
- No insight into cancer center’s hospice referral procedures
- Receive incomplete patient information

Source: Oncology Roundtable interviews and analysis.
In fact, there are opportunities for errors at each stage of the hospice referral process.

We know that patients are rarely referred in a timely manner, and at times, even after referral, the chosen facility may fail to meet the patient’s needs.

During transitions themselves, there may be a lack of information exchanged between the cancer center and hospice, which can lead to further issues.

Finally, upon admission, hospices may be ill-equipped to deal with some cancer patient needs, medication reconciliation may be conducted improperly, or the care plan for the patient may be financially unsustainable for the hospice.

Myriad Opportunities for Errors Across Settings

- Hospice services underutilized
- Improper care setting chosen
- Hospice unable, unwilling to accept referral
- Care coordinators unaware of facility-specific hospice offerings

- Information exchange process lacks key patient information
- Hospice liaisons clinically ill-equipped to assess, transfer patient
- Hospice facility overwhelmed with transfer paperwork, key details overlooked

- Hospice clinically unprepared to handle patient acuity
- Patient care regimen financially unsustainable for hospice provider
- Medication review and management improperly performed

Source: Oncology Roundtable interviews and analysis.
Financial Constraints May Limit Service Offerings

Finances can be a significant barrier to ensuring smooth transitions to hospice. The reality is that hospices face tight budgets and may be limited in the services they can offer. On average, the hospice per diem reimbursement for Medicare is just $140.

It is no surprise that over half of the hospices participating in a recent survey reported that they would not accept a patient who could be fed only intravenously, or more significantly, they would not accept a patient who wanted palliative chemotherapy.

Ultimately the many barriers preventing a smooth and safe transition to hospice will require cancer care providers to think strategically about the partnerships they will choose to pursue. In addition, taking the time to address the finances early and proactively can help avoid many of the access and patient experience issues that may occur down the road.

The Elephant in the Room

“Finances are still the elephant in the room between hospices and hospitals. Hospices and hospitals should have more open dialogue about this issue.”

Hospice Medical Director
Hospice Program in the East

<table>
<thead>
<tr>
<th>$140</th>
<th>55%</th>
<th>61%</th>
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<tbody>
<tr>
<td>Average hospice per diem reimbursement</td>
<td>Hospices that would not accept a patient who could only be fed intravenously</td>
<td>Hospices that would not accept a patient who requested palliative chemotherapy</td>
</tr>
</tbody>
</table>

When selecting a hospice partner, the same priorities apply as with any other potential partnership or acquisition. Quality and safety, patient experience, and access are above all, the most important factors to consider.

Acknowledging that some cancer care providers have a choice of hospice providers and some may not, we’ve provided some key considerations depending on each organization’s unique market scenario.

Key Considerations for Potential Market Scenarios

**Single Hospice Partner**
- Establish mutually beneficial goals
- Determine communication guidelines

**Multiple Hospice Providers**
- Assess capabilities and service offerings
- Consolidate common communication protocols

**Hospice Within Health System**
- Align goals with system-wide initiatives
- Utilize system resources to enhance partnership

**Seeking New Partners**
- Assess new partnership opportunities
- Evaluate partners against internally vetted criteria

**Quality & Safety**

**Patient Experience**

**Access**

Source: Oncology Roundtable interviews and analysis.
Seeking Strategic Hospice Partnerships

When seeking to develop strategic hospice partnerships, members must first take stock of internal priorities. Determine what’s important to the cancer program and its patients.

Second, develop informal relationships with nearby hospice providers. This will serve as the foundation for future partnerships or alignment.

Next, not all providers are created equal, so evaluate their services and capabilities to ensure they are able to meet the needs of the cancer program’s patients.

And last, advance partnerships that are mutually beneficial. Cancer providers may want to consider developing formal agreements or preferred provider contracts to hardwire shared goals.

Multiple Steps to Developing Sustainable Hospice Partnerships

- **Take Stock of Internal Priorities**
- **Develop Relationships with Hospices**
- **Evaluate Hospice Services and Capabilities**
- **Advance Mutually Beneficial Hospice Partnerships**

Degree of Integration

Time

Source: Oncology Roundtable interviews and analysis.
Practice #18: Internal Stakeholder Priority Assessment

Internal Assessment Serves as Starting Point

As with all new ventures, cancer care providers should first think about what their needs and requirements are.

UT Southwestern used a relatively simple process for developing their criteria for partnership with hospice. First, they convened a group of stakeholders to develop the list of priorities.

Over the course of several meetings, the group developed a list of priorities for a potential partnership. The list included home visits by the hospice medical director, specialty nurse care, and requirements for communication and follow-up. This list then served as the basis for vetting potential partners.

This process is a simple, yet often overlooked, step. Take the time to seek input from stakeholders and develop a list of priorities. This will not only ease physicians’ concerns by involving them in the selection process but also ensure a solid starting point for future discussions and negotiations.

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Stakeholders Determine Priorities for Hospice Partnership

UT Southwestern Hospice Selection Process

<table>
<thead>
<tr>
<th>Convene Stakeholders</th>
<th>Determine Priorities</th>
<th>Evaluate Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workgroup Participants</strong></td>
<td><strong>Priorities for Partnership with Hospice</strong></td>
<td><strong>Final Steps</strong></td>
</tr>
<tr>
<td>AVP, cancer service line</td>
<td>Hospice medical director home visits</td>
<td>Transitional care coordinator met with several hospices in the area</td>
</tr>
<tr>
<td>Cancer center director</td>
<td>Specialty-trained nurse care</td>
<td>Select hospices were invited to meet cancer service line executive leaders</td>
</tr>
<tr>
<td>Director of supportive care services</td>
<td>Consistent communication and follow-up</td>
<td>Selected one hospice for partnership</td>
</tr>
<tr>
<td>Palliative care physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical oncologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitional care coordinator</td>
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Case in Brief: UT Southwestern University Hospitals

- Two-hospital academic medical center based in Dallas, Texas; includes the NCI-designated Simmons Cancer Center
- Developed step-by-step process for selecting a preferred hospice provider
- Process involved convening workgroup of cancer center leaders, including cancer center director, care transition coordinator, service line AVP, palliative care physicians, and medical oncologists
- Cancer center service line leaders and transitional care coordinator met with several local hospices to determine whether a potential hospice partner would be a good fit based on predetermined criteria

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Forging Better Hospice Relationships

After compiling internal priorities, the next step is to develop an initial working relationship.

To build better relationships with their hospice providers, MedStar Health and Middlesex Hospital invited representatives from their hospice program to attend existing cancer program meetings.

MedStar did so by inviting hospice nurses to their quarterly cancer committee meetings. These nurses were responsible for providing updates about the hospice program, reviewing the referral process, and answering any outlying questions.

Middlesex, on the other hand, invited their hospice and palliative care medical director to their cancer committee and tumor board meetings. As medical director, he is able to consult on certain patient cases as needed and address any oncologist concerns.

Hospice Liaisons Provide Updates on Services, Referral Procedures

Two Models for Hospice-Cancer Center Liaisons

Case in Brief: MedStar Health
- 10-hospital health system, based in the Baltimore-Washington, DC region
- Hospice nurses attend regional cancer committee to provide hospice program updates and report any hospice quality measures such as length of stay
- Hospice nurse executive attends system-wide cancer committee, made up of cancer service line leadership

Case in Brief: Middlesex Hospital
- 150-bed hospital located in Middletown, Connecticut
- Hospice and palliative care medical director attends cancer committee and tumor board
- Offers consultative guidance on certain patient cases, as well as updates on hospice program

Source: MedStar Health, Baltimore, MD; Middlesex Hospital, Middletown, CT; Oncology Roundtable interviews and analysis.
Broad Collaboration Valuable

Fiola Health System, a pseudonym, works with a number of post-acute care providers, including several different hospices in their area. To engage this diverse group of providers, Fiola created a care collaborative meeting and invited all the post-acute care facilities with whom they work. At first they were worried that no one would show up to the first meeting, but it turned out that everyone, even the ambulance transport staff, wanted to be a part of it. The collaborative has since undertaken a number of process improvement projects.

Multiple PACs Involved in Community Collaborative

Fiola Health System¹ Community Care Collaborative

- Includes approximately 50 participants
- Meets monthly
- Care collaborative encourages shared responsibility for PAC² transitions across hospital and PAC facilities

Participants

- VNA nurses
- Hospice clinicians
- SNF clinicians
- Ambulance transport staff
- Cancer center nurse navigators

Collaborative Initiatives

Universal patient transfer form:
Developed form to standardize patient transfers to and from PACs

Patient admission timing:
Standardized times when PACs would accept new patient referrals

¹ Pseudonym
² Post-Acute Care

Source: Oncology Roundtable interviews and analysis.
One of these projects involved improving patient transfer forms. Not only was Fiola using multiple forms for each facility, but these forms suffered from many shortcomings. For example, the forms often included an overwhelming amount of information and key patient information was either difficult to find, or missing altogether.

The care collaborative then reviewed all existing forms and took the best elements from each to create one standardized, single page form that included only the essential pieces of patient information.

Each organization within the collaborative is now committed to using the form for all patient transfers and has benefited from clear communication across sites of care.

**Case in Brief: Fiola Health System¹**

- Eight-hospital health system based in the Northeast
- Health system created post-acute care facility collaborative to engage the multiple facilities they work with
- Care collaborative meets monthly and includes representatives from local SNFs, hospices, VNA, cancer center nurse navigators, and ambulance transport agency
- Care collaborative takes on a variety of quality improvement initiatives, including the development of a universal patient transfer form and a provider capability spreadsheet that is updated continuously

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¹: Pseudonym.

Source: Oncology Roundtable interviews and analysis.
Practice # 20: Hospice Capability Inventory

Promoting Appropriate Patient Referrals

As discussed earlier, hospices may be limited in their service offerings depending on a number of factors, including finances. The next practice focuses on evaluating hospice capabilities to ensure patients are receiving care that meets their needs.

Fiola Health System’s care collaborative also undertook a project to document the services and capabilities of the providers within their area. A Fiola administrator collected the information through Survey Monkey, documenting things like facility type, services offered, and types of insurance accepted, to equip clinicians with information so that they are able to match patients’ needs with a facility’s capabilities.

Interestingly, the spreadsheet is updated continuously, as no one wants to miss out on a potential patient referral.

Along with an explanation of the process, we have provided a few questions to get started. Of course these questions are only a sample, and they may vary by organization, but this resource can serve as a starting point for future conversations.

Assessment Aligns Facility Capabilities with Patient Needs

Fiola Health System¹ PAC Spreadsheet Development Process

Information Collection

- Fiola system administrator developed Survey Monkey questionnaire to collect information on PAC capabilities, service offerings
- 100% of collaborative participants responded

Capability Spreadsheet

- Survey information compiled into Excel spreadsheet that is available on a shared drive within Fiola system
- Spreadsheet includes:
  - Facility type
  - Types of insurance accepted
  - Hours of new patient acceptance
  - Services offered

Informed Referrals

- Spreadsheet updated continuously
- Cancer center social workers and navigators use spreadsheet to make appropriate referrals to PACs

Sample Hospice Capability Questions

1. Do you provide home care visits?
2. Do any of your nurses have specialty training in oncology or palliative care?
3. Do you offer palliative chemotherapy or palliative radiation therapy?
4. Does your facility have particular insurance contracts?
5. What amenities does your facility provide?
   a. How many private rooms and bathrooms do you have?
   b. Can residents keep pets?

¹ Pseudonym.

Source: Oncology Roundtable interviews and analysis.
The last component of ensuring smooth handoffs to hospice involves developing preferred provider contracts that encompass many of the principles we have discussed thus far, including determining internal priorities and evaluating potential partners’ capabilities.

The remaining portion of this section will showcase how one cancer program is developing a formalized agreement with its hospice provider to ensure seamless and coordinated care for patients at the end of life.

**Hardwiring Shared Accountability**

**Preferred Provider Contracts Ensure Continued Success**

**Hospital-Hospice Affiliation Agreements**

- Formalizes written agreement between hospital and hospice/PAC organization to develop and meet quality standards
- Creates joint infrastructure for future quality improvement collaboration, review of relationship performance
- Tracks operational metrics, clinical outcomes, patient satisfaction

**Affiliation Agreement Metrics**

- Hospice length of stay
- Symptom management score/burden
- Hospice/hospital committee meeting attendance
- Patient and family satisfaction
- Percentage complete patient transfer records received
- Referral turnaround time

Source: Oncology Roundtable interviews and analysis.
UT Southwestern went through a step-by-step process to develop a list of internal priorities. This list then served as the basis for vetting potential partners.

The workgroup at UT Southwestern consisted of various stakeholders, including the cancer center director, the director for supportive care services, and the transitional care coordinator. Together, they developed a list of priorities that they felt were important for their patients, and therefore necessary for a hospice partner.

Once a hospice program was selected, the cancer center and hospice program engaged in a series of negotiations to establish shared goals and priorities and to ensure that the collaboration would be a win-win for all.

Practice #21: Preferred Provider Contracts

Cancer Center Workgroup Establishes Priorities

Priorities Used to Screen Potential Hospice Partners

Hospice Partnership Selection Process at UT Southwestern

1. Developing Selection Criteria
   - Cancer Center Workgroup
     - AVP, cancer service line
     - Cancer center director
     - Director of supportive care services
     - Palliative care physicians
     - Medical oncologists
     - Transitional care coordinator
   - Priorities for Partnership
     - Hospice home visits
     - Specialty trained nurse care
     - Consistent communication and follow-up

2. Vetting Potential Partners
   - Care coordinator reaches out to regional hospices to vet against criteria
   - Leaders of select hospices meet with cancer center executive team

3. Preferred Provider Agreements
   - Preferred partner care agreements

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Establishing Mutually Beneficial Program Elements

The cancer center worked hard to negotiate for timely communication and co-management of patients, hoping that this approach would help oncologists feel more comfortable with the referral process.

Additionally, believing that the first few days during a transition are critical, they requested that the hospice medical director visit with each patient within three to five days of their referral.

On the other side of the equation, the hospice requested that the inpatient and outpatient oncology units standardize their referral processes, as each unit was doing things differently.

Additionally, the hospice asked that the cancer center take on the responsibility of educating staff and patients about hospice services and the co-management model itself.

Negotiations Necessary for Sustained Collaboration

<table>
<thead>
<tr>
<th>Cancer Center Requests</th>
<th>Hospice Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice medical director conducts home visit within 3-5 days of patient admission depending on patient’s acuity</td>
<td>Cancer center standardizes both inpatient and outpatient hospice referral processes</td>
</tr>
<tr>
<td>Primary oncologist comanages patients</td>
<td></td>
</tr>
<tr>
<td>Hospice commits to certain communication protocols</td>
<td>Cancer center conducts patient and staff education about hospice and about hospice-cancer center co-management model</td>
</tr>
</tbody>
</table>

Case in Brief: UT Southwestern University Hospitals

- Two-hospital academic medical center based in Dallas, Texas; includes the NCI-designated Simmons Cancer Center
- Once a hospice partner was selected, cancer center and hospice went through series of negotiations to finalize components of partnership agreement
- Partnership agreement includes guidelines on communication follow-up, patient information shared, when and by which provider hospice patient education should be conducted, patient comanagement arrangements, and appropriate outcomes measures

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Once cancer patients are referred to hospice, they’re provided with information on the transfer and about the comanagement model.

Next, the hospice medical director conducts an initial home visit within the first three to five days of admission to hospice.

At this time, the hospice director evaluates the patient, reviews the treatment plan, and develops a plan for hospice care. The medical director’s notes from this visit are then sent to the patient’s oncologist, as well as to the cancer service line administrator, so that all parties stay informed of the situation.

After this initial visit, the oncologist has the opportunity to continue to see the patients for a few visits known as “closure visits.” During this time, the oncologist may go over any follow-up items, test results, and answer any questions the patient may have.

These closure visits have had a huge impact on both patient and oncologist satisfaction. Physicians feel like they still can see the patient and oversee their care, and patients don’t feel abandoned after their referral to hospice.

Comanagement Model Ensures Continuity of Care

Hospice Patient Comanagement at UT Southwestern

- Patient Referral
  - Patient is referred to hospice
  - Patient receives information about referral process and comanagement model

- Hospice Admission
  - Hospice medical director conducts patient home visit within 3-5 days of admission
  - Hospice medical director sends oncologist notes from home visit

- Ongoing Management
  - Primary oncologist conducts patient “closure visits”
  - Hospice emails monthly census; cancer care coordinators and hospice liaisons meet regularly

Visit notes include changes to patient care plan, any symptom management needs, medications

Address any follow-up items including treatments, labs

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Though UT Southwestern is still in the early stages of finalizing this agreement, they've already seen early benefits.

Patient and physician satisfaction has increased substantially, and their hospice average length of stay has quadrupled, growing from 7 to 28 days.

**Hospice-Cancer Center Partnership Benefits**

- Coordinated patient care
- Increased patient and family satisfaction with hospice referral process
- Increased physician comfort with hospice referral and satisfaction with hospice services

**Average Hospice Length of Stay for Cancer Patients at UT Southwestern**

<table>
<thead>
<tr>
<th>Days</th>
<th>Before Preferred Contract</th>
<th>After Preferred Contract</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>28</td>
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</table>

Source: UT Southwestern University Hospitals, Dallas, TX; Oncology Roundtable interviews and analysis.
Key Takeaways

Developing Collaborative Hospice Relationships

In the face of physical and psychosocial challenges and lack of appropriate guidelines for referrals, transitions to hospice can be a difficult process for both patients and physicians. Developing a strong, sustainable hospice-cancer center relationship can mitigate some of the common barriers to a timely and seamless hospice transition.

1. **Take stock of internal priorities**
   Determining internal priorities for hospice services is a necessary first step in ensuring that cancer patients’ needs are being met.

2. **Develop relationships with hospices**
   Establishing a baseline working relationship can serve as the foundation for future collaboration.

3. **Evaluate hospice services and capabilities**
   Using predetermined criteria, cancer centers should evaluate a hospice’s services and capabilities to ensure appropriate referrals and to ensure patients are receiving appropriate level of care.

4. **Advance mutually beneficial hospice partnerships**
   Some organizations may choose to formalize their partnerships with hospices to hardwire accountability for shared goals, performance standards, and communication requirements.

Source: Oncology Roundtable interviews and analysis.
Coda: Moving Toward a Seamless Future
Looking back across all of the transitions covered in this study, we see that five key themes underlie the tactics. Each one—from assessing current transitions to cultivating a transitions-oriented culture—builds on the last. Focusing on each step in turn will help cancer programs collaborate with other sites of care to build a seamless care experience for their patients.

In fact, these themes—and the tactics they represent—apply to smoothing other types of transitions not explicitly covered here. For instance, the handoff to survivorship care.
Envisioning the Ideal

Ultimately, the goal is the same: a coordinated cancer care continuum where all sites work together to provide high-quality care for patients. Developing partnerships beyond the cancer center will ensure that organizations are positioned well to meet the demands of an evolving, integrating care network.

Creating a Patient-Centered Cancer Care Continuum

Source: Oncology Roundtable interviews and analysis.
Appendix

- Oncology Transitions Assessment Toolkit
- Additional Online Care Transitions Resources
## Oncology Transitions Assessment Toolkit

**Designed to accompany the publication** *Coordinating Seamless Transitions Across Care Settings*

### Step 1

**Identify problems by gathering high-level data**

Gathering readily available information about the quality of care transitions through strategic conversations and key metrics provides a well-rounded view of transition problems within the cancer program.

#### Key Questions

1. **What transition challenges are patients and staff currently experiencing based on data from each source?**

   (See p. 18 for guidance on identifying these problems.)

2. **Which areas may require a deep dive to better understand potential problems? (Check all that apply.)**

   - Transitions with independent oncologists. *For practices to address these transitions, see p. 41.*
   - Transitions with the emergency department. *For practices to address these transitions, see p. 51.*
   - Transitions with the hospital inpatient unit. *For practices to address these transitions, see p. 65.*
   - Transitions with hospice programs. *For practices to address these transitions, see p. 93*
   - Other transitions. *For practices to empower patients across all transition types, see p. 29*

   *In addition, many practices designed for transitions to a particular care setting can be used across other care settings as well.*

#### Source of High-Level Data

<table>
<thead>
<tr>
<th>Source of High-Level Data</th>
<th>Potential Problems Identified by Each Source</th>
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<tbody>
<tr>
<td>Cancer Center Staff, Clinicians</td>
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<tr>
<td>Patients and Caregivers</td>
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<tr>
<td>Leaders from Other Care Settings</td>
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<tr>
<td>Billing Records, Payer Data</td>
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</tbody>
</table>

*Source: Oncology Roundtable interviews and analysis.*
**Oncology Transitions Assessment Toolkit (cont.)**

### Step 2

**Assess the underlying sources of transition problems**

Targeted assessment of problems helps to identify their causes. Select the appropriate assessment method based on resources available to your cancer center.

<table>
<thead>
<tr>
<th>Key Questions</th>
<th>Notes/Responses</th>
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</table>
| Which resources are available for further assessing the underlying sources of the problems identified in step 1? (Check all that apply.) | - Cancer center staff availability to conduct gap analysis (appropriate staff have titles such as navigator, social worker, quality director, etc.).  
  *Suggested assessment method: Multi-Stakeholder Gap Analysis (see p.20)*  
- Cancer center staff experience with analysis of hospital billing data.  
  *Suggested assessment method: Patient Data Deep Dive (see p. 22)*  
- IT/Analytics department personnel with availability to conduct a preliminary analysis of hospital billing data for cancer patients.  
  *Suggested assessment method: Patient Data Deep Dive (see p. 22)*  
- Clinical staff flexibility to observe operations in another care setting.  
  *Suggested assessment method: Cross-Site Shadowing (see p. 24)* |

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Based on your assessment of underlying problems, what are the key care transition problems for patients from your cancer program?

1. 

2. 

3. 

4. 

5. 

Source: Oncology Roundtable interviews and analysis.
Oncology Transitions Assessment Toolkit (cont.)

**Step 3**

Strategically prioritize follow-up steps to address underlying problems

Focusing initial efforts on the highest-impact areas will ensure the best use of limited resources in addressing transition problems. Identify the highest-impact areas by comparing identified problems based on criteria that is important within your organization.

### Key Questions

- Which prioritization factors are most important within your organization? (Select up to 5 factors.)

- Use the prioritization grid exercise on the next page to systematically evaluate how well each problem aligns with your selected prioritization factors.

### Notes/Responses

1. Overall number of patients experiencing each problem
2. Relative volume of high-risk patients
3. Patient safety concerns
4. Patient, provider satisfaction concerns
5. Resource utilization concerns
6. Preparation for value-based payment reforms

- Alignment with institution- or system-level priorities
- Congruence with other cancer program initiatives
- Ability to inflect change on areas needing improvement
- Potential to have a measurable impact on problem

Source: Oncology Roundtable interviews and analysis.
Oncology Transitions Assessment Toolkit (cont.)

**Step 3 (cont.) Create Prioritization Grid**

**Directions:**
1. On the left side of the grid, list the key transition problems identified in step 2.
2. Across the top of the grid, list the criteria selected earlier in step 3.
3. Write a score for each problem in the grid, based on how well each problem aligns with each criterion. You may use the following rating scale or create your own specific to each criterion. After completing this step, each space on the grid should be filled in.
   - 3 = High alignment with criteria
   - 2 = Medium alignment with criteria
   - 1 = Low alignment with criteria
4. (Optional) If the criteria differ in importance, assign weights to each criterion to account for these differences. For example, if Criterion 1 is twice as important as Criterion 2, you may assign Criterion 1 a weight of 10, while assigning Criterion 2 a weight of 5. Once you have assigned a weight for each criterion, multiply the score assigned above by the weight of the criteria in each cell of the grid. Write this weighted score in each cell. If the chosen criteria all have an equal level of importance, this step can be skipped.
5. Once the cells of the grid have been completed, calculate the total points for each problem by adding the scores across the row. More points means the problem may be considered a higher priority for addressing first.

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Source: Oncology Roundtable interviews and analysis.
Additional Online Care Transitions Resources

Related Materials Available on the Study Website

- Strategic Questions for Assessing Care Transitions
- Lessons from the Field: Requesting, Analyzing, and Reporting on Quality Data
- Holy Cross Health Oncology Patient Admission Protocols and Pathway
- Elective Scheduled Admission Check-Sheet
- Lehigh Valley Health Network Cooperative Care Agreement

To access these resources, and an electronic version of this study, please visit our website: advisory.com/research/oncology-roundtable/studies/2013/coordinating-seamless-transitions-across-care-settings