

Vol. 2, No. 2, April 2015

JOURNAL of MANAGED CARE NURSING

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ISSN: 2374-359X. The Journal of Managed Care Nursing is published by AAMCN. Corporate and Circulation offices: 4435 Waterfront Drive, Suite 101, Glen Allen, VA 23060; Tel (804) 747-9698; Fax (804) 747-5316. Advertising Offices: April Snyder, 4435 Waterfront Drive, Suite 101, Glen Allen, VA 23060 asnyder@aamcn.org; Tel (804) 747-9698. All rights reserved. Copyright 2014. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage or retrieval system, without written consent from the publisher. The publisher does not guarantee, either expressly or by implication, the factual accuracy of the articles and descriptions herein, nor does the publisher guarantee the accuracy of any views or opinions offered by the authors of said articles or descriptions.

Journal of Managed Care Nursing

The Official Journal of the
AMERICAN ASSOCIATION OF MANAGED CARE NURSES

A Peer-Reviewed Publication

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Is There a Financial Benefit to Utilizing RNs for your Care Coordinator/Manager Within your Practice?

Written by: Sheryl A. Riley, RN, OCN, CMCN, Edited by: Cortney C. Riley, DPT

Recently the health care market has begun to redefine or change the qualifications of the care coordinator/manager. This redefinition is not being driven by the new care models, service changes or qualifications. Simply put, it is due to financial reimbursement, government regulation and subsidies.

For the first time in years, the clinical delivery models are moving in the right direction. They are focused on patient centered care, including the family or caregivers as well as education and wellness. Another benefit of the new models is the support of a strong physician-patient relationship which is strategic to driving patients and their families toward self-care and wellness.

Consequently, with all of the focus on the patients, wellness, education and community-based medicine, why would physicians' practices move away from utilizing Registered Nurses (RN) and transition to non-clinical or Social Worker (SW) as their care coordinator/manager for their patients? More than likely, it is due to the cost difference between a registered nurse and a social worker and/or non-health care personnel.

Social workers and non-clinical staff are vital members of the care coordination/management team and serve a significant function; however neither of them can fulfill the responsibilities or have the training and knowledge level of a highly qualified registered nurse. Nor are they qualified to educate the patient on evidenced-based medicine, medication adherence drug interactions and side effects, preventative medicine, exercise, nutrition and urgent or emergency care.

The government continues to cut the physician reimbursement yearly but conversely increases the requirements and regulations. In the past three to five years the government has poured billions of dollars into new regulations, requirements and qualifications. The following represents a sampling of the requirements.

Examples:

- All physicians need to convert all paper records to an electronic medical record by 2015, supported by the federal government
- All billing for the Centers for Medicaid/Medicare Services (CMS) must be electronic by 2015, supported by the federal government
- Meaningful use dollars; for physicians to qualify they must meet 32 standards in regards to software, patient satisfaction and other quality metrics
- Transitions of care, care coordination and community out-reach all supported by dollars from the federal government

Due to the lack of any specific requirements in regard to how these improved quality standards are met and without guidelines recommending the use of highly trained and qualified RNs to support the model, many practices use "other" professionals or non-professionals in that role. To put it bluntly, "You get what you pay for."

The American Nurses Association (ANA) released an excellent white paper in 2012 with hard and soft data that lends credence to the idea of using RNs for the care coordinator or care manager position. Since the recent standards have forced physicians, as well as all other fields of healthcare, to be more concerned about their "bottom line", it might be prudent to compare some numbers. Social workers make between \$35 and \$65,000 yearly, depending upon the region of the county, and non-clinical personnel make

between \$20 and \$40,000 yearly.^{1,2} This may appear to be a cost saving at first, if you only consider the dollars and not the value each brings to the practice.

Conversely, highly qualified RNs with strong clinical and managed care background will cost between \$55 to \$100,000 per year depending on your location in the country and the role they are required to fulfill.³

I know at first blush it might give you sticker shock but the return on investment is great when considering that in the long run they may save you money through more effective and efficient navigation of the healthcare system for your patients. Educated and trained professionals with clinical specialties such as oncology, chronic care, diabetes, heart disease and behavioral health will cost more than a social worker or a non-professional but with good reason.

Registered nurses have skills and expertise in patient education, medication and symptom management, care management, coordination of services, and resource and care coaching. The RN can speak with the patient and family on topics the physicians may not be as comfortable with or does not have the time due to increased demands under the new system to see more patients in a short period of time. Such topics may include, medication management, weight loss, smoking cessation as well as palliative and end of life care. The RN can follow up with the member after the physician visit and explain the treatments, medications, and laboratory and screening tests. They can make follow up phone calls, hospital and home visits if warranted. They are physician extenders who communicate the physician plan of care to the patient and their family as well as continue to educate and teach them how and why they should follow the treatment plan. These nurses can then communicate all the findings to the physician via the electronic record and daily communication. Nurses as professionals are considered extremely trustworthy and patients may feel more comfortable speaking to them rather than to the physician about certain aspects of care.⁴ By connecting with the patient early in the care management process it would also decrease the amount of calls, emails and patient follow-ups the physician has to do his or herself.

In past and recent studies, Nurses continue to come out on top of all professions, as well as physicians and pharmacists, as most honest, ethical and trusted of professionals.⁴ Nurses give the patients a feeling of security and trust which improves patient compliance, satisfaction, communication with referrals and transitions to hospitals, home care and skilled nursing facilities, as well as decreasing ED visits and urgent hospitalizations.

In this new world of quality metrics, regulations and subsidies dollars directed to only the best practices, the question to ask is: Can you afford not to hire a nurse for the care coordinator/manager in your practice?

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Enhanced Transitional Care Model: A Hospital-to-Home 30 Day Pilot Program

Home Instead Senior Care

Summary

Research shows that patients may only remember half of what clinicians explain to them, so action needs to be taken to ensure that we do more than educate the patients, we must engage them in their health care. This pilot study, conducted by Home Instead Senior Care, gathers data from thirty senior patients who were diagnosed with either COPD or CHF. The purpose and goal was to improve patient outcomes and their ability to live independently, while simultaneously reducing the overall readmission cost to the local, involved hospitals.

Key Points

- Care transition refers to the shift of a patient from one care setting or professional to another.
- Seniors in the Medicare population are vulnerable to poor transitional situations.

One in five Medicare recipients discharged from the hospital today is reportedly readmitted within 30 days - often unnecessarily.¹ Eighteen percent of Medicare patients who are readmitted back into the hospital within 30 days of their discharge account for over \$15 billion in annual spending.² Medical breakthroughs and other advancements have allowed individuals with chronic illnesses to live longer, but not without exacting a huge toll on the healthcare system in the form of potentially avoidable hospital readmissions. It is not enough to educate patients for success. The time is here to move the healthcare model from patient education to patient engagement.

A care transition refers to the shift of a patient from one care setting or professional, to another. These transitions are often triggered by exacerbations of chronic illnesses. Unfortunately, frequent care transitions across multiple settings or professionals are far too common in the Medicare population. Vulnerable seniors must navigate through healthcare systems while often times receiving uncoordinated information which, in turn, often causes difficulty in finding the services they need. The coordination of a transition from hospital to home frequently falls on family caregivers who are typically insufficiently prepared to address the needs of the chronically ill patient. Both the patient and family caregiver often find themselves sorting through a myriad of information overload. Research shows that patients typically remember and understand less than half of what clinicians explain to them.³

Creating strategies to help maximize the patient's quality of life are critical to helping a senior to manage the difficult stages of a chronic illness. There are often gaps in the medical system's ability to assist patients in helping themselves. While Medicare and other insurers generally pay for medically necessary care, there remains a huge void for support of non-medical in-home

care services. Therefore, patients must become their own advocate of care in order to help manage their chronic illnesses. Otherwise, the effects of these chronic illnesses could have a dramatic impact on seniors by reducing their quality of life and their ability to remain independent in their home.

While some patients are able to navigate the healthcare system with success, many are not. Variables like cognitive level, financial status and family support are just some of the factors that contribute to a successful transition to home. Traditional transitional care models appear to lack the elevated support needed for more complex patients with higher psychosocial needs. This problem is indicated by the reported unnecessary high readmission rates currently experienced by the healthcare system.

This transitional care pilot program was designed to determine whether patient compliance with hospital discharge instructions, and monitoring of key indicators that drive quality outcomes in the home, would correlate to reducing unnecessary hospital readmissions of high risk patients within the first 30 days of discharge.

Additionally, vital information about factors in the home that could contribute to unnecessary readmissions would be tracked. Participation in the pilot program was offered at no cost to the patient or participating hospital. All patients admitted into the pilot program would receive non-medical in-home care throughout their 30 days post hospital discharge. The overriding objective was to help improve patient outcomes while enabling seniors to attain their personal healthcare goals.

Pilot overview

The enhanced transitional care pilot program was facilitated by a local Home Instead Senior Care® franchise office, as a unique in-home care program for seniors transitioning from hospital to

home. The pilot program was designed to provide support during the critical first four weeks at home. While the pilot program outlined general guidelines for scheduled visits, individual care plans provided the flexibility needed for this high risk patient population. Participation in the pilot program could be terminated early depending upon the circumstances of care, as well as the needs and wishes of the patient and family. In two instances, participants chose to extend their services from the local Home Instead Senior Care franchise office when their 30 day participation in the pilot program had ended.

The complimentary program was offered to two area hospitals from May 2012 through November 2012. Referrals were made based on diagnosis, age and eligibility. A total of 30 patients were admitted to the hospitals during the pilot program's seven month period. Ten patients were discharged from the hospitals with the admitting diagnosis of congestive heart failure (CHF). Twenty patients were discharged with the admitting diagnosis of chronic obstructive pulmonary disease (COPD). In many instances, comorbidity was also present. All 30 patients had a history of one or more recent hospitalizations in the past year.

The pilot program was supervised by a registered nurse who opened all cases. Two Home Instead Senior Care CAREGiversSM were dedicated to the pilot program. They received training with the nurse emphasizing the recording of key vital signs to include electronic blood pressure readings, weight, temperature and blood sugar readings (performed by patient). They were also trained to use a coaching model with the patients utilizing teach-back techniques. Patients were encouraged to take control of their health care needs and develop problem solving skills by monitoring their own red flag identifiers for their specific health care condition.

Pilot program admission criteria:

- Patient lives alone or is home alone for 4 or more hours daily
- Assistance needed with 1 or more activities of daily living (ADL)
- Visited emergency department in previous 6 months or is identified as a high risk for readmission by the referring hospital
- 4 or more medications upon discharge, or new medication with discharge
- 60 years of age or older

Eligibility diagnoses:

- COPD/pneumonia
- CHF
- Urinary tract infection

Qualifying criteria:

- Patient must satisfy one admission criterion and have one eligible diagnosis
- Patient must live within geographic boundaries of the participating Home Instead Senior Care franchise office's service footprint
- Care consultation must be done preferably in the hospital prior to discharge, or within 3 days of discharge
- Patient must agree to see primary care physician within 5-7 days of discharge
- Copies of all discharge plans and medication regimen provided

to the pilot program's participants

- Signed permission of the patient/family for the participating Home Instead Senior Care franchise office to provide non-medical care in the home for 30 days

Process of delivery

Established guidelines for communication involved:

- Daily tracking in a journal performed by CAREGiver
- Medication list and fluid tracking worksheets completed by patient
- Excel spreadsheets for all data tracking monitored by RN
- Calls made by CAREGiver to Home Instead Senior Care franchise office to report any adverse changes or events

Core non-medical service focused on patient centered goals with action steps during each one hour visit:

- Promoting medication self-management (dosage and purpose of each medication)
- Organizing patient medical records in the home
- Following up with physician appointments and scheduling tests in a timely manner
- Observing and recording vitals (weight, blood pressure, blood sugar)
- Ensuring patient knowledge and ability to monitor red flags specific to the patient's chronic illness (e.g., weight gain, elevated blood pressure, difficulty breathing)
- Review of "zone sheets" for patients' diagnoses
- Reviewing patient centered goals

Model

- All patient participation in the pilot program ended at 30 days post hospital discharge
- Flexibility in the pilot program allowed the addition or subtraction of visits within the 30 day period based on the individual patient's needs

1. Week One: Up to one hour of service for five visits post hospital discharge (hospital discharge date was day # 1 in the model). Service was extended beyond one hour, as necessary, to accommodate physician appointments
2. Week 2: Four 1-hour visits
3. Week 3: Three 1-hour visits
4. Week 4: One or two 1-hour visit(s)

Measurement of success

Metrics measured:

- readmissions within 30 days post hospital discharge
- quality outcomes
- achievement of patients' personal goals
- quality of communication between patients, physicians and family members
- identification of key contributing factors or barriers that contributed to repeat hospital readmissions

Case Studies

Patient M

Patient M is an 80 year old female with CHF, atrial fibrillation and COPD. She had two previous hospitalizations with these diagnoses in the same calendar year prior to participating in the

pilot program. Patient M is alert, oriented and lives alone. She uses a walker and cane for ambulation. Upon hospital discharge, she had swelling of both lower extremities and was short of breath with any exertion. She had very little family or social support. Prior to her last hospitalization, she was still driving and was also the main caregiving support and transportation for her widowed friend.

During her initial interview, she reported that her overall personal goal was to be able to drive again. Her health care goals were to be able to better manage her health care and diet. She willingly agreed to track her diet, fluid intake and weight. She stated, "I weigh myself every day!" When she was asked to demonstrate weighing herself, it was determined that she could not read the scale where it was placed in the home, thus, resulting in inaccurate readings of the scale by eight pounds.

The CAREGiver worked with Patient M for a total of 17 visits, totaling 12 hours over the 30 day period. During each visit, discussions centered on Patient M's goals, understanding her red flag zones, and when she should call her doctor in an effort to help avoid a hospitalization.

During week 2, Patient M's weight went up by more than three pounds, and with a prompt from her 'CAREGiver', she called her primary care physician who immediately increased her diuretics. She was also fitted by her doctor for compression stockings. The CAREGiver transported Patient M to her doctors' appointments, picked up her prescriptions, helped her with bathing in the first two weeks, and did some light housekeeping so that she could conserve energy.

By the end of the 30 day period, Patient M had lost 18 pounds and was regaining her strength. She was still unable to drive but was determined to continue following her plan in an attempt to achieve her health care goals. A second follow-up call was placed to Patient M at 60 days post discharge, and she was thrilled to report that she was down a total of 42 pounds and able to drive again. She completed the post care survey with a written comment stating, "I just could not have done it without your help. Thank you all for your help."

Patient B

Patient B is a 90 year old female with end stage CHF. She is on continuous oxygen. She uses a walker to assist with ambulation which frequently gets hung up in the oxygen tubing. She is short of breath with exertion. She had two hospitalizations within three months. Patient B lives alone with occasional help from her son. She had refused to allow any additional help in her home as a result of trust issues. With additional prompting from the hospital case manager, Patient B hesitantly agreed to participate in the pilot program.

Her personal and health care goals were the same: "I just want to feel better and be able to stay in my home." Upon review of her discharge medication regimen, it was discovered that two important medications were missing in the home. She was not confident in calling her physician herself as she feared he would be upset with her not complying with his orders. She had been prescribed both medications during both previous admissions, yet the medications could not be located in the home. According to the pharmacy, one prescription had not been filled for six months. After reconciling with both the physician and pharmacy, Patient B received both of her needed prescriptions.

The CAREGiver worked with Patient B for 11 visits, totaling 9 hours. She assisted Patient B with bathing, light housekeeping and transportation. During each visit, meal plans and potential red flags were reviewed. Safety awareness related to the oxygen tubing and potential for falling was also reiterated. Patient B appeared to understand that placement and awareness of the tubing location was very important. At the end of the 30 day period, Patient B stated that she felt better as a result of participating in the pilot program and had a more complete personal health record to share with her physician.

Patient P

Patient P is a 70 year old male with COPD, non-insulin dependent diabetes and hypertension. He is obese, and uses a walker and motorized chair for mobility. He is short of breath with exertion. Patient P lives alone and is socially isolated. He does not drive and, therefore, uses public transportation to grocery shop or go to appointments. He had three previous hospital admissions for exacerbation of his COPD in five months.

During the initial assessment, Patient P stated, "I know everything that I need to know about what is wrong with me!" Patient P was discharged on a low sodium, low fat, diabetic diet; however, his daily intake consisted of deliverable take-out food and frozen microwaveable dinners. Prior to his participation in the pilot program, Patient P had never tracked his blood sugar levels and did not use a pill box for medication tracking.

Patient P agreed to start tracking his daily blood sugar and weight. The CAREGiver and Patient P worked on creating a more healthy diet plan. This plan required trips to the grocery store. It was identified that part of his exertion problems was related to carrying groceries and transportation. The bus would not allow him to bring a cart onto the bus in order to carry his groceries. He would become very short of breath if he carried them without a cart. Together, a strategy was developed where Patient P could bring down his cart and leave it in the foyer of the building. Then, when he used the public transportation, even though he could not bring the cart on the bus, he could have the driver retrieve it so that he didn't need to carry the bags. Simple as it seems, this discussion fostered greater sense of independence for Patient P.

Transportation for doctor appointments was also an issue as the "free" transportation available to him frequently needed to be scheduled two weeks in advance. This type of schedule would not accommodate urgent visits to the doctor. During the first week of service, Patient P developed increased swelling in his arm and hand. He stated, "I just was feeling crappy." He said he thought about calling EMS to go to the emergency department (ED) but then decided to call his physician. The CAREGiver was able to transport Patient P to the doctor and help him to avoid a potentially unnecessary ED visit.

The CAREGiver worked with Patient P for a total of 18 visits, totaling 20 hours. Patient P received transportation to multiple physician appointments, light housekeeping, prescription pick up and trips to the grocery store. During each visit, discussions focused on understanding his red flag zones and steps he could take to help avoid an unnecessary hospitalization. Patient P successfully completed the 30 day pilot program, resulting in a loss of 11 pounds. He had a more complete home medical record that included his daily weight and blood sugar readings. During the

final visit, Patient P stood up out of his chair and said, “Can I just have a hug?” Patient P remained out of the hospital greater than 90 days. He was re-hospitalized in his fourth month post-discharge. The complimentary pilot study had been completed at the time of this last discharge. Patient P was disappointed to learn that most of these non-medical in-home care services are not covered under his current Medicare benefits.

Patient S

Multiple barriers for patient success were identified throughout the pilot program; some simple, some more complex. Patient S was a COPD patient who was referred to the pilot program because she had six hospital admissions and one ED visit in the past five months. It was identified that her barrier to a successful transition home was the need for cleaning assistance. She would come home from the hospital each time to a dust and cat dander ridden home. She did not have the strength to do anything about it. It was a vicious circle for the patient. Light housekeeping to reduce the dust and dander also are believed to have helped her reduce her hospitalizations. A simple skill set transfer that provided the patient knowledge of her red flags and the cause behind the exacerbations of her illness has enabled her to remain out of the hospital for five months and counting.

Pilot Program results

30 patients were admitted into the pilot program.

- 96% stayed out of the hospital greater than 30 days post discharge
- 93% stayed out of the hospital greater than 60 days post discharge
- 90% stayed out of the hospital greater than 90 days post discharge
- 93% remained in their own homes
- 7% transferred to a skilled nursing facility due to limited family support, but stayed out of the hospital. They did not receive care in the pilot program once transferred.

A total of 289 CAREGiver hours were provided, averaging 9.625 hours and 11 visits per patient during the 30 day period.

- 37% of the patients needed transportation to their primary care physician appointments
- 30% of the patients needed prescriptions to be picked up
- 43% of the patients needed some sort of physical assistance with activities of daily living, such as bathing or dressing
- 100% of the patients were assisted in organizing their medical records which included all discharge instructions, medications and pertinent health information to share with their physician.

An exit survey was completed by 94% of the patients to identify patient and family satisfaction with the care transition interventions and overall pilot program experience.

- 100% of the survey respondents “Strongly Agreed” in response to the question: I feel better as a result of participating in this Home Instead Senior Care transitional care program.
- 89% of the survey respondents “Strongly Agreed” in response to the question: I felt more confident having a Home Instead CAREGiver visit.

Barriers Identified

- language barriers
- cognitive disabilities
- physical disabilities
- poor diet
- medication reconciliation/management
- transportation
- social isolation
- confusion with discharge instructions
- issues related to obtaining durable medical supplies
- health status of family caregivers providing care to the patient

Summary

Easing the transition from hospital to home by empowerment of patients in the management of their care is essential for their future success. As patients traverse from one health care setting to another, the only common denominator between settings is the patient. The patient must become the focal point of all communication and coordination of care. Streamlined care plans and proper hospital discharge preparation of patients and family members are crucial for the prevention of multiple hospitalizations. Millions of older adults are suffering from chronic illnesses causing a rapid rise in healthcare costs. According to a study conducted by the Alliance for Aging, Americans who lose their ability to live independently increase the overall national healthcare cost by over \$26 billion nationally. Both patients and their healthcare partners have a vested interest in the collaboration of care across settings for the purposes of achieving positive patient outcomes while reducing costs. It is not enough to educate patients. The time is here for active patient engagement for the purpose of meeting their goals. This pilot program using patient involvement in monitoring and managing their health care needs demonstrated significantly improved outcomes and reduced hospital readmissions for high risk, cognitively intact older adults when compared to their own previous hospital readmission rates.

LaNita Knoke, RN, CMCN, is the Healthcare Strategist at Home Instead Senior Care.

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Acute Hospital and Home Care Collaborative to Reduce Hospital Readmissions

Henrico Doctor's Hospital & Home Instead Senior Care

Summary

Rehospitalization rates are steadily on the rise, despite this issue being a national priority for several years. Different programs have been established, like BOOST, RED, and STAAR, which seek to ensure smooth care transitions at discharge to reduce unnecessary readmissions. Through this study of patients with congestive heart failure, it is evident that early follow-up appointments, ensuring basic nutrition, proper medication management and a patients' understanding of the early warning signs of their disease are key to reducing these numbers.

Key Points

- Medicare has established 1 in 5 patients are readmitted within 30 days of discharge.
- Patients who receive appropriate transitional care services are less likely to be readmitted.

Heart failure affects more than five million Americans or 1 in 56 individuals and these numbers are expected to double over the next 30 years as the population ages. All heart failure patients are at risk to be readmitted (Jencks et al, 2009). In spite of efforts to reduce hospital readmissions, readmission rates have continued to rise. According to the Department of Health and Human Services, one in five patients who leave the hospital will be readmitted within 30 days. It is estimated that up to 76% of these readmissions may be preventable and that the average cost to Medicare per readmission is \$7,200 (Cakir & Gammon, 2010). These numbers are staggering considering that some of the contributing causes could be avoided with a variety of low-cost, nonmedical solutions. Heart failure is one of the most common admission diagnoses for hospitalized patients in Henrico Doctor's Hospital (HDH). For this reason, HDH elected to collaborate with Home Instead Senior Care (HISC) to identify and target heart failure patients offering them the opportunity to participate in the project. The overall primary objective of this quality improvement project was to evaluate whether patients who receive the transitional care services provided by a non-skilled provider are less likely to be readmitted compared to a similar group of patients from the same hospital who received usual care post discharge. By adopting a best practice approach to care, and collaborating with a non-medical, in-home care provider, the hospital did experience a reduction in avoidable readmissions in patients who participated in the pilot.

Several Centers for Medicare and Medicaid Services programs have demonstrated that creating discharge programs focused on transitions of care have been successful in reducing avoidable hospital readmissions.

- Better Outcomes for Older Adults Through Safe Transitions (BOOST) was started in 2008 by the Society of Hospital Medicine. BOOST identifies high risk patients on admission and uses specific interventions to improve the information flow between

inpatient and outpatient providers (Society of Hospital Medicine, 2012).

- Reengineered Hospital Discharge Program (RED) is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. This project found that patients who have a clear understanding of their after-hospital discharge instructions, how to take their medications and when to make follow-up appointments are less likely to experience a hospital readmission (Project Red 2007-2012).

- The State Action on Avoidable Rehospitalizations Program (STAAR) is a program of the Institute of Healthcare Improvement (IHI) that aims to reduce rehospitalizations and improve the coordination between providers and care settings. The program worked with organizations across four states (Massachusetts, Michigan, Ohio, and Washington) and accomplished the goal of decreasing hospital readmission rates by assessing post discharge needs, patient teaching, cross-provider communication at discharge, and timely post-acute follow-up care (Boutwell, et al, 2011).

Based on these models and programs, this collaboration between an acute care hospital and a non-medical, in-home care provider helped reduce avoidable hospital readmissions for patients with heart failure in that it sought to ensure smooth care transitions when patients are discharged, helping them avoid deterioration in health status that often brings them back to the hospital. The project provided non-skilled level of care to patients with congestive heart failure and two aims were established for the program which began prior to hospital discharge and continued for 30 days post-discharge. The aims included: 1) Ensure smooth care transitions during and after discharge, and 2) Reduce preventable readmissions by identifying best practices to assist patients after discharge.

This quality improvement project began on May 1, 2012, and concluded on March 31, 2013. During this demonstration period, HDH and HISC collaborated to care for 48 seniors with Congestive Heart Failure (CHF), each of whom voluntarily participated in this project. The cost of the in-home care intervention was funded by HISC, and the project was jointly administered.

Interventions: The patients meeting inclusion criteria were offered the option to participate in the program. Those who agreed to participate received a pre-discharge visit from the HISC case manager along with non-skilled level of care interventions which included:

1. Assistance with Prescription Medication (34/48 = 71%)

- Ensured that medications were picked up from pharmacy
- Assisted patients and families to compare the medications actually present in the home with the medications listed on the discharge instruction sheet
- Encouraged to validate with physician and/or home health nurse for any discrepancies
- Encouraged to contact physician and/or pharmacy for generic and/or lower cost alternative medications (10%)
- Recommended that all patients have a medication system or box that patient/family filled weekly

2. Transportation (40/48 = 83.3%)

- Offered transportation from hospital to home at discharge if needed
- Provided transportation to doctor's office and to other locations as needed to meet essential needs (pharmacy, groceries, church, dialysis, doctor's office, other)

3. Home Safety Evaluation (48/48 = 100%)

- Performed a home safety evaluation
- Suggested safety modifications to patients/families
- Encouraged Lifeline services as needed
- Provided light housekeeping

4. Meal Preparation/Nutrition (47/48 = 97.9%)

- Assisted with various nutritional needs
- Validated the physician recommended diet in the discharge instructions with the actual patient diet and the food that was in the house
- Provided transportation to the grocery store
- Assisted to select healthy alternatives to food that was in the house (lower Na⁺, lower fats, & canned foods)
- Educated on healthy eating

5. Communication (48/48 = 100%)

- Facilitated communication between patient/family/significant others
- Located the discharge instructions documentation
- Communicated with patients and families the actual DC instruction that had been provided when leaving the hospital
- Looked beyond the 30 days post-discharge to ensure a plan was in place

6. Education and Teaching of Red Flags (48/48 = 100%)

- Provided educational materials to patients and families
- Encouraged daily weight and documentation
- Provided scales if needed

7. Coordinated Care between Post-Acute Providers (48/48 = 100%)

- Included physician office, specialists office, PCP, hospice, home healthcare
- Provided encouragement to perform the physical therapy recommended exercises throughout the day
- Monitored compliance with recommended therapy

8. Review Post Discharge Instructions (48/48 = 100%)

- Located the actual discharge instruction document in the home
- Encouraged the patient and/or family to implement the activities prescribed per the discharge instructions

9. Arranged Follow-up Appointments (44/48 = 91.6 %)

- Assisted patients and/or families to make follow-up appointments
- Accompanied patient to the follow-up appointment as needed and assisted with compliance of recommendations

10. Facilitated Provision of Personal Care (48/48 = 100%)

- Assisted with bathing and grooming
- Assisted with dressing

Process: This quality improvement project followed a cooperatively-planned and jointly-administered implementation model which consisted of four core protocols. Responsibility for adhering to these protocols was assigned to the care management manager for HDH and the client care coordinator for HISC. These protocols were:

1. Discharge Process – which governed the transfer of patients from hospital to home care which included:

- Development of an individual care plan to be followed upon discharge;
- Briefing of the care coordinator for HISC for each discharge of patients with emphasis on post-discharge care and nutritional needs; and
- Arrangement for in-hospital consultation with client or client's family.

2. Communication Plan – which involved the hospital care management staff and home care provider which began at discharge and was sustained throughout the 30-day duration of care for each client. This communication plan addressed needs at four critical junctures during the care process:

- I. The development and design of the quality improvement project;
- II. The initial transfer of each individual client from hospital to home care;
- III. Periodic reporting throughout the 30-day period for individual clients; and
- IV. As required in emergency situations.

Communication between HDH and HISC case managers was critical and was ongoing on a daily/weekly basis throughout the 11-month pilot. The entire team met bi-monthly, monthly, or bi-weekly throughout the project.

3. Caregiver Selection and Training – the HISC caregivers were selected from the existing roster of Home Instead caregivers with a preference for those with credentials as CNA (Certified Nursing

Assistant) or PCA (Personal Caregiver Assistant). Continuity of caregivers was a priority and a special effort was made to ensure a consistent client/caregiver experience throughout the 30-day care period. Caregivers were provided an orientation to congestive heart failure by the Heart Failure Clinical Nurse Practitioner of HDH. This training also included an orientation to the importance of nutrition for the congestive heart failure patient.

4. Care Supervision -- supervision of caregivers and caregiving services was accomplished by a dedicated project manager/care coordinator from HISC for the duration of the 11-month test. This care coordinator provided consistency to both the overall project and in each of the individual care scenarios and served as the liaison between HISC and HDH. Communication with the client's family was also facilitated by the care manager throughout the pilot.

The hospital case manager reviewed the daily census sheet for heart failure patients and applied the inclusion/exclusion criteria to identify patients who might qualify for the project. After describing the program to the patient, the hospital case manager communicated to the attending physician that the patient might qualify for additional supportive services at home and requested an order for the patient to be enrolled in the program. Once the patient agreed to participate, the hospital case manager would then contact the HISC case manager and provide the demographics, after which the HISC case manager arranged for a hospital visit and acquired the patient's consent to participate prior to the patient discharge.

Data and Methods: A retrospective observational quality improvement project compared the likelihood of hospital readmission among heart failure patients who received transitional care by the HISC staff (N=48) and a similar group of patients who received traditional discharge care (N=48). All patients were referred from a single intermediate for-profit medical and surgical hospital in Richmond, Virginia. Patients were categorized into two study groups: an intervention group and a control group. The intervention group (N=48) included patients meeting inclusion criteria and agreed to participate who received interventions by the home care staff during the first 30 days post-discharge. The control group was selected (N=48) and included those patients who met the inclusion criteria for the project, but declined to participate. Patients in the intervention and control groups were selected from the same time period. Data for the project was collected from the plan of care, electronic medical records and outcomes data were collected by the HDH case management staff and the HISC case management staff. Demographic characteristics that were assessed included gender, age and race/ethnicity. Other health conditions and data that were measured include the number of co-morbidities that existed, whether patients were receiving home health care, hospice, or resided in an assisted living facility during the pilot, and whether there was family or significant other care provider involvement in the home during the pilot project. The service utilization characteristics included the number of weekly visits, hours per patient, and number of interventions required. The primary outcome measure was rehospitalizations within 30 days from the initial discharge.

Inclusion criteria:

- Inpatient with congestive heart failure principal diagnosis
- Medicare as primary payer

- Discharge to home or assisted living in the Richmond area

Exclusion criteria:

- Observation services
- Non-Medicare payer
- Discharge out of the Richmond area
- Discharge to nursing facility

Interventions included:

- Assistance with prescription medication
- Transportation to doctor's office
- Evaluation of home safety
- Assistance with meal prep and nutrition compliance
- Facilitation of communication with family/significant others
- Education and teaching of red flags
- Coordination of care between post-acute providers
- Review post-discharge instructions
- Assistance to make follow-up appointments
- Provision of personal care

Data Collection

- Hours of care per patient over the 30 days – 103
- Visits per week over the 30 days – 5
- Completion rate was 78.5%
- Attrition rate – 21.5%
- 61 started in the project and 48 completed
- Signed but died prior to beginning pilot – 3
- Signed but canceled prior to beginning pilot – 3
- In pilot 18 days prior to ending pilot – 1
- Died during pilot – 3
- Signed but canceled after starting and did not complete – 3

Results: This pilot has shown that improved communication, support and assistance to understand discharge instructions, assistance in coordinating care between post-acute providers, recognition of red flags and standardized education leads to reducing avoidable hospital readmissions. The readmission rate among those patients receiving interventions was 12.5% while the readmission rate among the control group not receiving interventions was 14.5%.

HDH readmission rates overall during that same period for patients with congestive heart failure were 16.9%. The national Medicare readmission rate for patients with congestive heart failure was 24.6%. Although the goal for the project was to provide interventions to 60 patients, only 48 patients were able to complete the project. An extraneous variable included the ongoing and simultaneous efforts within the hospital system to reduce readmissions in the heart failure patients which might have affected the hospitals overall comparison rates of readmissions. The attrition rate in the project was 21.3% with the 61 patients who initially agreed to participate completing the project being 48. Service utilization included five mean visits per week per patient and 103 mean hours were spent in total for each patient throughout the 30 day engagement. Most of the patients in the study required all 10 interventions with the range being 5-10 per patient. The mean number of interventions per patient was 9.1. Eight or 16.6% of the patients in the intervention group utilized the services of skilled home health care during the pilot, two entered hospice during the pilot and two lived in an assisted living facility. Seven (15%) of the

Data Tables

<i>Variable</i>	<i>Intervention Group</i>	<i>Control Group</i>
Mean Age of Participants	81	77
Gender		
Male	18	22
Female	30	26
Race/Ethnicity		
White non-Hispanic	33	35
African American	15	12
Hispanic	0	1
Mean # Co-morbidities Per Participant	5	4.8
Service Utilization		
Number of hours per patient		103
Number of visits per week		5

Heart Failure Readmission Rates	
US Medicare 3rd Qtr '09--2nd Qtr '11	24.60%
HCA 2nd Qtr '12--1st Qtr '13	19.90%
HCA Capital Division 2nd Qtr 12--1st Qtr '13	19.80%
HDH 2nd Qtr '12--1st Qtr '13	16.90%
HISC/HDH Collaborative Control Group	14.50%
HISC/HDH Collaborative Intervention Group	12.50%

Receiving Additional Services Throughout the Pilot		
Hospice	2	4%
Home Health Care	8	16.60%
Assisted Living	2	4%

Number of Interventions Required	
Range	5-10
Mean Interventions per patient	9.1

patients in the intervention group had little or no family support.

Discussion: All participants have learned valuable lessons and improved their systems. One of the key strategies has been to pay close attention to the transition from hospital to home. Additional strategies have been to assure that all patients have an early follow-up appointment with their physician after leaving the hospital and those patients and their caregivers understand their disease, its treatment and the early warning signs that require attention. It is evident that the small study group size limits the ability to apply the results across the entire population. More quality improvement projects are needed to address the gaps and limitations of this project.

Although no financial incentives were involved in the project, this collaboration provided a way for the hospital and the non-skilled home care system to team together and share best practices and strategies to prevent readmissions in this population sample of patients. The readmission challenge is not one that can be fixed overnight, but real progress has been made during this pilot. We are proud and optimistic that HISC and HDH are taking a proactive stance to reduce avoidable hospital readmissions across the country in communities served by HISC. In summary, this pilot has shown that improved communication, support and assistance to understand discharge instructions, assistance in coordinating care between post-acute providers and recognition of red flags and standardized education led to better health care outcomes and reduced hospital readmissions in the congestive heart failure patients studied.

Acknowledgements: The pilot team would like to acknowledge the efforts of Teresa Steinfatt and Barbara Stanley of HISC, Bill Butler and Linda Woods of HDH, and Carolyn Hamilton of HCA's Capital Division for their efforts in implementing the project. We are also grateful to Kelly McAdams, the family nurse practitioner of HDH for assisting in the development of educational materials and for educating the implementation team on heart failure and to Christine Butler for assistance in data assessment and retrieval. We are also grateful to Jim Beck, Director of Public Affairs for Home Instead Senior Care, Rob Carrell, CFO of the HCA Capital Division, and Chris Denton, the CFO of HDH for their administrative support.

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What Constitutes Good Oncology Care?

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Summary

“Good” care in oncology lacks definition. Advocacy groups can lend some insight, but are often vague and tend to generalize. Physicians’, nurses’, and care managers’ views on the subject often differ from each other and that of the patients and their families. “Good” care is in the eye of the beholder, and one must consider all possible viewpoints for effective methods.

Key Point

- Patients and care providers define “good” care differently
- Speak with colleagues in oncology fields, as well as those in patient education and advocacy
- Spending money appropriately and wisely may be most effective in cancer treatment

As an Oncology Care Manager, quite often I am asked what constitutes “good” oncology care. Many people have their opinions. Patients, doctors, allied medical professionals and even the health plans like to weigh in on this issue but unfortunately no one seems to be on the same page. I think most healthcare professionals know that “good” oncology care is essential but without a unified set of standards on how to define “GOOD” care, it makes it almost impossible for everyone to be on the same page.

Those in the industry often use buzz words such as quality, outcomes and cost interchangeably, however, are they really the same? Without distinct definitions or standards for these terms it will be difficult for all of us to speak the same language. We must then ask ourselves, “What is our benchmark? Should we be utilizing medical terminology such as overall survival, time until recurrence, response to a particular medication (partial, complete, partial/complete)?” The factor that must be considered when creating these definitions is the cost of the drug versus the total treatment and consequently can we illustrate any savings by the methods employed in the process. In this ever changing world of healthcare, where so much of the services we provide are guided by a bottom line, would it be prudent to teach more self-management to patients and families such as how to monitor tumor markers and lab results so they can ascertain the effectiveness of their treatment? One of the defining elements of good care might also come in the form of a standardized plan of care to keep patients in their home rather than in the hospital and maintaining their health during and after treatment so we might maximize their time in normal pursuits such as work and time with family. Yet often times we must also assist patients with “good” end of life care; for example, helping patients and their families determine whether a clinical trial or palliative or hospice care will provide the highest quality of life.

After surveying the available data on this subject, one of the main problems I have noted is that the medical profession has one set of criteria. The payers might have another and subsequently patients and patient advocacy groups may have an entirely different set of measurements. This separatism begs the question that if we are all attempting to provide what is best for the patient, how do we collectively bring it all together to make sense, not just for us but for

our patients and their families. Close review of the literature uncovers what the experts are saying, identification of the organizations responsible for creating standards for oncology care and most of all discovery of who is monitoring all of this to make certain we are taking this seriously. Another avenue that can be beneficial is to speak with colleagues, practicing oncologists, oncology care management nurses, medical directors from health plans, as well as those working in cancer education and advocacy. Finally, in order to round out your analysis one should speak with patients and families to see how they measure quality care.

The literature revealed some of the following findings:

- The Susan G Komen Foundation for Breast Cancer (a patient advocacy group), states that “Every person diagnosed with breast cancer deserves the best care possible.”

Quality of care is a measure of:

- Whether or not you receive the best treatment for your breast cancer and your treatment is given with compassion
- How well your breast cancer is treated
- How well you are cared for during and after treatment

The Institutes of Medicine define good quality of care as:

- “Providing patients with appropriate services in a technically competent manner, with good communication, shared decision-making and cultural sensitivity”

A quality hospital or medical center should have:

- Clean, up-to-date facilities
- Well-stocked examining and operating rooms
- Up-to-date diagnostic equipment
- Health care providers with appropriate professional credentials

Hospitals and medical offices that have the above to offer are capable of providing good care. However, just having the clean and up to date facilities and supplies does not always guarantee good quality care.

Leonard Lichtenfeld, MD, MACP the Deputy Chief Medical Officer for the national office of the American Cancer Society has been interviewed on this topic many times he stated in a recent interview. He felt this topic is a “proverbial head scratcher”. He also stated that there are some key organizations dedicated to this cause such as:

- The National Quality Forum
- The American Society of Clinical Oncology’s QOPI program (which is a voluntary program that measures the quality of care in oncologists’ offices) and the widely accepted guidelines of the
- National Comprehensive Cancer Network (NCCN), nationally accepted evidence based guidelines
- National Initiative on Cancer Care Quality (NICCCQ).

In the April 1999 Institute of Medicine report, *Ensuring Quality Cancer Care*, the National Cancer Policy Board suggested that many patients with cancer are not receiving the care known to be effective for their disease. The NCPB believed the problem to be significant, but observed there was insufficient evidence to determine the true magnitude.

In his opinion, he feels it is spending money appropriately and wisely that is the key to success in cancer treatment. Measuring how accurately and consistently continues to be a significant problem. However, he feels it would be terrific if the medical profession stood up and took charge of this issue. Offering transparency into patient care workflow and multidisciplinary operational processes, as well as accepting accountability in some reasonable way, offers assurances that the care we provide our patients meets a fundamental measure of quality care.

Organizations such as the American Society Community Oncologists (ASCO) recognizes the importance of integrating continuous quality improvement into patient-centered clinical practice, and has collaborated with the world’s leading cancer care experts to develop two key quality programs: Quality Oncology Practice Initiative (QOPI) and QOPI Certification Program (QCPT™). These tools assist oncologists and their practice in creating programs that effectively measure and compare their care to other practices in a continuous and meaningful way.

The Association of Community Cancer Centers (ACCC) is working with advocacy organizations, such as Oncology Nursing Society (ONS), the American Cancer Society Cancer Action Network (ACS CAN), and other organizations to increase the support for ensuring good, quality oncology care. These actions are evident by the introduction of two bills in 2013. The first, introduced by Reps. Israel (D-NY) and Tiberi (R-OH), is HR 1661. This bill would provide reimbursement for a one-hour chemotherapy teaching session by nurses in the physician-office setting. This legislation has been introduced in previous Congresses, with the primary support of the Oncology Nursing Society (ONS). ACCC has supported this legislation in the past and will be supporting it again this year.

The second bill is the “Patient Centered Quality of Life Act” (HR 1666). This bill would support the growing demand for palliative care, which is specialized medical care that focuses on care coordination and relief from pain, stress, and other symptoms of treatment for a life-threatening disease such as cancer. The bipartisan bill, co-sponsored by Reps. Cleaver (D-MO) and Bachus (R-AL), would facilitate and expand federal research into palliative care, support training for nurses, nurse practitioners, and other allied health professionals to effectively practice palliative care.

Another group that is active on this front is Community Oncology Alliance (COA). Their mission is “to protect and foster the community oncology delivery system in the United States through public policy, advocacy, and education. Because the majority of Americans battling cancer receive treatment in the community setting, ensuring

the vitality of the community cancer care delivery system is imperative for patient well-being”.

Oncology nurses, care managers and alike believe that good oncology care is related to early detection, early and accurate diagnosis, timely implementation of the correct treatment of first line treatment. Followed by, proper monitoring of tumor markers for treatment adjustments, proactive control of side effects as well as a strong patient advocacy for palliative and end of life care when appropriate. Subsequently, they focus on the patients physical, emotional and social needs being met early on in the process and throughout. Oncology professionals that manage, treat and educate patients and families measure good care based on the patient’s ability to continue to function daily, work and be productive with family.

After speaking with a physician colleague of mine, it became apparent that their focus was on cost and efficiency. In my opinion, that focus is being driven by the necessity of them having to fill dual roles as a physician and business owner. Another key factor in this conundrum is the healthcare reimbursement system.

I believe they want to do the right thing for all their patients and families to make their experience the best as possible, but sometimes they are driven by the wrong incentives.

When speaking with health plan medical directors they are looking for ways to cut costs and be effective but are also looking to partner with community oncologists and their practices. We discussed their ideas and thoughts around the oncology patient centered medical home, and how that might work to improve care as well as cost. Give more control of patient care and management back to the oncologist but request assurances based on the use of treatment guidelines, clinical trials and strong oncology care management that focus on the patient and their needs as the center of care and treatment plan.

Finally, I spoke with patients, families and other caregivers and their focus is much different than Oncology Patient Centered Medical Home (OPCMH). They view good cancer care as whether their family member was diagnosed correctly and given the right treatment the first time, how rapidly their social and emotional needs were met and the type of experience they had moving a family member to palliative care or hospice.

Most of the national organizations do their best to manage the process, place tools in the hands of the practicing oncologist and their teams and promote the best care possible for the patients and their families. I am still concerned that they have lost sight of what the patients care expectations are and how the patient gages good care. Quite often the focus is on the diagnosis, which is important, but in doing so we forget to ask the patient what their goals and expectations are in the process of treating their cancer. I think for us to truly measure good care we need to make certain that we address our patient’s needs in the beginning and continue to reassess and reevaluate throughout the process. Just as we set goals for our patients we should make our primary goal to ask the patient, “What are your expectations through your treatment process?” In doing so, we might be surprised at some of the answers and subsequently how that might affect the treatment path followed. By making this step part of the workflow and operational process we will have the missing information needed to measure good oncology care and treatment. My fear is that without this information we will never achieve “good” oncology care in their eyes, and they are the ones that matter the most.

As a whole, the collective oncology community needs to work more closely together and begin to gather and assess our patient expectations of care, for this information has been lacking in the way we measure our commitment to good oncology care to our patients and their families.

