Oncology Management Consulting Group
Outstanding experts, outstanding results!

Embedding Distress Measurements IN CANCER PATIENTS' RECORDS

By Tara M. Lock, MHA, Administrator, Oncology Integrated Center of Clinical Excellence, Hollings Cancer Center, Medical University of South Carolina

There was an article I read in graduate school[1] that described a patient in Oregon with chronic heart failure. This patient was in and out of the ED routinely and the physicians were incredibly frustrated every time they saw her. Every time she came to the ED she had the same issues. It wasn't that her medications weren't working. It wasn't that she was in horrific pain or suffering from an uncontrollable condition.

She was there because it was the heat of the summer and she didn't have an air conditioner in her apartment. The excessive heat in her home worsened her cardiac symptoms to the point that she took several rides via ambulance to the ED where she was stabilized at a cost of $50,000 to Medicare for each visit. The article went on to point out that a $200 air conditioner would have eliminated this cost to Medicare and her ED visits but because hospitals were not allowed to buy an air conditioner for the patient and Medicare deemed it to be a 'non-covered device', the hospital's hands were tied. The patient couldn't afford it and the hospital couldn't buy it.

> ***"The excessive heat in her home worsened her cardiac symptoms..."***

Fast forward to 2019 and Value Based Care is all the rage. Payers (including Medicare) are lining up to partner with organizations and providers to eliminate unnecessary visits, procedures, and admissions for their patient population. Oncology is of course one of the largest areas on which they've set their sights for improvement.

Although the example above is related to a cardiac patient, oncology patients also have social determinants that will ultimately impact the quality of their care as well. But how do we measure those needs? How do we screen for them in advance of noticing a problem?

CMS has also recognized this shortfall and has partnered with 30 organizations to gather data on the social determinants of health in a project called The Accountable Health Communities Model[2]. They have developed a tool to assess a patient's potential barriers to care in an effort to engage clinical community 'linkages' to

improve health outcomes and reduce cost. Unfortunately, this is not a tool or a project specific to oncology.

At MUSC's Hollings Cancer Center, we were struggling with these same challenges so we decided to do something about it. Our oncology team is comprised of a vast group of skilled team members. From Behavioral Health to Social Work, Surgical Oncology to Radiation Oncology, Nurse Navigators to Financial Counselors. You would think we were set up to cover every need that a patient may have given our large support structure. And we certainly were ready for the need as it arose. The problem was that we didn't have a single, consistent, electronic way of assessing these needs as they didn't fit into our 'clinical' review of systems built into our EMR. Our EMR was focused around vitals, chemo administration, medication reconciliation, demographics, diagnosis, etc. but nowhere in the patient's record was there a way to share information with the team on a patient's level of distress or the social barriers that could impede their ability to complete treatment.

> ***"CMS has also recognized this shortfall and has partnered with 30 organizations to gather data on the social determinants of health..."***

We had a small internal group with representation from Behavioral Health, IT, Nursing, Chaplaincy, Social Work, and Administration that spent many months trying to come up with a way to bridge this gap. After many early morning meetings establishing exactly what we wanted to ask, when we wanted to ask it, and what we would do with that information, we then needed to figure out how to make that part of the patient's review of systems. This is where the name 'the sixth vital sign' was coined. We wanted it to be exactly that. Exactly like taking a patient's blood pressure and temperature, we wanted to take their distress temperature just as routinely, have it documented as clearly, and align the resources necessary to address those needs.

We took our basic direction on the questions that we should ask from the infamous NCCN Distress Tool[3]. There was no need to reinvent the wheel as this was a widely known tool but it was not embedded in the EMR as a functional assessment. Sure you can scan it in if a patient fills it out but the ability to make these answers discrete data fields that in turn allow you to quantify your patient population and document follow up on those results was, up until now, not possible for us. The questions followed the same categories: Practical Problems, Family Problems, Emotional Problems, Physical Problems, and Spiritual Concerns.

From there our IT lead got to work on creating something that would live in the patient record and be a regular assessment by our clinical support team. She then took it one step further and created the ability to generate referrals to Social Work, Financial Counseling, Chaplaincy, Behavioral Health, and Nutrition Services using the patient's response to the questions on the electronic tool. This now allowed us to both quantify a patient's need and then engage the appropriate care team member based on the patient's responses. This new tool was a win-win for us on many levels. We now had the ability to document the demand for those services that are innately known to be invaluable to our program (financial counseling, social work, etc.) in a systematic way. We also entered this tool into the MUSC Shark Tank competition in 2018 and won the Innovator of the Year award for our efforts.

We believe that what we have created is just the beginning for our organization. If you consider the numerous other service lines that can benefit from such

an assessment, tailored to their own patient population, the potential impact is incredible. Not to mention the ability to run reports from discreet data fields that demonstrate how much need there is in which area within your patient population. Thinking back to the beginning of this article and to the cardiac patient who simply needed an air conditioner to avoid those costly ED visits: what could an assessment in clinic have done to help that patient? CMS is slowly coming along to the idea that paying for a $200 air conditioner may save them $50,000. Several Medicare Advantage plans now cover things like air conditioners for people with asthma, rides to medical appointments, and healthy groceries for the participants so it is going to be up to the provider to distinguish which patient may need which resource. This tool has provided that resource for oncology patients at MUSC and we intend to continue to build onto the tool routinely.

Written by Tara M. Lock, MHA, Administrator, Hollings Cancer Center, MUSC, SC

Edited by Teri U. Guidi, MBA FAAMA, President & CEO of Oncology Management Consulting Group.

Article references:

(1) https://www.washingtonpost.com/news/wonk/wp/2013/05/20/is-the-future-of-american-health-care-in-oregon/?noredirect=on

(2) https://innovation.cms.gov/initiatives/ahcm/

(3) https://www.nccn.org/about/permissions/thermometer.aspx