

Urgent Care for Cancer Patients

Four Tactics to Reduce ED Visits and Hospitalizations

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Advisors to Our Work

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Executive Summary

Most cancer patients will suffer severe symptoms at some point during their treatment. In many cases, they turn to the emergency department (ED) for care, either because they are unaware that their cancer care team may be available to help, they need assistance outside of regularly scheduled clinic hours, or the clinic does not have the capacity or capability to meet their needs.

Unfortunately the ED is not the ideal place to manage cancer patients' symptoms. Many EDs struggle with overcrowding, and consequently patients may have to wait for hours. In the process, they may be exposed to pathogens, which is a particular concern for immunocompromised cancer patients. Few ED clinicians have oncology-specific training, which can lead to unnecessary hospitalization, inappropriate utilization of services, and lower quality care. As cancer centers become increasingly responsible for both improving the patient experience and reducing avoidable costs, providing urgent care in the most appropriate setting is becoming a top priority.

According to responses to the Oncology Roundtable's 2013 Engineering an Exceptional Patient Experience Quick Poll, most programs have either ineffective or inadequate urgent symptom management programs. Only 20% of cancer programs provide support for patients with urgent symptoms after business hours. In fact, 27% of programs say they routinely send all patients with urgent symptoms straight to the ED. To help our members build a strategy for urgent symptom management, we have outlined four key tactics for meeting the needs of patients with urgent symptoms.

Tactic 1. Implement standardized telephone triage

At a minimum, cancer programs should operate a phone line that patients can call to receive immediate assistance if they have urgent symptoms. Programs should ensure that the line is staffed with an adequate number of well-trained staff who are able to address patients' urgent care needs over the phone or guide them to the most appropriate care setting.

This first tactic is applicable to all cancer programs, although the scale will vary depending on the size and complexity of the patient population. In contrast, the following three tactics will be more appropriate for programs struggling to manage high volumes of patients seeking same-day care in their facilities.

Tactic 2. Implement flexible scheduling systems

In many cases, clinicians can free up time to see urgent patients during the day by transitioning to more flexible scheduling systems. There are several systems administrators may wish to examine, ranging from blocking add-on patient time in each provider's schedule all the way to implementing an open-access scheduling system.

Tactic 3. Deploy advanced practice providers

Although many cancer programs employ advanced practice providers (APPs), they are often underutilized by oncologists. To ensure APPs are deployed appropriately, programs may need to educate physicians about APP skills and scope of practice, and remove financial disincentives that discourage physicians from referring to them. In contrast, if a program's physicians lack the capacity to address patients' urgent symptoms, they may want to hire one or more APPs.

Tactic 4. Create dedicated space for urgent care

Programs with a high volume of regular appointments and significant demand for urgent add-on appointments may want to create a dedicated facility for urgent cancer care outside of the cancer center. Though the initial investment is large, early movers have seen significant benefits in terms of reduced ED visits and improved market differentiation.

This publication will explore the mandate to provide timely, evidence-based symptom management as well as the various tactics cancer programs are deploying to achieve it. We sincerely hope that you will call upon us to facilitate discussions with your team, offer consultative guidance, or provide any other needed support in putting these tactics in place. As always, we close with appreciation for the opportunity to serve you

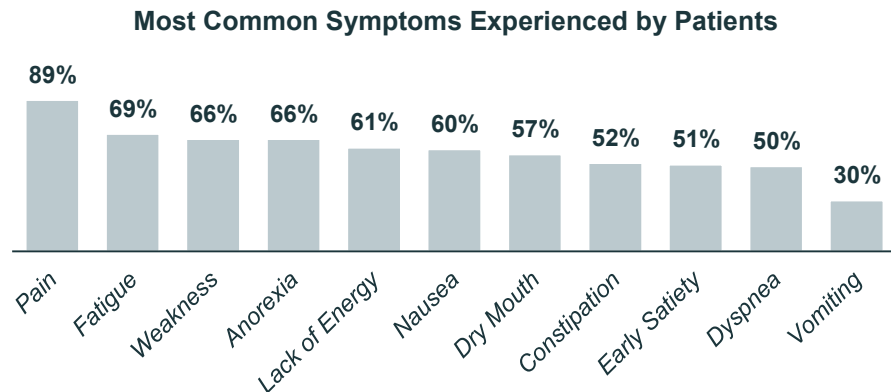
Essay

Cancer patients struggling with significant symptom burden



Many patients suffering multiple symptoms, reluctant to report concerns

During the course of their treatment, most cancer patients will struggle with symptoms stemming from cancer progression, their treatments, and comorbidities. Data suggests that almost 90% of patients experience pain and almost 70% experience fatigue, weakness, or anorexia. Despite the prevalence and severity of these symptoms, many patients are reluctant to report the full extent of their symptoms to clinicians. On average, most patients report only a small fraction of their total symptom burden to their care team.

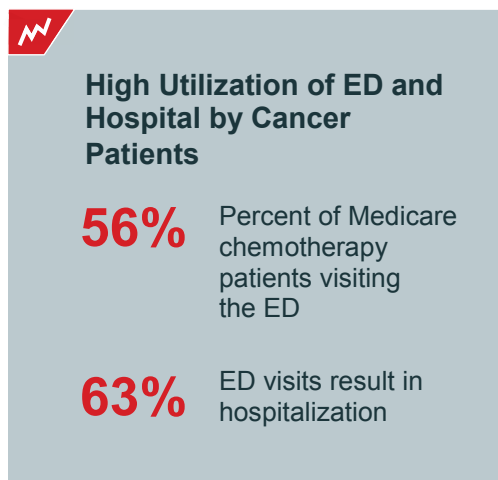


Severe symptoms often leading to ED visits, hospitalizations

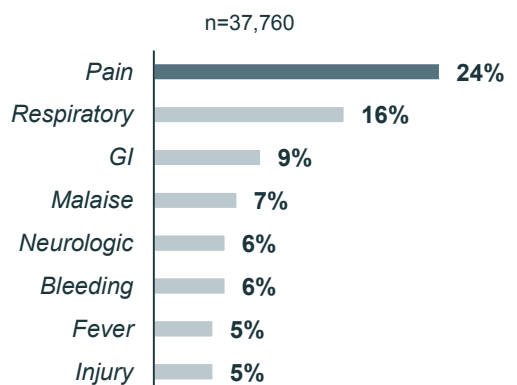
Though care teams provide as much support as possible to help patients manage symptoms on their own, most will face severe symptoms at some point during their treatment that will require immediate clinical interventions. Unfortunately, when these severe symptoms arise, many patients will have no other option but to go to the emergency department (ED).

Fifty-six percent of Medicare patients actively receiving chemotherapy visit the ED each year, and studies suggest that up to 63% of these visits result in hospitalization.

According to a study from University of North Carolina at Chapel Hill, the chief reason for these ED visits is pain, which in many cases is more easily and effectively managed at home or in a clinic setting. Though some cancer-related symptoms do require treatment in the ED, a concerning high number of patients are utilizing the ED for routine pain management.



Chief Complaint of Cancer Patients Presenting at Emergency Department



ED a suboptimal setting for cancer patients

The ED is not the ideal setting for cancer patients. Cancer patients who visit the emergency department are often immunocompromised, which means they face a risk of infection while waiting to be seen. When they are seen, they are often treated by ED physicians who lack oncology-specific training and experience. Out of an abundance of caution, these clinicians may prescribe superfluous diagnostic procedures and inappropriate treatments. These unnecessary services add avoidable costs to both the patient as well as the health system.

Waiting for long periods in the ED is also stressful for patients and families, and is consistently ranked as a source of dissatisfaction on patient experience surveys.



Quality

- High-risk setting for immunocompromised patients
- ED physicians may lack oncology expertise



Cost

- Higher likelihood of unnecessary testing
- Higher likelihood of unnecessary interventions, prescriptions

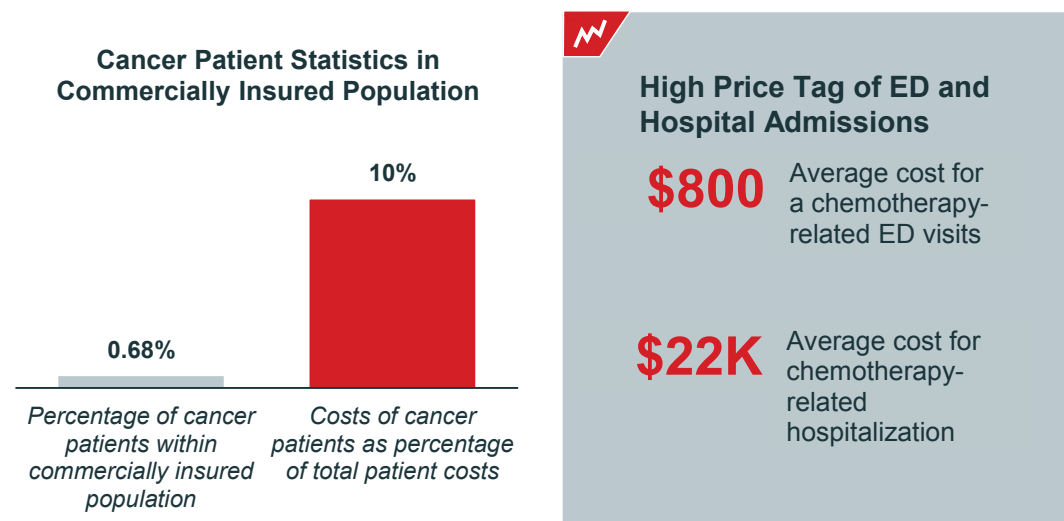


Dissatisfaction

- Patients consistently cite ED as a dissatisfier
- Average ED wait time six hours

Reducing unnecessary utilization a priority under accountable care

With the transition to accountable care, providers must reduce unnecessary utilization to meet cost and quality goals. An analysis by the actuarial firm Milliman found that the average chemotherapy-related ED visit costs \$800 and the average inpatient hospitalization costs \$22,000. Given the implications for costs and patient outcomes, it is not surprising that many payers are interested in tracking chemotherapy-related ED visits and hospitalizations and tying provider performance to reimbursement.



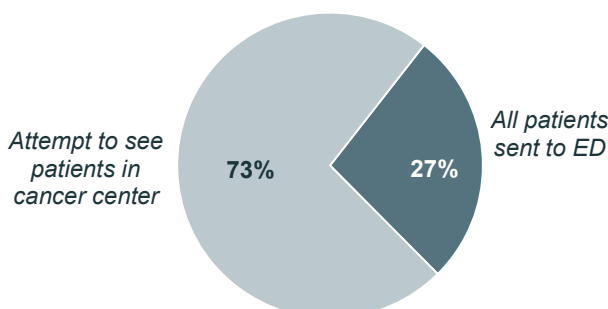
Most cancer programs have serious gaps in support

Given the significant concerns associated with ED use, progressive cancer programs are now attempting to identify and support patients with urgent symptoms before they seek help in the ED. Unfortunately, according to the Oncology Roundtable's 2013 Engineering an Exceptional Patient Experience Quick Poll, many cancer programs still send all patients with urgent symptoms straight to the ED. Of those programs that do see patients with urgent symptoms in an outpatient setting, only a small number are able to see patients after hours.

How do you manage cancer patients with urgent needs?

2013 Patient Experience Quick Poll

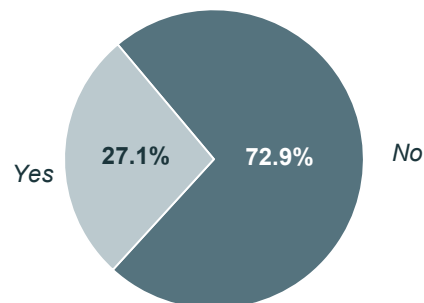
n=140



Does your cancer center see patients with urgent symptom needs after hours?

2013 Patient Experience Quick Poll

n=140



Significant challenges associated with urgent symptom management

Managing patients' symptoms presents many challenges. The first is knowing when patients need support. In the event that patients need an appointment with a clinician, finding time in providers' schedules can be extremely challenging, and the challenge is even tougher when patients suffer urgent symptoms after hours. Even when providers do find time to see urgent add-on patients, finding space to treat them can be a significant challenge.

1



Encouraging patients to proactively communicate urgent symptoms

2



Finding time in providers' daily schedules

3



Supporting patients after hours

4



Finding space to treat add-on patients

Four key tactics for urgent symptom management

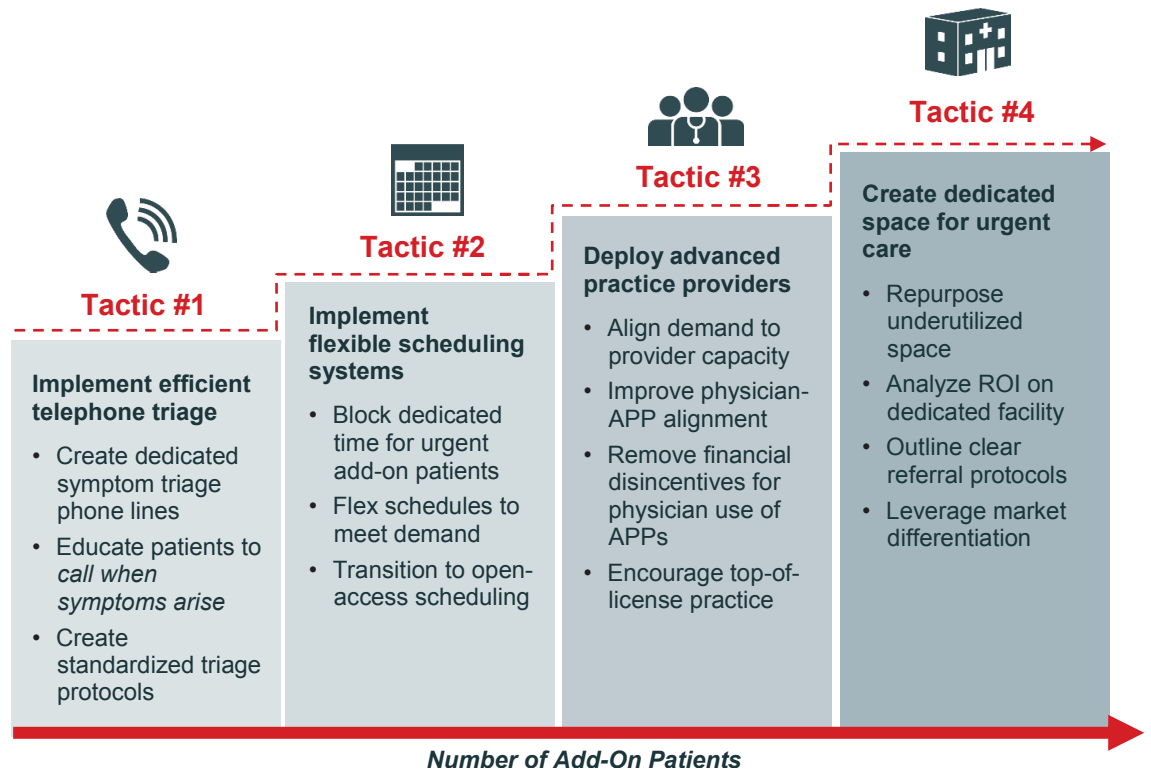
To help cancer programs better manage cancer patients with urgent care needs, and overcome the challenges outlined above, we identified four tactics for improving urgent symptom management. The first tactic is to implement efficient and standardized telephone triage. At a minimum, all programs should have an urgent symptom phone line. To maximize its effectiveness, programs will need to invest in patient education, dedicated staff, and standardized telephone triage protocols.

If providers have excess capacity but cannot find appropriate time in their schedules to see patients with urgent symptoms, cancer programs should explore more flexible scheduling models. To determine which model is most appropriate, programs should assess expected daily demand, for both urgent and routine patients.

Cancer programs with high patient volumes may find it is more efficient to hire advanced practice providers specifically to manage patients' urgent symptoms. This approach requires carefully analyzing the financial impact of hiring APPs and ensuring that oncologists are utilizing them effectively.

The final tactic is to provide dedicated space for urgent care. This is the most resource-intensive urgent care strategy, requiring not only dedicated space, but staff, referral protocols,

and above all, support from oncologists. Though not necessary for most smaller programs, large programs may see significant financial benefits from this approach.



Tactic # 1: Implement Standardized Telephone Triage

Urgent symptom phone lines common, but often ineffective

The first step in managing patients' urgent symptoms is to make sure patients are communicating their symptoms to their care team. To that end, cancer programs should:

1. Have a phone line(s) patients can call when they have symptoms or questions
2. Encourage patients to call the phone line whenever they have questions or concerns
3. Train staff who field calls to triage patients based on standardized protocols

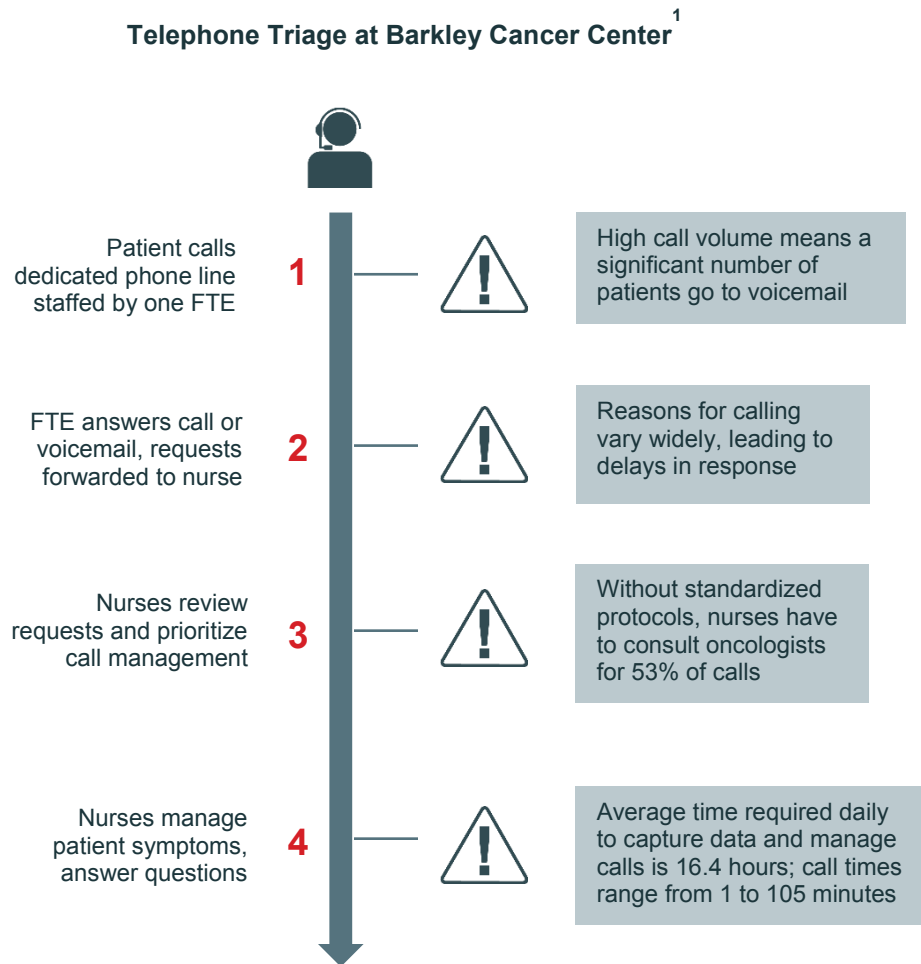
Just over half of all cancer programs reported through our Patient Experience Quick Poll that they had accomplished at least the first step in this process. However, few are actively tracking its effectiveness despite the significant investment.

Below are some key questions for cancer program leaders to evaluate the effectiveness of their phone triage line.

- How many patient calls are answered each week? How many calls are not answered?
- What are the outcomes of patient calls? Are patients' symptoms managed at home, do they come to the clinic, or do they go to the ED?
- How often can the issue be resolved by the person answering the phone? How often are additional individuals involved (e.g., oncology nurses, Oncologists)?
- How long do patients usually wait to speak with someone?
- How often are patients going to the ED without first contacting the phone triage line?

Many phone triage lines suffer from poorly planned workflow

In many cases, cancer programs do not know how inefficient their phone triage process has become. Barkley Cancer Center (a pseudonym) had a full-time employee managing its urgent symptom phone line, yet its success was limited by workflow problems.¹



The primary problem was that the phone line received too many calls each day for one FTE to manage. As a result, the staff person spent hours each day sifting through a backlog of voicemails. If your institution is encouraging patients to call the phone line before seeking help elsewhere, it is important that patients are not waiting on the line for extended periods or being sent to voicemail multiple times.

At Barkley, patient backlog was undoubtedly exacerbated by another major problem with the line: the FTE staffing the phone line wasn't equipped to answer most patients' questions. In most cases, the FTE had to consult either a nurse or an oncologist, which was a disruption to nurse and physician workflow and led to further delays in responding to patient requests for help.

Use standardized algorithms for phone triage

Promoting an 'accept nothing' philosophy

At Consultants in Medical Oncology and Hematology in Drexel Hill, Pennsylvania, effective phone triage is a key element of their successful medical home model. Clinicians there emphasize to patients that they should call the phone triage line with any question or

1) Pseudonym

concern, no matter how trivial. “We tell patients to accept nothing,” says CMOH’s lead physician Dr. John Sprandio. “If you have issues, you call.” This message is routinely reinforced by all members of the CMOH staff.

To manage the enormous volume of calls they receive each year, leaders at CMOH have developed a standardized process to support staff in effectively and efficiently managing patients’ urgent needs.

Triage algorithms ensure consistent, timely symptom management

Physicians and nurses manning the phone line follow a set of symptom management algorithms that were originally adapted in the late 1990s from Oncology Nursing Society (ONS) guidelines. CMOH has since expanded and greatly modified the algorithms to include additional symptoms and to reflect specific management options and recommendations revealed through nurses’ reviews of real-time data from individual patients’ electronic files.

CMOH relies on the algorithms to better serve patients by giving them consistent, standardized, and timely symptom management information that, in turn, prevents unnecessary ED evaluations and hospital admissions. Everyone at CMOH is trained to follow these algorithms in both the clinic setting and for phone triage.

Nurses the backbone of the system

The phone triage line, which receives 15 to 20 symptom-related calls per weekday, operates from 7 a.m. to 6 p.m. Monday through Friday. On any given day, one RN is dedicated to managing the phone triage line. Two additional RNs are available to provide backup. They work in the infusion center but have flexible responsibilities so they can be interrupted to take calls as needed.

CMOH has four offices with infusion centers, but all of the phone triage is centralized at their largest site. The chemotherapy nurses rotate responsibility for phone triage every three to four days and spend the remainder of their time working in the infusion center.

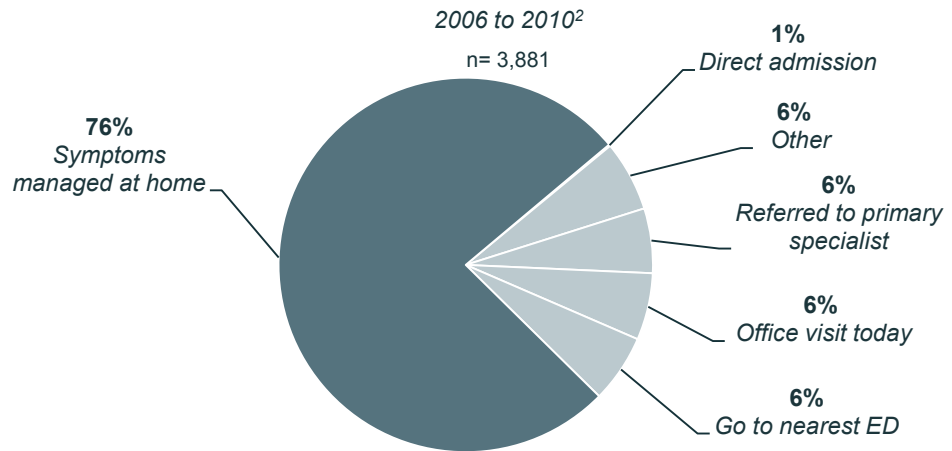
After 6 p.m., calls are redirected to an answering service, with the physician on call fielding patients’ questions. On-call physicians have remote access to the practice’s EMR, allowing them to follow the same symptom management algorithms used by the RNs.

Callers guided to appropriate care setting

Patients typically call the triage line when experiencing cancer-related symptoms or treatment-related side effects, including nausea, vomiting, pain, shortness of breath, fatigue, and skin rashes. Nurses triage patients based on the type of symptoms and their degree of severity. They use the practice’s EMR to track reasons for patients’ phone calls as well as the prescribed interventions.

Most patients calling with a symptom receive instructions for self-management, while a small percentage are scheduled for a same-day appointment in the clinic or are referred to the ED.

Outcomes of Phone Calls to the Nurse Triage Phone Line

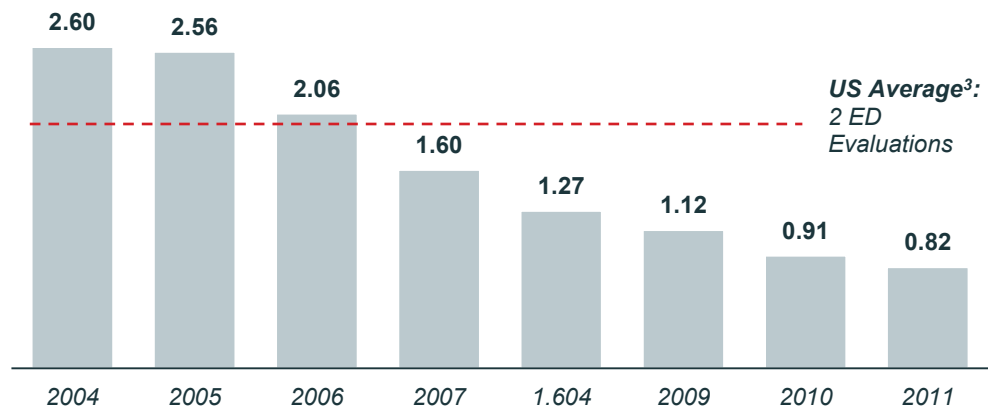


Effective phone triage a key factor in success of CMOH medical home model

Practice administrators link their phone triage system to a 65% decrease in ED visits across a five-year period and a 43% decrease in overall hospital admissions per chemotherapy patient per year. Notably CMOH achieved these gains despite a simultaneous 30% increase in patient volumes.

Average ED Evaluations per Chemotherapy Patient per Year

CMOH Patient Population, 2004-2011



For additional information see the Oncology Roundtable webconference "Lessons from the Medical Home"

2) Total may not add up to 100% due to rounding

3) Based on sample of 104,273 commercially insured cancer patients.



Case in Brief: Consultants in Medical Oncology and Hematology

- Private practice medical oncology and hematology group located in Drexel Hill, Pennsylvania
- First oncology practice to earn level III recognition from the National Committee for Quality Assurance (NCQA) under its Physician Practice Connections-Patient Centered Medical Home program, in April 2010
- Core components of program include active patient engagement, comprehensive EMR with disease registry capabilities, robust phone triage system, and extensive patient navigation infrastructure

Link phone triage to the EMR

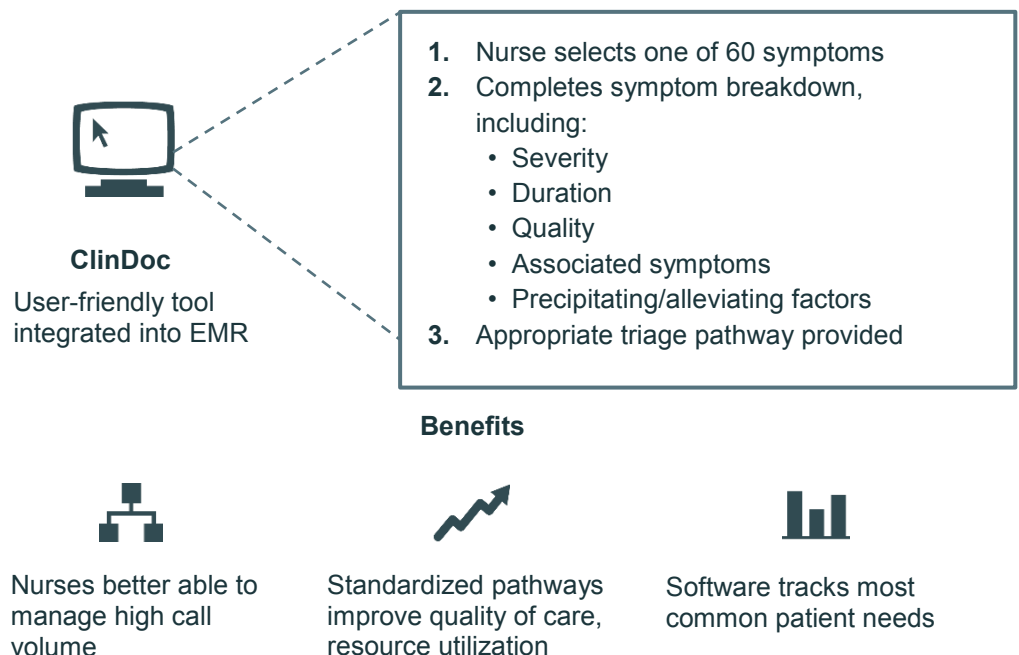
Memorial Sloan Kettering's homegrown 'ClinDoc' triage tool

To help support nurses manning their phone triage line, Memorial Sloan Kettering (MSK) has built a phone triage software tool called ClinDoc. Using this tool, nurses at MSK are able to quickly and appropriately triage over 200,000 calls each year.

When patients call MSK's urgent symptom line, nurses use the ClinDoc software to access preloaded evidence-based guidelines for symptom management. This improves the speed with which patient requests are handled and reduces nurses' need to call on other clinicians.

A key feature of ClinDoc is its integration with the patient's electronic medical record. This allows nurses to record the reason for patients' calls, the outcome of the call, and how their need was addressed, in the medical record. This integration allows MSK to track the prevalence and severity of their patients' symptoms in aggregate, and consequently make more informed decisions about how best to allocate resources to meet patients' needs.

Memorial Sloan-Kettering's Electronic Telephone Triage Document





Case in Brief: Memorial Sloan-Kettering Cancer Center

- NCI-designated comprehensive cancer center located in New York, New York
- Nurse triage line typically receives about 200,000 patient calls a year
- ClinDoc integrated into ambulatory EMR to document patient calls and includes an explicit breakdown of each symptom

Tactic #2: Implement flexible scheduling systems

Finding time for add-on patients challenging

Traditionally, providers try to fill every free minute of the day with scheduled appointments. This leaves little to no room in their schedules for add-on patients who need to be seen immediately. Often when patients call with urgent symptoms, they are told they cannot be seen that day and scheduled for the following morning or later. Unfortunately, if a patient's condition worsens throughout the day, they may not wait for their appointment and instead go to the ED where they will be seen that day.

Typical Patient Pathway



Patient Reports Urgent Symptom

- Patient calls cancer center with symptom complaint
- No availability for patient to be seen that day

No Cushion in Provider Schedules

- Tight schedules during operating hours
- Lack of flex time to handle unscheduled events
- Schedule appointment first thing next day

Patient Visits ED

- Symptom worsens throughout the day
- Patient visits ED for immediate care

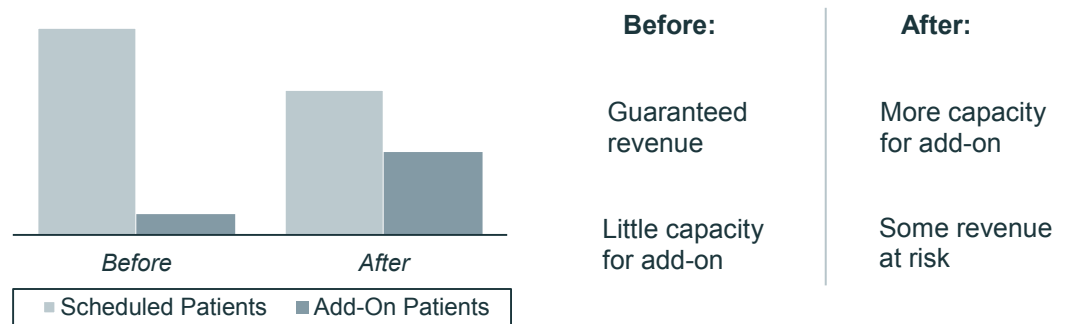
Innovative approach to scheduling opens up APP capacity

Providers have developed a number of different systems to manage same-day patient needs. One strategy is to dedicate a clinician to seeing urgent patients. Another option is to block off a certain amount of time in each clinician's schedule for same-day patients. Unfortunately, due to the inherent unpredictability of urgent symptoms, this can often lead to inefficient use of resources.

The University of Minnesota Physicians Fairview Cancer Center has radically overhauled the schedules of advanced practice providers in their cancer center, incorporating elements from both of the above examples. At Fairview, APPs still see scheduled patients, but they have only one scheduled appointment per hour. This provides them with extra time throughout the day to evaluate and treat add-on patients. Fairview patients with urgent care needs simply

call Fairview's phone triage line; if their symptom cannot be managed from home, they are added to an APP's schedule that day.

APP Time Dedicated to Scheduled Versus Unscheduled Patients



Example morning schedule for typical APP before and after open access scheduling

| | | | |
|----------|---------------|----------|----------------|
| 9:00 AM | D. Patterson | 9:00 AM | D. Patterson |
| 9:30 AM | K. Belmont | | Add-On Patient |
| 10:00 AM | E. Poe | 10:00 AM | K. Belmont |
| 10:30 AM | B. Preston | | Add-On Patient |
| 11:00 AM | L. Garry | 11:00 AM | E. Poe |
| 11:30 AM | R. Montgomery | | Add-On Patient |

Keeping Patients in the Cancer Center

>45%

Percentage of APP-led interventions that prevented ED visits

>20%

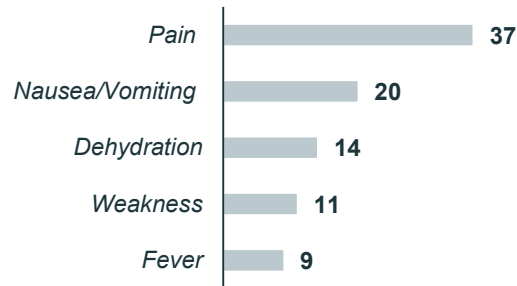
Percentage of APP-led interventions that prevented hospitalization

The transition to more flexible scheduling for APPs at Fairview has been a tremendous success; 63% of patients who needed same-day appointments in 2012 were able to come in for care on the same day.

Fairview has also tracked data on the number and outcomes of the add-on patients they see. The results show that the transition has been extremely effective in preventing ED visits and hospitalizations. Fairview estimates that if they had not accommodated these patients as "add-ons," 45% of them would have gone to the ED and over 20% would have ultimately been hospitalized.

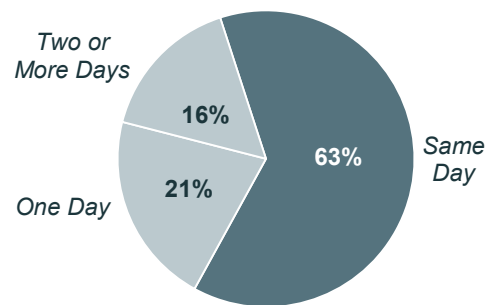
Fairview APPs Provide Symptom Management for Add-On Patients

Reasons for Add-On Visit Over One Month



Time from Patient Call until Add-On Appointment

n=95



Case in Brief: University of Minnesota Physicians Cancer Care at Fairview

- Primary oncology practice associated with the Masonic Cancer Center at University of Minnesota, an NCI-designated comprehensive cancer center located in Minneapolis, Minnesota
- Cancer center staffed by four FTE advanced practice providers (APPs), including two physician assistants and two nurse practitioners

Considering the merits of open access scheduling

Despite some success with the tactics above, many physician practices are looking towards more radical approach to managing urgent patients, transitioning to “open access scheduling” or “same-day scheduling.” At a basic level, open-access scheduling involves seeing all patients on the day they call for an appointment, whether they have urgent needs or not. This approach generally involves:

- Working down existing appointment backlogs
- Allowing patients to schedule appointments no more than two to five days in advance
- Rigorously aligning available clinician supply to average demand at all times of year using past appointments as predictor of future demand.

Physicians and hospital administrators who have implemented open access scheduling in the primary care setting have reduced appointment wait times, no-show appointments, and improved patient and physician satisfaction. Consequently, the tactic has seen a great deal of interest from hospital administrators over the years, especially in ancillary outpatient departments such as radiology.

Though many physicians and hospital programs have had success with open access scheduling, the technique can be very difficult to implement and can be unpopular among physicians. Most importantly, there is a risk that physicians will wind up with unscheduled appointment slots or that patients will be unable to make a timely appointment.

Four tips for implementing more flexible scheduling models

1



Align scope to demand

Gather data from phone triage lines on the number of patients who need same-day add-on appointments before determining scope of scheduling changes. Do not carve out more time in the day for add-on appointments than is justified through existing data, or you may risk losing revenue.

2



Obtain clinician buy-in before proceeding

Take time to educate all advanced practice providers and physicians on the benefits of new scheduling changes before proceeding. More efficient scheduling can not only improve patient access (not just patients with urgent needs), it can also reduce stress for clinicians trying to squeeze add-on patients into an already packed schedule.

3



Maintain schedule flexibility but remain disciplined

Provide schedulers with enough flexibility to maximize the number of patients per day, but avoid the temptation to schedule regular patients over appointment slots purposefully left open for add-on patients.

4



Take broad approach to measuring success

Keep a close eye on patient volumes and payer mix to ensure that flexible scheduling is not adversely affecting financial performance. At the same time, make sure you are tracking more patient-centered measures of success, such as how often urgent patients are able to get same-day appointments, and how many patients would have otherwise gone to the ED.

Tactic #3: Deploy advanced practice providers



Study in Brief: Developing the Care Delivery Model of the Future

- Reviews literature on APPs in oncology practice
- Includes sample pro forma to help determine whether hiring an APP is financially justified
- Available for [order](#) or [online](#) from the [Oncology Roundtable](#)

Making the case for extra advanced practice providers

Even when provider schedules are managed at maximum efficiency, demand for add-on appointments may outstrip available clinician time. When that happens, cancer programs will have to decide whether there is a financial case for hiring more clinicians. In most cases, the most accessible solution is to hire an advanced practice provider.

More information about integrating advanced practice providers into oncology practice can be found in our publication [Developing the Care Delivery Model of the Future](#). The publication walks through the business case for hiring an advanced practice provider, and includes a pro forma from Vanderbilt University that estimates the number of patient visits an APP would have to bill to recoup their salary.

| Vanderbilt Advanced Practitioner Pro Forma | |
|--|----------|
| Productivity | |
| Add-On patients per week | 24 |
| Productive weeks per year | 48 |
| Visits per year | 1152 |
| Personnel Expense | |
| Salary | \$77,000 |
| Benefits | \$20,000 |
| Total | \$97,000 |
| Payer Mix | |
| Medicare | 35% |
| Medicaid | 23% |
| Commercial | 37% |
| Self-Pay | 16% |
| Average Visit Mix | |
| 99204 | 6% |
| 99211 | 2% |
| 99212,99213 | 2% |
| 99214 | 74% |
| 99215 | 16% |

Physicians often concerned about off-loading work to APPs

Study in Brief: Integrating Mid-Level Providers into Oncology Practice

- Examines the various mid-level provider models currently in use in oncology
- Provides strategies for ensuring their successful integration
- Available for order or online from the Oncology Roundtable

Even when APPs are available to manage add-on patients, many programs may find they are under-utilized. In some cases, this is because physicians are hesitant to off-load patients to APPs; physicians may wish to see patients themselves or may be skeptical of the quality of care APPs provide. But in most cases, physicians just are not familiar with the skills and scope of practice of APPs.

To maximize APP productivity, and to encourage their use in managing add-on patients, programs may need to foster more collaborative physician-APP relationships. There are a number of steps programs can take to do this; some ideas are listed below. Arguably the most important step is to educate physicians about the skills and scope of practice of their APPs.

Physician Concerns about Off-Loading Work to APPs



- Quality of APP care
- Care coordination
- APP scope of practice
- Loss of RVUs

Strengthening APP-Physician Collaboration

| | |
|---|--|
| ✓ | Formalize process to identify where APPs most needed |
| ✓ | Educate physicians about APP's skills, training, scope of practice |
| ✓ | Ensure APP clinical preparedness |
| ✓ | Incorporate performance incentives into APP compensation |
| ✓ | Structure physician incentives to maximize APP productivity |

Programs may also find it beneficial to financially incentivize physicians to maximize APP productivity. The table below lists the pros and cons of several compensation models we encountered in our research.

| | Per-RVU Fee | Supervision Stipend | Cost Defrayment | Profit Sharing |
|---|--|--|--|---|
| Description | MD paid fee for each RVU generated by APP | MD paid set annual amount to supervise APP | APP covers MD practice costs in proportion to revenue | Portion of revenue generated by APP paid out to MD |
| Advantages | <ul style="list-style-type: none">Lucrative for MDRewards MD for APP productivity | <ul style="list-style-type: none">Explicitly rewards supervisionLower cost to group | <ul style="list-style-type: none">Motivates APP to raise productivityLower cost to group | <ul style="list-style-type: none">Can share profit among APP, MDRewards MD for APP productivityRewards practice (not just individual) success |
| Drawbacks | <ul style="list-style-type: none">May be expensive for medical groupPerceived by APPs as unfair | <ul style="list-style-type: none">Reward not linked to APP productivity, performanceOften lower compensation potential for MD | <ul style="list-style-type: none">Requires accurate assessment of APP-generated revenueLimited incentive if MD not fully exposed to costs | <ul style="list-style-type: none">Requires accurate assessment of APP-generated revenue |
| Potential to Align Group, MD, APP Goals | | | | |

Tactic #4: Create Dedicated Space for Urgent Care

Many cancer programs struggle to find space for add-on patients

For some cancer programs, finding time to see patients with urgent symptom needs is not the only challenge; finding enough space to treat them can also be a problem. Depending on the severity of the patient's symptoms, their needs may range from a simple prescription to an infusion. When space is unavailable, patients face delays and may be sent straight to the ED.

Barnes-Jewish Siteman Cancer Center bursting at the seams

Before the construction of their dedicated care clinic, Barnes-Jewish Siteman Cancer Center struggled to find space to care for add-on patients. Patients often crowded the cancer center waiting for space to open up and frequently ended up in the ED, where they often had to wait several more hours. Even more problematic, cancer patients were not just going to the Barnes-Jewish ED. During 2006, 780 Siteman cancer patients were sent to local community emergency departments to receive urgent care.



Capacity Constraints Force Patients to Go Elsewhere

2,478

Siteman cancer patients visit Barnes-Jewish ED over the course of one year

780

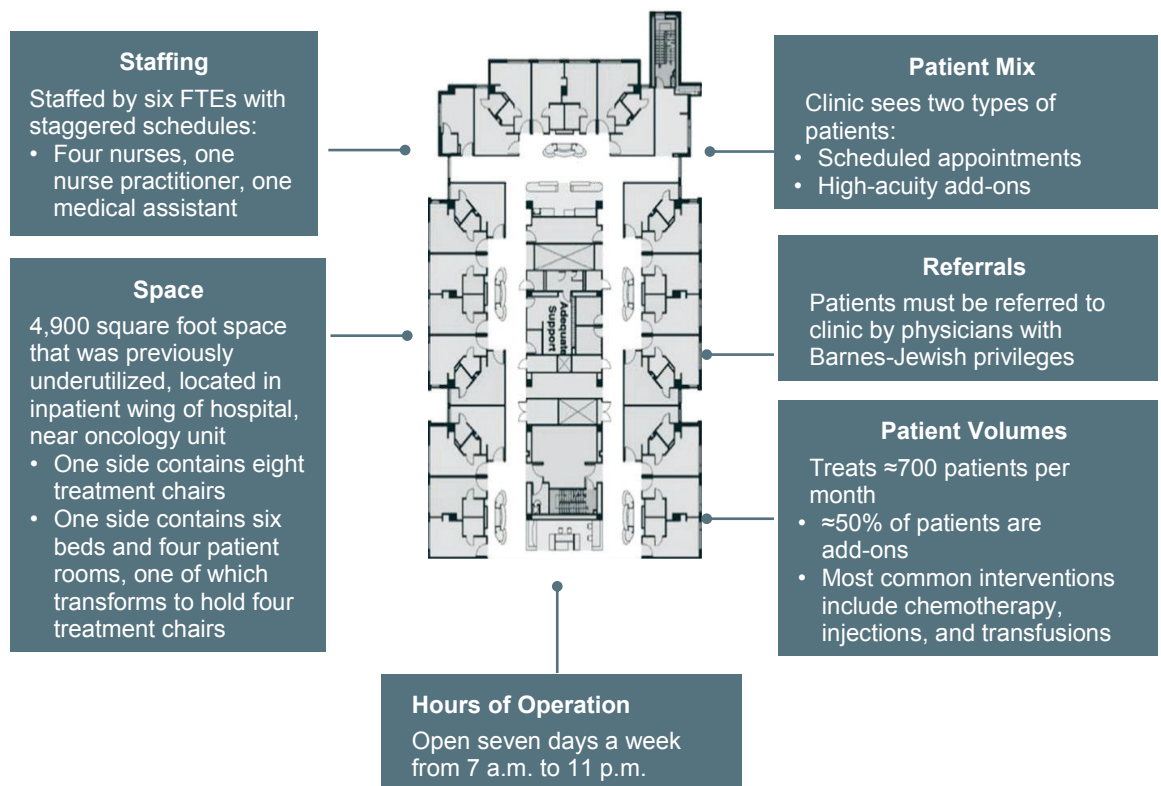
Siteman cancer patients directed to local community EDs over the course of one year

Barnes-Jewish Siteman Cancer Center converts existing space into dedicated urgent care facility

Space constraints and the implications for care quality led Siteman to create a dedicated urgent cancer care facility. Details of the new facility are laid out on the next page. Two key facets to the build should be noted:

1. Siteman did not build a new facility from scratch. The Siteman Cancer Care Clinic, as the dedicated facility is called, was retooled from existing inpatient space that was underutilized. Programs considering such an approach should assess the possibility of repurposing existing underutilized space.
2. The facility is flexible enough to accommodate patients with urgent care needs as well as routine patients needing infusions. During times of peak demand for urgent care, the facility is dedicated to those patients. But when the regular cancer center is overwhelmed, the facility can accommodate overflow patients. Again, programs considering such an approach should consider how urgent care facilities might provide an extra return on investment by providing additional space for regular patients.

Siteman Cancer Care Clinic

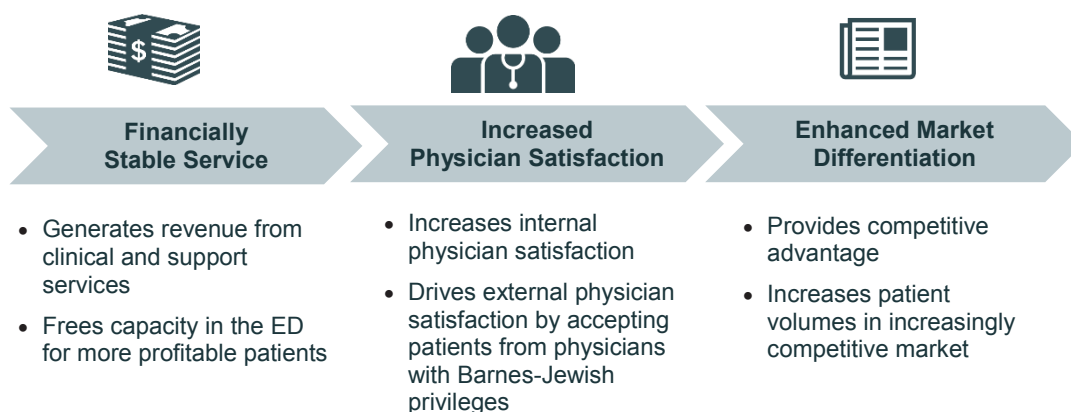


Siteman Cancer Care Clinic results

Since it was established in 2010, the cancer care clinic has been an enormous success. The clinic generates enough revenue to cover its costs, while also improving the revenue of the system as a whole. Because cancer patients with relatively minor symptoms no longer crowd the Barnes-Jewish ED, the ED is free to see higher acuity patients with more lucrative conditions. Perhaps more importantly, cancer program leaders at Siteman highlight that their urgent care clinic has helped differentiate their program in an increasingly competitive market.

From a patient care quality standpoint, the clinic is also a success. Physicians appreciate that their patients can go to the clinic where they can see oncology-trained physicians rather than going to the ED. Patients also benefit from access to oncology support services. The urgent care clinic maintains an information center that provides visiting patients with educational resources on symptom management, psychosocial distress, and local community support resources, helping them better manage their symptoms for the duration of their cancer care.

Benefits to Siteman Cancer Center



Case in Brief: Barnes-Jewish Siteman Cancer Center

- NCI-designated comprehensive cancer center based in St. Louis, Missouri
- High utilization of the ED by cancer patients prompted cancer center to develop a clinic to manage urgent patient symptoms
- Siteman Cancer Care Clinic staffed by four RNs, one nurse practitioner, and one medical assistant; schedules staggered to cover the 16-hour operation
- Cancer Care Clinic is a financially viable entity that has provided market differentiation for the cancer center, increased physician satisfaction, enhanced quality of care, and improved patient education

Comprehensive approach yields real reductions in utilization

Patients receiving care at the Baylor Charles A. Sammons Cancer Center also benefit from access to dedicated urgent care facilities, reducing both their wait for urgent care as well as their hospitalization rate. Several years ago, Baylor University Medical Center at Dallas (BUMC), and Texas Oncology, a large statewide private oncology practice, established two independent cancer care clinics that function cooperatively within the Baylor Charles A. Sammons Cancer Center.

- The first, **The Oncology Evaluation and Treatment Center (OETC)** sees scheduled patients for diagnostic and therapeutic procedures during the day, and provides urgent care after hours.
- The second, an **Infusion Center**, provides patients with 24/7 access to blood transfusions, hydration, and chemotherapy to treat urgent symptoms and minimize interruptions in treatment when the cancer center and physician offices are closed.

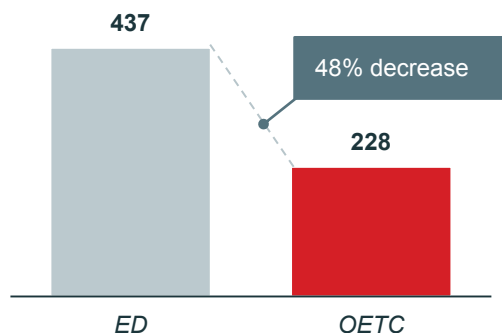
Since these facilities opened in April 2012, 90% of Baylor oncology patients who needed urgent care were referred to the OETC rather than the ED, and data shows that they receive significantly higher quality care.

Doing the Math:
Savings
Generated by
Using the OETC

\$4.5M

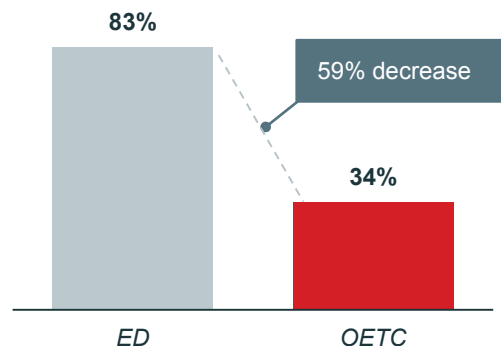
Average Oncology Patient Time Spent at Baylor Facilities

Minutes, April-December 2012



Average Oncology Patient Admission Rate at Baylor Facilities

April-December 2012



Oncology patients treated in the OETC spend 48% less time from check-in through treatment than oncology patients treated within the ED. Remarkably, as shown above, only 34% of cancer patients treated in the OETC are hospitalized compared to 83% of cancer patients who receive care in the ED.

These improvements in wait time and admission rate confer enormous savings on the health system as a whole. Between April and December of last year, 423 patients received urgent care in the OETC; 144 of these patients were admitted. If those 423 patients had gone to the ED, on average 351 would have been admitted. If the average cost of an inpatient event is \$22,000, this translates to \$4.5 million in savings. This is a huge cost savings to the health care system and positions Baylor well in a risk-based payment model.

Proactive communication, integration of care are keys to success

Huntsman Acute Care Clinic fits into multidisciplinary care model

In many cases, physicians may be hesitant to send their patients to a dedicated urgent care center, preferring to see patients themselves. To address these concerns, the Huntsman Acute Care Clinic, an urgent cancer care center in Utah, has created a standardized process to ensure that they are coordinating any urgent care with their patients' regular care teams. When patients arrive at the Acute Care Clinic with urgent symptoms, providers follow three steps.



1. Clinicians **consult the EMR** to learn about the patients specific case and current treatment



2. Clinicians **call the patient's oncologist** to ensure that urgent care does not interfere with the patient's regular care plan and that oncologist treatment preferences are respected



3. Within 12 hours of a patient visit, the Acute Care Clinic **emails the entire cancer care team** with a report on the patient's visit

To further encourage familiarity between the providers in the Acute Care Clinic and the providers in the cancer center, clinic clinicians also round in the cancer center.



Case in Brief: Huntsman Cancer Institute

- NCI-designated cancer center based in Salt Lake City, Utah
- Acute Care Clinic provides scheduled, same-day urgent care to oncology patients during normal operating hours
- Clinic treats an average of eight high-acuity patients per day, all of whom are referred by Huntsman physicians or nurses
- Clinic staffed by 1.5 physician FTEs, 2 RNs, one medical assistant, and one administrative assistant
- Acute Care Clinic team has successfully integrated itself into the Huntsman Cancer Institute's multidisciplinary model of care

Key Takeaways

Inadequate symptom management processes lead to suboptimal patient outcomes, excess costs, and patient and family dissatisfaction. Cancer programs can improve care quality, reduce avoidable costs, and even gain market advantage by implementing systems that provide patients who have urgent symptoms with timely access to specialized outpatient care. To help your program implement the tactics presented in this publication, we have put together three key takeaways:

1. **Best-in-class cancer programs use standardized phone triage protocols to reduce ED visits and hospitalizations**

Leading cancer programs use phone triage not only to address patients' questions and concerns in a timely way, but also to reduce ED visits and hospitalizations, which ultimately improves outcomes and lowers costs. The success of these programs is due to: having sufficient staff available to answer calls throughout the day; equipping staff with tools, including evidence-based protocols, to manage patients' needs in the moment; empowering staff to act independent of physicians; and regularly encouraging patients and families to use the phone triage system.

2. **Successful cancer programs use a data-driven approach to align scheduling and staffing to demand for urgent care**

Successful cancer programs collect and analyze retrospective data on patients' urgent symptom needs to ensure that clinician schedules are aligned to support demand for urgent care. This ultimately maximizes utilization of existing resources, improves access to urgent care for cancer patients, and reduces ED visits and hospitalizations. Some cancer programs, reaching the limits of their existing capacity, are also using this retrospective data to quantify, and justify, the business case for hiring new APPs.

3. **Cancer programs can increase capacity for urgent patients by encouraging greater physician utilization of APPs.**

Cancer programs can encourage greater physician utilization of APPs, thereby increasing capacity for urgent patients, by fostering more collaborative APP-physician relationships. To foster this collaboration, best-in-class programs: educate physicians about the skills and scope of practice of their APPs, formalize a process to identify where APPs are most needed, and may even tie physician incentives to APP utilization.

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