Onco-SNF: Building Trust in Oncology Care Transitions

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Problem

- About 15% of new Post Acute & Long Term Care (PALTC) admissions are cancer patients, facing potential medication errors and logistical issues due to fragmented transitions
- Primary root causes: fragmented communication and coordination systems
- The issue threatens patient safety and strains the healthcare system, fostering mistrust and inefficiency
- Urgent need to improve care coordination and minimize transitional challenges

Goal

- To survey providers involved in transitions to Symphony of South Shore and Montgomery Place within a 6-month period, with the aim to identify Transition of Care (TOC) challenges and develop strategic solutions, aligning with the objectives outlined in the UCM Annual Operating Plan & equitable care

Strategy

- Develop REDCap survey to be completed within 20 days of care transition → Establish weekly communication with PALTC physician team February-August 2023 → Chart review and interviews with oncologists to identify barriers to successful TOC
- Success determined by achieving 100% documentation of comorbidity issues, medication reconciliation errors, readmissions or urgent ER transfers, and appointment discrepancies within the first 20 days of patient transition to PALTC facilities
- Stakeholders:
  - Multidisciplinary team: NM (Oncology), LG (Geriatrics), KM (Social Work)
  - Providers (MDs and APPs) from the Cancer Center and Nursing Homes
  - Sites: Symphony of South Shore and Montgomery Place (PALTCs affiliated with UCM)

Transition of Care (TOC) survey components

- Patient Identification (including record ID, names, age, gender, race, etc.) Discharging Service Details Medical Details (including comorbidities, medication reconciliation errors, etc.)
- Advance Care Planning (including information on substitute decision-maker and health care power of attorney)
- Social Morbidities (with an array of choices to indicate specific issues the patient is facing)
- High Fall Risk & Activities of Daily Living Deficits Analysis
- Oncology Specific Information (including cancer type, stage, treatment plan, and concerns)
- Missed Appointments and Emergency Transfers (documenting any missed, rescheduled, or delayed appointments, and details on ER transfers or readmissions)

Results

Demographics (n=9 total care transitions)

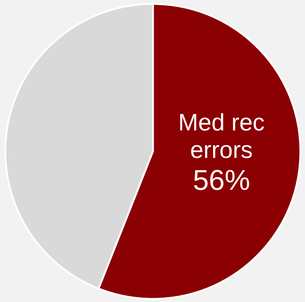
- Median age: 76 years old (range 62-86 yrs)
- 78% male, 56% living alone at baseline
- Diverse cancer types: largest percentage were head & neck cancers (33%); 67% had poor prognostic features

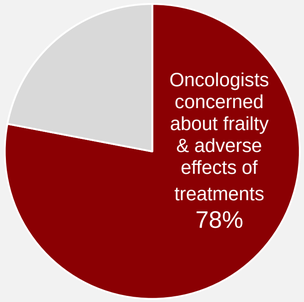
Features of TOC

- 44% were managed and discharged by oncology hospitalist service
- ~ 78% of patients had oncology appointments scheduled before discharge
- Treatment primarily involved infusion or IV systemic therapy (44%), supplemented by oral systemic therapy (33%) and radiation (22%), with daily (M-F) sessions being the most common frequency (22%)
- Cancer therapy goals were largely directed towards palliative care (56%), with a notable portion unclear (33%), and a minority focusing on curative approaches (11%)

Barriers to potentially successful TOC

- Nearly half (44%) of PALTC providers highlighted issues such as patients' declining functional status affecting treatment continuation, difficulties in appointment scheduling and attendance, and patients altering or discontinuing their treatment due to various complications or changing preferences on care intensity





Complications of TOC

- 89% had missed, rescheduled, or delayed appointments
- 66.7% of patients needed urgent transfers or readmissions

- Medical Complexity: Several delays and admissions were attributed to infectious complications (78%)
- Care Coordination Issues: Some instances showed signs of potential communication gaps in coordinating appointments (33%)

Geriatric Syndromes and Themes

Category	Prevalence
Delirium and Capacity Concerns	
Concerns about delirium	12%
Capacity concerns	22%
No dementia or psychiatric concerns	100%
Advance Care Planning	
Completed upon transfer	44%
Not completed or unable to complete	44%
Others	12%
Code Status	
Full code	44%
DNR/DNI	22%
Others	34%
Surrogate Decision-makers	
Identified	44%
Documented Health care power of attorney	78%
Medical Comorbidities	
Unmanaged	22%
Predominantly gastrointestinal	-
Social Determinants of Health	
Poorly controlled	33%
Predominantly Housing and environment issues	-
Physical Therapy Assessments	
High fall risk	78%
Activities of Daily Living	
Deficits present	100%
With ≥3 ADL deficits	78%

Conclusions

- TOC surveys had a 100% completion rate within 20 days of transition.
- 56% experienced med-rec errors while 56% received palliative treatment plans, 78% needed transfer with 44% of PALTC docs noting challenges concerning patients' changing preferences on treatment intensity and issues in scheduling and attending appointments.
- Improvements needed: Enhancing stakeholder communication can bridge care transition gaps. Developing robust mechanisms is vital to reduce medication errors, particularly in dosage clarification and prescription issues.
- Next steps
  - Expand the study
  - Develop a unified system of communication with stakeholders & PALTC network
  - Interview oncology and PALTC providers to determine what minimum data set is necessary to be included