Transitions Between Care Settings

An education program from
ACCC's Center for Provider Education

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The Center for Provider Education ACCC

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The Association of Community Cancer Centers (ACCC) with an interdisciplinary membership of17,000 oncology professionals from approximately 900 hospitals and more than 1,200 practices nationwide

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"Given the complexities of modern cancer treatment, it is more important now than ever before that hospitals and physician practices work together to improve care by ensuring adequate patient transition between the two care settings."

Christian Downs, JD
Executive Director, ACCC

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Project Goals:

- To understand the challenges involved in transitioning cancer patients between inpatient hospital setting and oncology practice care settings;
- To identify effective practices for ensuring a smooth transition between the two care settings; and
- To provide educational materials and disseminate findings.

Project Looked at 3 Key Components of the Patient Transition

- Adequacy and completeness of the medical record
- Continuity of drug therapy (medication reconciliation)
- Communication among providers—both internally (within programs) and externally (between two settings of care)

Two-Phase Project

- Phase 1: An interdisciplinary ACCC Advisory Committee worked with Health2 Resources to develop two online survey instruments (one for hospitals; one for oncology practices).
- Findings were organized into 3 categories:

  1) patient transition management activities

  2) medication reconciliation activities

  3) transmission of discharge summaries and medical records data for patient transition
- Phase 2: Nine cancer programs (hospitals and practices) were identified as having exemplary practices relating to some key patient transition activities.

Phase 2 (continued):

- In-depth interviews were conducted with the nine programs and case studies, highlighting specific transition activities, were developed.
- Programs shared details of some transition activities; some provided sample tools and transition policies.
- ACCC's Transitions Project featured in May/June 2011 *Oncology Issues.*

Survey Key Findings

- Some community cancer programs handling transition of patients well
  - Respondents report a variety of transition activities at some programs
  - Substantial progress in EHR implementation and CPOE (computerized physician order entry) systems
  - EHR and CPOE have improved medication reconciliation and access to medical records
- Still a great deal of room for improvement, survey revealed that
  - Only 35% of hospitals respondents can transmit EHR data to independent oncology groups
  - Only 32% automatically forward discharge summary to independent groups

Survey Key Findings (continued)

Most hospitals and practices have fairly effective medication reconciliation procedures in place.

- Almost all hospitals attempt to determine which drugs patient is taking at time of entry into the hospital, but most rely on having patient or family member tell them drugs, dosages, and prescribed use.
- Challenge is to make confirmatory call to patient's physician or pharmacist when needed.

Key Findings—Hospitals

- Oncology-specific transition policies rare (3%).

  About 85% of responding hospitals have a function (or team) assigned to manage oncology patient transitions between care settings. However, only 50% of hospitals have a written policy managing general patient's transition, and just 3% have oncology-specific transition policies.
- Transition checklists also rare (15%).
- Almost 90% of responding hospitals have CPOE system, but operationalization of those systems for oncology patient transition is far from complete.
- Few hospitals reported monitoring readmissions or follow-up with their discharged patients:
  - 30% conduct follow-up telephone survey
  - 17% monitor readmissions.
- Of those with transition programs in place, few use survey and measurement tools to analyze those processes for quality improvement.

Key Findings—Practices

- Less than half of respondents report that oncologist is “almost always” notified by the hospital if patient is admitted by another physician.
- About half of respondent practices have designated staff to manage patient transition after hospital discharge. However, few practices have specific policies or checklists to help manage patient transition.
- Medication reconciliation activities seem fairly advanced. About 3 in 4 oncology groups have a CPOE system. But survey results suggest that certain capabilities within CPOE systems are not being used or do not yet have full linkages to hospital systems.
- Oncology groups’ in-house EHR systems did not appear to have strong capabilities (or operationalized uses) that tied in to the patient transition.
- Management of patient transition depends primarily on EHR systems in place at the hospital, and to a lesser extent on complementary EHR systems used by oncologists at their

Key Findings—Hospitals & Practices

The patient is moving between two important settings of care, i.e., the hospital inpatient setting and the outpatient oncology care setting, that are generally operated by two separate organizations, often without common information systems, and sometimes with only limited shared information. EHR challenges include:

- Transfer of data between systems
- Issues with system interoperability
- Systems without useful oncology components

Select Exemplary Transition Activities—Hospital

- Written policy covering post-discharge patient transition.
- Attempt at admission to notify oncologist: formal process (cancer as primary diagnosis).
- Attempt at admission to notify oncology: formal process (cancer as secondary diagnosis).
- Clinical staff assigned to patient transition management function.
- Procedural checklist used to ensure proper handoff to oncology group.
- Discharge team member makes follow-up oncology appointment for patient.

Exemplary Transition Activities: Oncology Physician Groups

- Group always notified by hospital of cancer admission by systematic process.
- Group always notified of cancer patient admission by hospital even when cancer is not primary diagnosis.
- Proactive steps taken (by group or oncologist) to ensure oncologist is aware of patients that may have been admitted.
- Discharge transition team or discharge planner typically makes follow-up outpatient oncology appointment.
- Procedural checklist used by member of group's clinical staff to ensure proper patient transition and handoff.
- RN or LPN flags important information received from hospital about patient's hospital experience and treatment plan.

Measuring Performance

- Survey indicates that few performance measures focus specifically on patient transition.
- Follow-up surveys by hospitals typically cover the hospital experience itself and not the transition.
- Measurement of 30-day readmissions rates are not often part of the transition process.
- Key challenge is for organizations to upgrade and expand post-care surveys and analysis of survey to address patient's transition experience.

Select Case Examples

- Geisinger Cancer Institute
- Capital Region Medical Center, Goldschmidt Cancer Center
- Holy Family Memorial
- John B. Amos Cancer Center
- North Colorado Medical Center
- Quincy Medical Group

Geisinger Cancer Institute

- *Danville, PA*
- Comprehensive EHR used across multiple hospitals and 60 system-owned practices
- Multidisciplinary model: PAs in inpatient setting like residents in teaching hospital; oncology pharmacists round with MDs
- Inpatient nurse navigators, social workers work to manage transitions including ensuring equipment is ready at home
  - Select patients visited in home post-discharge
- Nurse navigators conduct patient education for chemotherapy
- Measurement includes 30-day readmission rate and palliative care consults; goal to reduce readmissions by 10% by using checklists

Capital Region Medical Center, Goldschmidt Cancer Center

- *Jefferson City, MO*
- Comprehensive EHR
- Information is fluid across entire cancer service and all equipment
- Safety and quality reporting components include drug toxicity reports, medication reconciliation, and drug interactions
- E-prescribing
- Cancer Center can view inpatient records and hospital ER can view Cancer Center records
- EHR supports face-to-face and telephone elements

Holy Family Memorial

- *Manitowoc, WI*
- Medication Quality Team focused on medication reconciliation
- System-wide EHR enhances continuity
- Patients asked to bring meds with them on first visit to cancer center
- RN face-to-face review of meds
- Medication checklist, includes when last dose taken
- Conflicts between lists and patient report are reconciled with call to pharmacy
- Medication lists shared during handoffs between treatment sites

John B. Amos Cancer Center

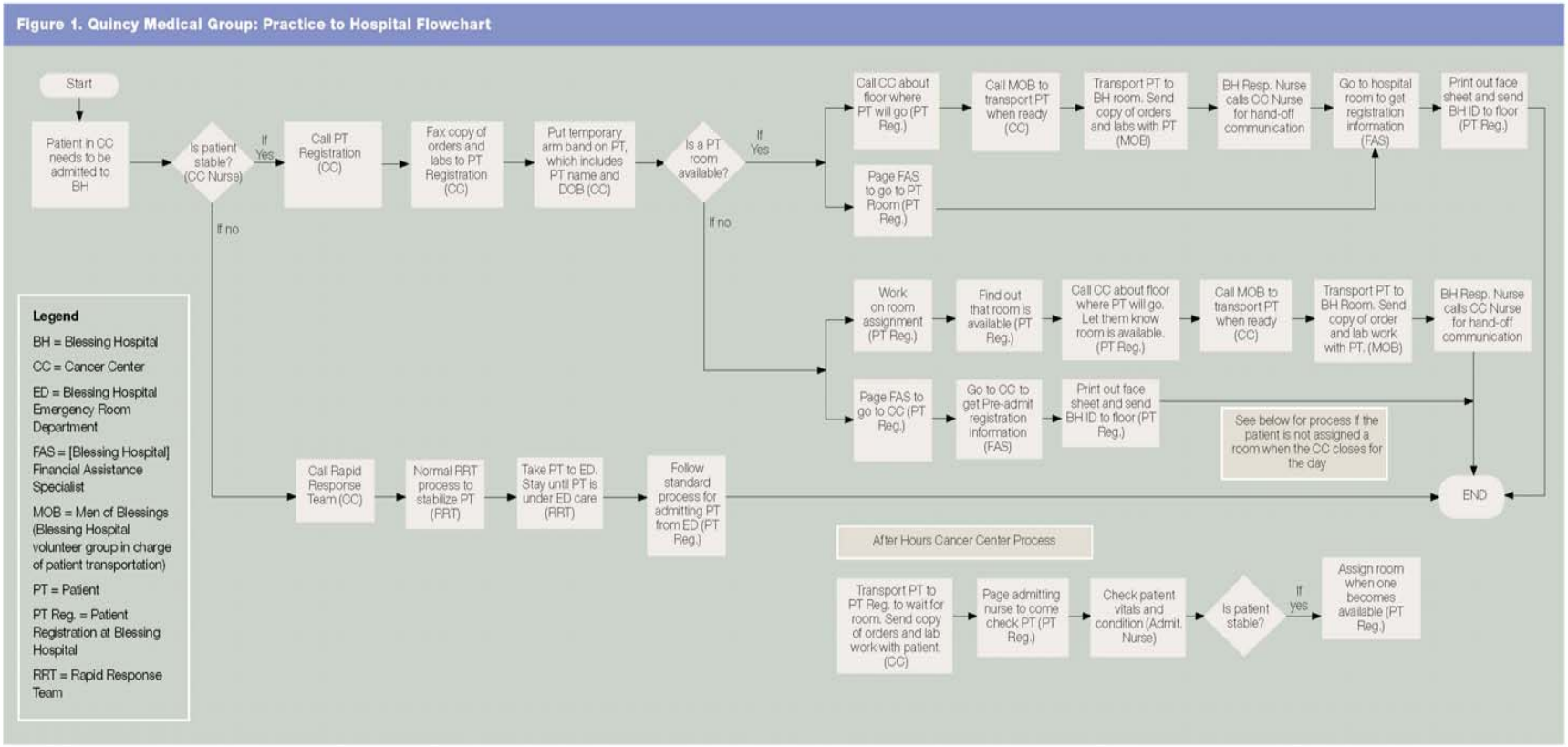
- *Columbus, GA*
- When patients are discharged from The Medical Center, cancer center staff contacts patients and mails an admissions packet *before* first appointment
- Medication reconciliation checklist completed at first appointment
  - Cancer center calls pharmacy over any discrepancies
- The Medical Center developed an electronic handoff tool for inpatients
  - Used in transition from department to department, floor to floor, and even shift to shift
  - Patient receives copy of tool at discharge
  - Cancer Center can view handoff tool through EHR
- John B. Amos Cancer Center also a pilot site for ACCC Cancer Care Patient Navigation project

North Colorado Medical Center

- *Greeley, CO*
- Part of Banner Health
- Following relationship-based care model, inpatient nursing staff take active role in patient care
- Key elements: patient education, patient navigation, and post-discharge follow-up
- Before patients discharged, given education packet tailored to their care plan
- Patient Navigation Program with worksheet
- Within 48 hours of discharge, clinical staff calls patient to inquire on status and answer questions
- Patients given journal to track progress

Quincy Medical Group

- *Quincy, IL*



Resources

ACCC website: http://www.accc-cancer.org/education/education-transitions.asp

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Resources

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Questions?

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