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Avoiding Unplanned ED Admissions:

STRATEGIES FOR KEEPING CANCER "OUT"PATIENT

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In 2017, CMS released the first oncology measure to the Hospital Outpatient Quality Reporting (OQR) Program. Titled OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, this measure was intended to improve the care of patients receiving chemotherapy and reduce unnecessary ED and inpatient admissions. Through OP-35[1], which plans to go live in 2020, CMS is directing performance improvement among hospital based cancer programs by targeting unplanned ED visits and inpatient admissions for patients within 30 days of receiving chemotherapy. More specifically, this includes patients with one of the following 10 diagnoses: anemia, nausea, dehydration, neutropenia, diarrhea, pain, emesis, pneumonia, fever, and sepsis. Cancer programs need to understand their patient populations, and particularly what factors drive these unplanned admissions and visits to the ED. Ultimately, it is up to cancer programs to develop comprehensive outpatient services to potentially prevent these admissions.

In 2018, the Journal for Clinical Oncology Practice published an article by Handley, et. al.[2] with five strategies for reducing unplanned admissions: (1) identify patients at high risk for unplanned acute care; (2) enhance access and care coordination; (3) standardize clinical pathways for symptom management; (4) develop new loci for urgent cancer care; and (5) use early palliative care. Each of these strategies lays the groundwork for further exploration below.

For a cancer program to begin assessing their readiness for this new CMS measure, it is necessary to conduct a retrospective review of oncology patients with billable ED encounters and (or) inpatient admissions who had received chemotherapy within 30 days prior. A medical record review for key metrics such as cancer diagnosis, stage, chemotherapy regimen, co-morbidities, length of stay, and inpatient admission (if applicable) is needed to further stratify any trends among the patients. A better understanding of the high-risk patient population will signal opportunities for strategizing planned care interventions to avoid unplanned admissions.

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At Baptist Health Lexington, our clinical nurse specialist did a retrospective chart review of patients who received outpatient chemotherapy within 30 days of an ED visit. We pulled all cases over a one year period, looking at data points such as ED admission date and time, date of birth, insurance, length of stay if admitted, admission diagnosis if admitted, co-morbidities, cancer stage and chemotherapy regimen. We looked specifically at the patients' discharge diagnoses, and categorized them by the qualifying 10 CMS diagnoses. The most difficult part of this process was working with our data analysts and billing department to ensure we received the most accurate list of patients and then deciding what data elements we wanted to specifically collect in the review.

> ***"It was clear we had an opportunity to redirect patients to our outpatient clinic for urgent or symptom related needs and avoid many of these unnecessary ED admissions"***

We were quickly able to summarize the data from the chart review to present in an overview with our oncologists. We talked through the results of the most frequent presenting cancer diagnosis (27% of the patients going to the ED were lung cancer patients), as well as the most frequent qualifying diagnoses at discharge (anemia and nausea/vomiting were our highest). Providing real data helped frame a discussion for starting an urgent care/symptom management clinic.

It was clear we had an opportunity to redirect patients to our outpatient clinic for urgent or symptom related needs and avoid many of these unnecessary ED admissions. Thus, we took steps to develop an urgent care clinic staffed by a nurse practitioner who had both an oncology background, as well as several years working with hospitalists. At Baptist, we found that opportunities existed to ramp up our nurse triage call center to help with symptom management, and to improve the care coordination between physicians and nurses in an office and infusion treatment location. We also focused on improving patient education before and during chemotherapy treatment, and considered extending infusion treatment center hours to accommodate patients in the evening or on the weekends who may be experiencing symptoms.

Our retrospective patient review also uncovered opportunities to provide additional touch points for patients at high risk. For example, we noted that patients receiving a high toxicity chemotherapy regimen may require an additional phone call by a nurse to assess any distress or symptom management related concerns. The 10 most common admission diagnoses identified by CMS (see above) require educational emphasis to ensure patients under treatment know when to reach out to their outpatient provider. Likewise, establishing clinical pathways to be used in the outpatient setting for these diagnoses can expedite getting a patient started on supportive therapies like hydration or anti-nausea medications. Encouraging patients to call a physician office prior to going to the ED allows for additional opportunities to resolve symptom related concerns in an outpatient setting.

Urgent care does not need to be synonymous with the Emergency Department. Once patients are educated about symptom management and know whom to contact when they have a problem, they will likely utilize services as directed by that office rather than go to an ED. As a cancer program assesses its ED volumes related to symptom management, it may be necessary to explore the addition of a symptom management clinic with a dedicated provider. Such a clinic would allow for same day appointments with the provider, as well as add-on appointments

to the outpatient infusion center. Protocols/policies for how patient calls are managed/triaged and possibly added to a clinic schedule will have to be assessed based on each program's unique situation.

An additional component for patients with end stage disease, or those dealing with complex and difficult to manage symptoms, is to have access for consultation with a palliative care provider. Multidisciplinary approaches to pain management and symptom management through palliative care have proven to reduce unplanned ED admissions[3], as well as decreasing unnecessary costs related to end of life care. There can often be apprehension on the part of a provider to make a palliative care referral, as often it is synonymous to patients as "futile care." Therefore, introducing palliative care services at the beginning of a patient's relationship with the cancer program gives an opportunity to educate on the benefits of palliative care when or if it becomes needed down the road. At Baptist, we offer an outpatient palliative care clinic a of couple days per week in the same location as our medical oncology clinics. This has encouraged collaboration between providers, increased referrals and created a more streamlined experience for patients. We provide education about our palliative care program and work with patients to understand the distinct differences between palliative care and hospice.

It is no surprise that oncology care is getting its fair share of attention from CMS. Variations in cancer care delivery and utilization of acute care resources make it one of the most costly diseases to manage. Every cancer program should make it a goal to figure out the best way to care for cancer patients in the outpatient setting. This is not only the right thing to do for the patient, but it also will directly impact a program's performance on this proposed metric.

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