ACCC's Educational Project: Transitions Between Care

In 2010 the Association of Community Cancer Centers (ACCC) initiated the *Transitions Between Care Settings* educational project to study the issue of care transition between the hospital cancer program and the oncology physician practice care settings. For this project, ACCC contracted with Health2 Resources to provide strategic advisory services and analysis. This two-phase project examined three key components of the care transition:

1. Adequacy and completeness of the medical record
2. Continuity of drug therapy (medication reconciliation)
3. Communication among providers—both internally (within their own programs) and externally (between the two care settings).

During Phase 1, an ACCC Advisory Committee (see box at right) worked with Health2 Resources, a healthcare consulting firm, to develop two online surveys: one for hospital cancer programs and one for oncology groups (outpatient or physician office-based). The survey instruments and project final report are available on ACCC's members-only section at: *www.accc-cancer.org*.

Key Findings

The surveys revealed that some community cancer programs are handling the complex tasks of transitioning patients between care settings well. Survey responses demonstrate a variety of exemplary transition activities at some respondent programs. Survey results also reflect substantial progress in recent years in introducing EHR (electronic health record) and CPOE (computerized physician order entry) systems into hospitals and oncology practices. Those systems have greatly improved medication reconciliation and the ability of community oncologists to access appropriate medical records pertaining to their recently hospitalized patients.

Despite advances, the survey findings also revealed room for further improvement in developing specific processes and policies to manage the cancer patient's transition between care settings. On the hospital side, key findings include:

- Few hospitals reported monitoring readmissions or follow up with their discharged patients.
- Oncology-specific transition policies are largely nonexistent (3 percent of surveyed hospitals have one). Transition checklists are rare (15 percent of surveyed hospitals manage the transition with a checklist).
- Some organizations have transition programs in place; however, few use survey and measurement tools to analyze those processes for quality improvement.

On the practice side, the survey found that:

- Less than half of respondents report that the practice oncologist is "almost always" notified by the hospital when his or her patient is admitted by another physician. About 60 percent of the responding oncology groups take proactive steps to determine whether their patients have been admitted (by checking the electronic health record or the hospital lists).
- About half of the responding oncology groups have designated staff (clinical or administrative) to manage the patient transition after hospital discharge. Most (more than 60 percent) follow up on or make the post-discharge office appointment. However, few oncology groups have implemented specific policies or checklists to help manage the patient transition.
- Despite having CPOE systems, most groups performed fewer than half of the 11 medication reconciliation activities identified through the survey questions, suggesting that certain capabilities within CPOE systems are not being used, or do not yet have full linkages to the hospital systems.
- Almost all oncology groups obtain the hospital medical records and discharge summaries, and place that information in the patient's office chart, but only about one in four groups had a nurse or other clinician review and flag the records for special attention by the oncologist.

For Phase 2 of the project, nine cancer programs and oncology practices were identified as having exemplary practices related to patient transition activities. These programs participated in in-depth interviews about transition activities. In the following pages, these programs discuss key transition activities and share sample tools, policies, and procedures. The *Transitions Between Care Settings* final report groups major challenges into three categories: market challenges, operational challenges, and accountability challenges.

Market Challenge: A Competitive Environment

Hospitals compete with each other for patients, as do physicians, and sometimes the competition can impede good communication during the patient transition. Another market factor is the increased use of hospitalists, and potential care management issues between the oncologist and the hospitalist. While both providers co-manage the hospital experience, some patient management issues and disagreements were identified by the surveys. To meet this challenge, hospitalists and oncology group practices need to reach agreement on co-management and on how to maintain effective working relationships when hospitalist turnover occurs. On page 20, discover how Columbia Basin Hematology & Oncology has developed innovative

policies and procedures to ensure a collaborative working relationship with three hospitals.

Market Challenge: Costs and Reimbursement
Dedicated staff that follow standardized procedures along a continuum of care is an important component of effectively managing the patient transition between care settings. However, the cost of managing the patient transition is not built into the reimbursement structure. Affording the dedicated staff to help manage the transition is often a challenge. On page 46, Quincy Medical Group shares how the practice has benefited—both in billing efficiencies and patient satisfaction—from employing a financial counselor and a patient navigator. North Colorado Medical Center's (page 39) patient navigator uses a comprehensive checklist to assess the patient's financial, social, transportation, and clinical needs, and then contacts the community resources to help meet these needs. A follow-up phone call within 48 hours of discharge by clinical staff is designed to capture any remaining issues the patient may have.

Operational Challenge: Software
While nearly all hospitals and oncology groups that participated in this educational project have EHRs, these systems present several challenges for patient transition that include: 1) issues with system interoperability and standardization, 2) hospital EHR systems without oncology components that are useful, and 3) full capability use of EHR systems by hospital and group staff and physicians. Common problems include:

- ***Issues with electronic transfer of usable data between the hospital and the oncology group EHR systems.***
- ***Limited integration of data between systems.*** This limitation may lead to incomplete transfer of all information in the medical record. On page 24, Comprehensive Cancer & Hematology Specialists shares how the practice is building its own EHR system, bringing information systems with various strengths and capabilities together. For a different perspective, read how leadership at the Goldschmidt Cancer Center (page 30) chose to implement a single comprehensive, oncology-focused EHR.
- ***Hospital EHRs rarely include an oncology component.*** Even when oncology components do exist, they often receive poor ratings from the clinical staff, which may limit their use of the EHR's functional components. ***EHR technology and software are complex and still evolving.*** As a result, clinical staff members may not understand how to fully use the system. This may lead to less than full use of all functionalities.

Operational Challenge: Medication Reconciliation
Survey responses show that most hospitals and medical groups have fairly effective medication reconciliation procedures in place. One challenge is the area of home drugs (medications the patient is taking at the time of entry into the hospital or community practice). Almost all hospitals attempt to identify those drugs, but most rely on the patient or a family member for this information, i.e., what the drugs are, dosages, and prescribed use. The study found that while systems for electronically searching prescription drug databases and for integrating a broad range of drug information across both inpatient and outpatient systems are just becoming available, they are not yet in widespread use, and taking the time to call the patient's physician or pharmacist is not always part of the protocol. The challenge is to take the extra confirmatory step when it is needed.

Read about solutions and tools to address medication reconciliation challenges developed by Holy Family Memorial (page 32), the John B. Amos Cancer Center (page 35), and Providence Oncology and Hematology Care Clinic-Westside (page 44).

Operational Challenge: Measuring Performance
ACCC's survey found that very few hospitals or practices are measuring how well their patient transition process is working. Measurement of 30-day readmission rates or follow-up phone calls to systematically determine transition problems are not often part of the transition process. A challenge, then, is for organizations to upgrade and expand their post-care surveys and analysis of those surveys to address the patient's transition experience. Learn how Geisinger Cancer Institute (page 28) has focused on measurement and evaluation of its processes.

Accountability Challenge: The Patient at Home
As the patient is discharged, a wide range of follow-up care scenarios must be addressed and managed during the transition. ACCC's project focused on the first post-discharge outpatient oncology visit as a key transition event; however, several open-ended questions in the surveys revealed challenges inherent in identifying and obtaining services for the full range of the cancer patient's needs. Geisinger Cancer Institute provides an example of how, as part of the larger Geisinger Health System, case management is coordinated post-discharge.

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