Patient and Family Focused Transitional Care

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In 2010 and 2011, the ambulatory programs at Simmons Cancer Center, Dallas, Texas, experienced a double digit increase in new patient appointments. During the same period, the inpatient unit average daily census grew from 4 to 15+ patients. Because of this growth, Simmons Cancer Center evaluated its program and determined that it was not providing comprehensive seamless care across oncology treatment settings. These findings provided the cancer center with an opportunity to develop a transitional care program to better meet the needs of its patients and families. Coordinating care across healthcare settings involved multiple components of collaboration and communication with the goal of creating a seamless process for the patients and their families.

Gap Analysis

The process of building the transitional care team started with a gap analysis of patient hospital stays, with particular emphasis on the discharge process, care coordination, psychosocial needs, and transitions from the inpatient to outpatient care settings. The gap analysis included an assessment

of 62 patients over a three-month period.

The assessment process consisted of telephone interviews with patients after discharge from the inpatient oncology unit. An oncology-certified clinical social worker completed all interviews. The goal of the interviews was to collect data about the strengths and weaknesses of the existing model of patient care with particular attention to patient satisfaction, readiness for discharge, communication among professionals, and psychosocial needs. Through this interview methodology Simmons Cancer Center identified the following gaps in care:

- Discharge planning was reactive versus proactive.
- Supportive counseling during inpatient stay was absent.
- Referrals to oncology-specific community resources were limited.
- Education of disease process and clarification of care plan was limited.
- Communication and collaboration between care providers was inconsistent.
- Follow-up clinic appointments were inconsistently scheduled prior to discharge.
- Emotional needs were not adequately evaluated or addressed.
- Expensive discharge medication was not being preauthorized.

Simmons Cancer Center staff was informally interviewed and through this set of interviews the following additional gaps in care were identified:

- The outpatient medical teams were often unaware of the discharge plan until after it was executed and the patient showed up for his or her outpatient appointment.
- The outpatient medical team was often unaware of medical equipment that was set up, changes in the patient's status, the increased role of the patient's caregiver, or if an admission to skilled nursing facilities or rehabilitation centers occurred.
- Patients' medications were not being preauthorized, and patients often left the hospital with expensive drug prescriptions that they were unable to fill.
- The psychological and emotional needs of patients were not adequately evaluated or addressed.

Once patients and staff identified these issues, Simmons Cancer Center had the opportunity to build a transitional care team that would address these gaps in care.

Defining Transitional Care

The National Cancer Institute (NCI) defines transitional care as:[1]

> *Support given to patients when they move from one phase of treatment to another, such as from hospital care to ambulatory care. It involves helping patients and families with medical, practical, and emotional needs as they adjust to different levels and goals of care.*

The process of planning for these transitions is frequently referred to as discharge planning because it implies a release from one facility to another. To ensure successful discharges, however, transitions of care must occur through an integrated, seamless relationship between the inpatient and outpatient care teams.[2]

Transitional care planning helps the patient and family:

- Address medical, practical, and emotional issues that arise as they adjust to different levels and goals of care
- Make decisions that balance disease status and treatment options with family needs, finances, employment, spiritual or religious beliefs, and quality of life
- Identify and manage medical, practical, and emotional issues to prevent an interruption of care.

Peikes and colleagues recognized the need for a multidisciplinary team who would provide both healthcare and social support interventions.[2] This need is particularly true for oncology patients, many of whom are in the middle of treatment when admitted to the hospital. An acute episode can lead to delays or cessation of treatment, often resulting in less optimal medical outcomes, as well as emotional distress for

OUR PROGRAM AT-A-GLANCE

In 1988 Harold C. Simmons and his wife Annette, through a generous endowment, made provision for the Harold C. Simmons Cancer Center and Clinics, part of the University of Texas Southwestern (UT Southwestern) Medical Center. UT Southwestern consolidated in January 2005, and now consists of two hospitals, University Hospital Zale Lipshy, University Hospital St. Paul, and outpatient ambulatory clinics that provide comprehensive patient care to Dallas and surrounding areas. The Simmons Cancer Center sees nearly 3,000 analytic patients per year and has comprehensive cancer treatment programs in the following 10 areas: brain and spinal cord, breast, gastrointestinal, gynecological, head and neck, lung, hematological (including BMT) melanoma, sarcoma, and urologic. In addition to medical care, we offer a full complement of support services, including nutrition, clinical social work, psychology, and integrative therapies to enhance each medical treatment program. In 2010 Simmons Cancer Center was granted NCI cancer center designation; the entire program is working to achieve comprehensive cancer center designation.

both the patient and family. Building the care plan with the patient and family at the center is of upmost importance. The integration of the biopsychosocial assessment and medical assessment is necessary and must be the foundation for all successful transitional care plans.

Our Program Goals

The goal for Simmons Cancer Center's transitional care program is to implement NCI's vision for transitional care in order to reduce readmissions and expenditures, while improving quality, safety, and patient satisfaction. More specifically, Simmons Cancer Center set out to develop a transitional care program in which the patient and family would be supported regardless of location within the cancer program. The cancer center focused on four initial goals:

1. Develop a program that supports patients and their families as they transition from one treatment setting to another within the cancer program.
2. Focus on collaboration and communication across the treatment settings to create a perception of seamless transitions for patients and their families.
3. Ensure that patient data is communicated between settings in an accurate and timely manner.
4. Ensure that all of the needs of our patients and their families are addressed, including social, emotional, and spiritual needs.

Our Guiding Principle & Primary Focus

Focus on the patient and family first is the guiding principle at Simmons Cancer Center (see Figure 1, at right). Patients and their families are placed at the center of the decision-making process of the healthcare team. Regardless of the care setting, the healthcare team is responsible for:

- Supporting the patient and family as they transition from one setting to another
- Collaborating and communicating across settings
- Meeting the "whole patient" and family needs.

Simmons Cancer Center focused its transitional care program on the inpatient unit from the point of admission through a comprehensive hand-off to the next treatment setting. The transitional care team guides the patient and family through a myriad of issues, including:

- Insurance coverage
- Medication regimes
- Multiple consulting physicians
- Home health care needs
- Emotional adjustment
- Establishment of follow-up appointments prior to discharge.

In this way the team can help patients make the most informed choices possible in regard to their transitions in care and care settings.

How We Did It

Here's how Simmons Cancer Center closed the gaps in care and met the goals of its transitional care program.

The development of the program began with educating the inpatient nursing staff on the patient and family-focused model of transitional care. This education was conducted by members of the Simmons Cancer Center administration, oncology social work, and the nurse manager of the inpatient oncology unit. Transitional care planning committee members took the concept to the Unit-Based Council where we presented the gap analysis and discussed the transitional care program. Oncology staff nurses met with the oncology program's administrative leadership to provide support, feedback, guidance, and insight for each step of the process.

To put the plan in place, Simmons Cancer Center administration created a transitional care team comprised of a clinical oncology social worker and a physician assistant. This team works in partnership with the inpatient nursing team and the UT Southwestern (UTSW) inpatient nursing team, oncology residents, fellows, and attending physicians. The clinical oncology social worker, designated as the transitional care coordinator, is responsible for the biopsychosocial assessment for each oncology admission. This assessment is used to evaluate a patient's:

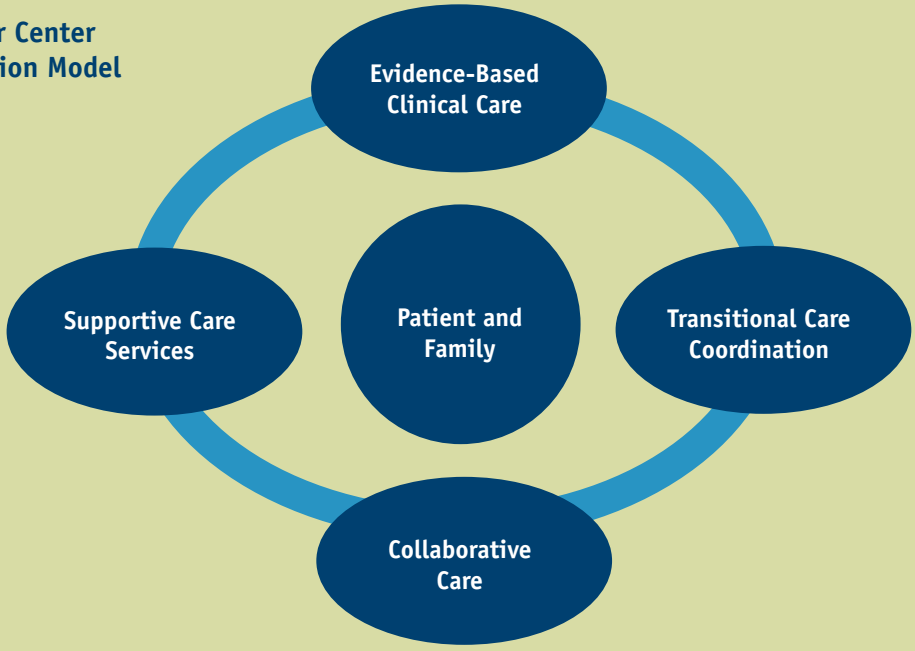
- Emotional and psychiatric distress
- Adjustment to illness, grief, and/or end-of-life concerns
- Existing support systems
- Financial issues
- Home care planning.

The transitional care coordinator also provides supportive counseling to patients and their families relevant to oncology issues.

The physician assistant works closely with both the inpatient and outpatient physician teams, acting as a liaison to ensure the comprehensive oncology treatment plan is delivered with accuracy. The physician assistant ensures that outpatient clinic appointments are made before discharge from the inpatient setting and that the family is involved in all decision making. Clinical handoff to the outpatient setting is a vital component of continuity of care and seamless transition between care settings.

The transitional care team meets with oncology residents, fellows, and attending physicians daily. During these meetings patient issues are discussed with the intent to identify and manage medical, practical, and emotional issues that may prevent or interrupt care. In addition, these meetings allow the treatment team to make decisions that balance disease status and treatment options with family needs, finances, employment, spiritual or religious beliefs, and quality of life. The oncology clinical social worker also works closely with the UTSW case management team to ensure a proactive approach to discharge planning.

Figure 1. Simmons Cancer Center Transition Care Coordination Model



Evaluating Our Program

Simmons Cancer Center used the following two Press Ganey questions to help evaluate its transitional care coordination program:

1. Overall rating of care given.
2. Staff worked together to care for you.

For question 1, the inpatient unit was given a mean score of 56.0 (n=25) for the second quarter of 2010. This mean score improved to 100.0 (n=3) in the fourth quarter of 2011. Given the low N for this mean score of 100.0, we looked at the third quarter score which was 80.6 (n=36). The general trend from second quarter 2010 to fourth quarter 2011 demonstrates an upward track in assessments of care quality.

For question 2, the inpatient unit was given a mean score of 53.8 (n=26) for the second quarter of 2010. This mean score also improved to 100.0 (n=3) in the fourth quarter of 2011. Given the low N for this mean score of 100.0, we looked at the third quarter score which was 75.0 (n=36). The general trend from second quarter 2010 to fourth quarter 2011 demonstrates an upward track in assessments of care coordination.

In the process of developing a transitional care program at Simmons Cancer Center, the team learned several lessons that could benefit community cancer centers looking to develop a similar program:

1. Development of a transitional care coordination program requires administrative support and, at Simmons Cancer Center, additional staff. The additional staff was justified in order to maintain our focus on patient- and family-centered care. In addition, the increase in staff allowed us to meet the goals of increased patient satisfaction, decreased length of stay, and cost containment. Although all transitional care services are not billable, the added attention to care coordination supports a decrease in length of stay and cost containment, which offsets the expense of additional staff.
2. Program success requires a multidisciplinary approach that includes: gap analysis, staff input, staff training, and staff support.
3. Multidisciplinary communication and the development of adequate communication systems across cancer treatment settings are primary components of success.
4. Program evaluation must include multiple assessment points and an ability to modify the program based on the assessment data. OI

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