ASCO's Quality Training Program

Project Title:

Creation of a Cross Functional Care Team to Develop Individualized Care Plans in High Utilizer Oncology Patients

Presenter's Name:

Girish Kunapareddy MD MBA, Joe Hooley MBA CPPS

Institution:

Cleveland Clinic Foundation, Cleveland, OH

Date:

Thursday, January 26, 2017

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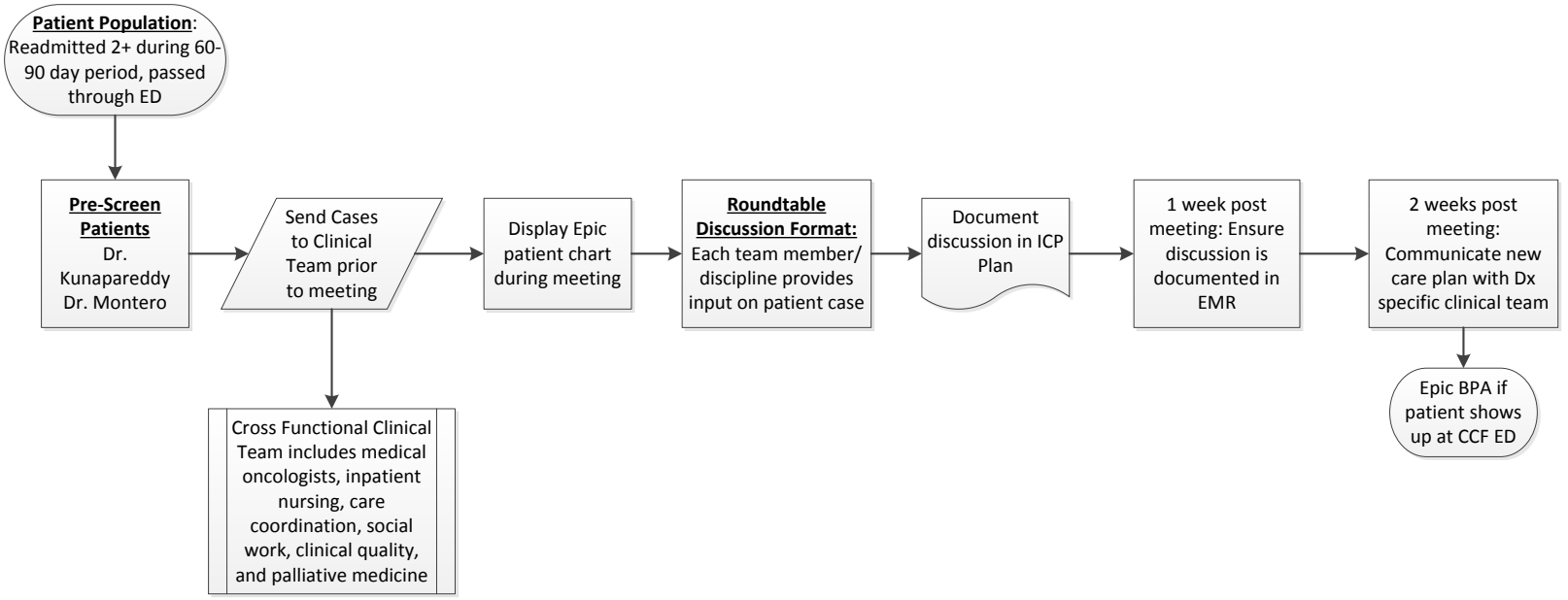
Problem Statement

- With growing attention to quality in health care, readmission have gained much of the national focus. At our institution, it has become clear that a small portion of our patient population drive a significant burden of our readmission rates and resource utilization

- In fact, just 6% of all discharged patients account for a staggering 41% of all readmissions

- However, patients who are most frequently readmitted have complex psychosocial barriers that no general intervention is likely to address

Process Map



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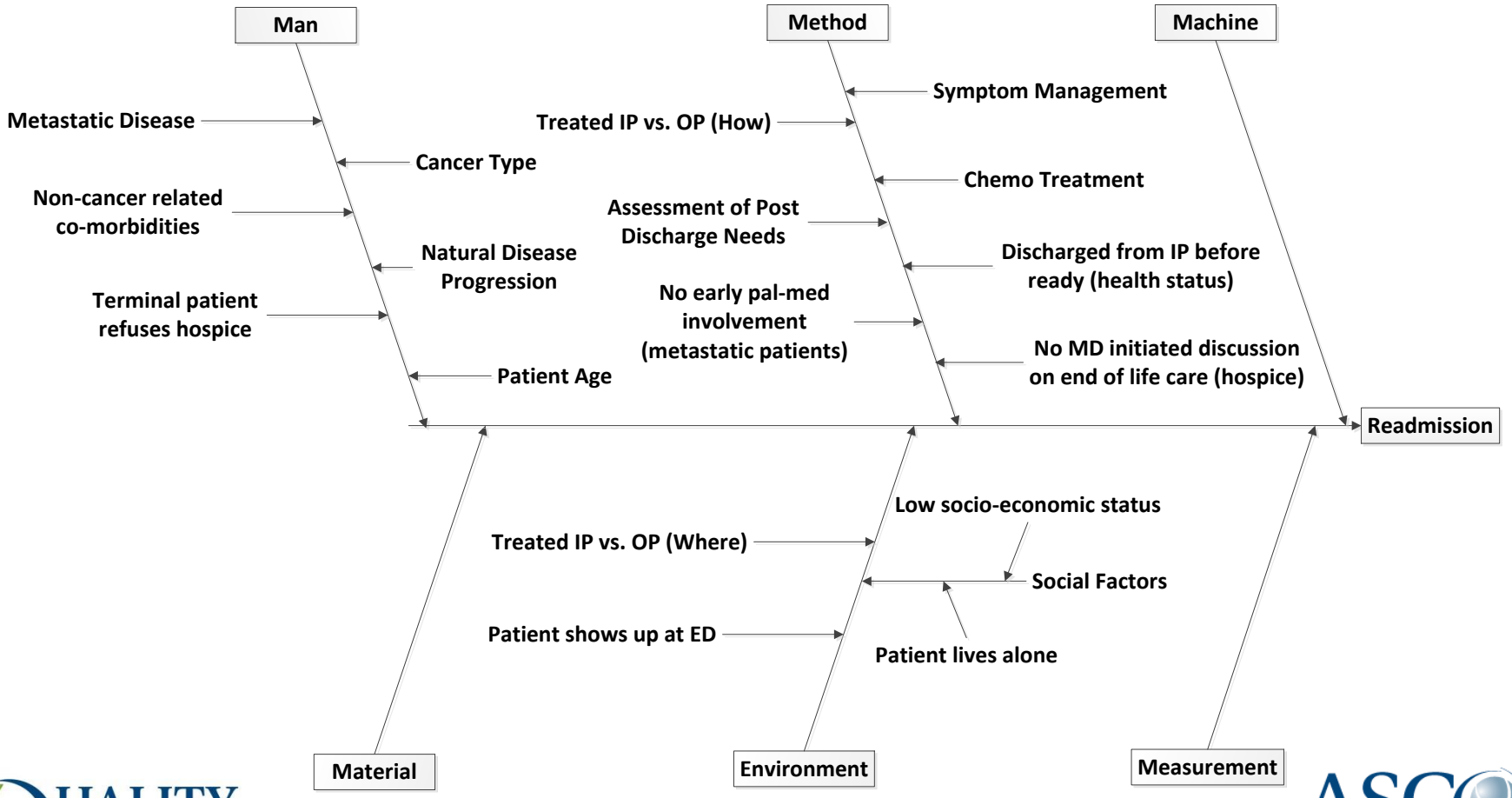
Institutional Overview

- Cleveland Clinic based in Cleveland, OH is a large academic institution with emphasis on education and research.
- The project will be based on the main campus within the Taussig Cancer Institute Department of Hematology and Oncology
- **Staff**: 18 hematology and oncology fellows, and estimate of 2500-3000 inpatient admissions/year.
- **Patient Population**: Mostly in the north east Ohio region but also serves as a major referral practice for across the Midwestern United States, as well as internationally.

Team Members

Stakeholders and Team Members	Represented Area
Dr. Alberto Montero	Project Sponsor
Dr. Girish Kunapareddy	Project Owner
Dr. Ruth Lagman	Palliative Medicine
Dr. Armida Parala	Palliative Medicine
Dr. Sudipto Mukherjee	Malignant Hematology
Dr. Bassam Estfan	Solid Tumor Oncology
Joseph Hooley	Clinical Quality
Lyn Best, Renata McBride	Inpatient Nursing
Christa Poole	Social Work
Helen Tackitt	APN/PA supervisor
Gerard Odafe	Continuous improvement
Yolanda Curry	Case Manager
Julie Fetto	Institute Nursing Director
Stacey Booker	Care Coordinator

Cause & Effect Diagram



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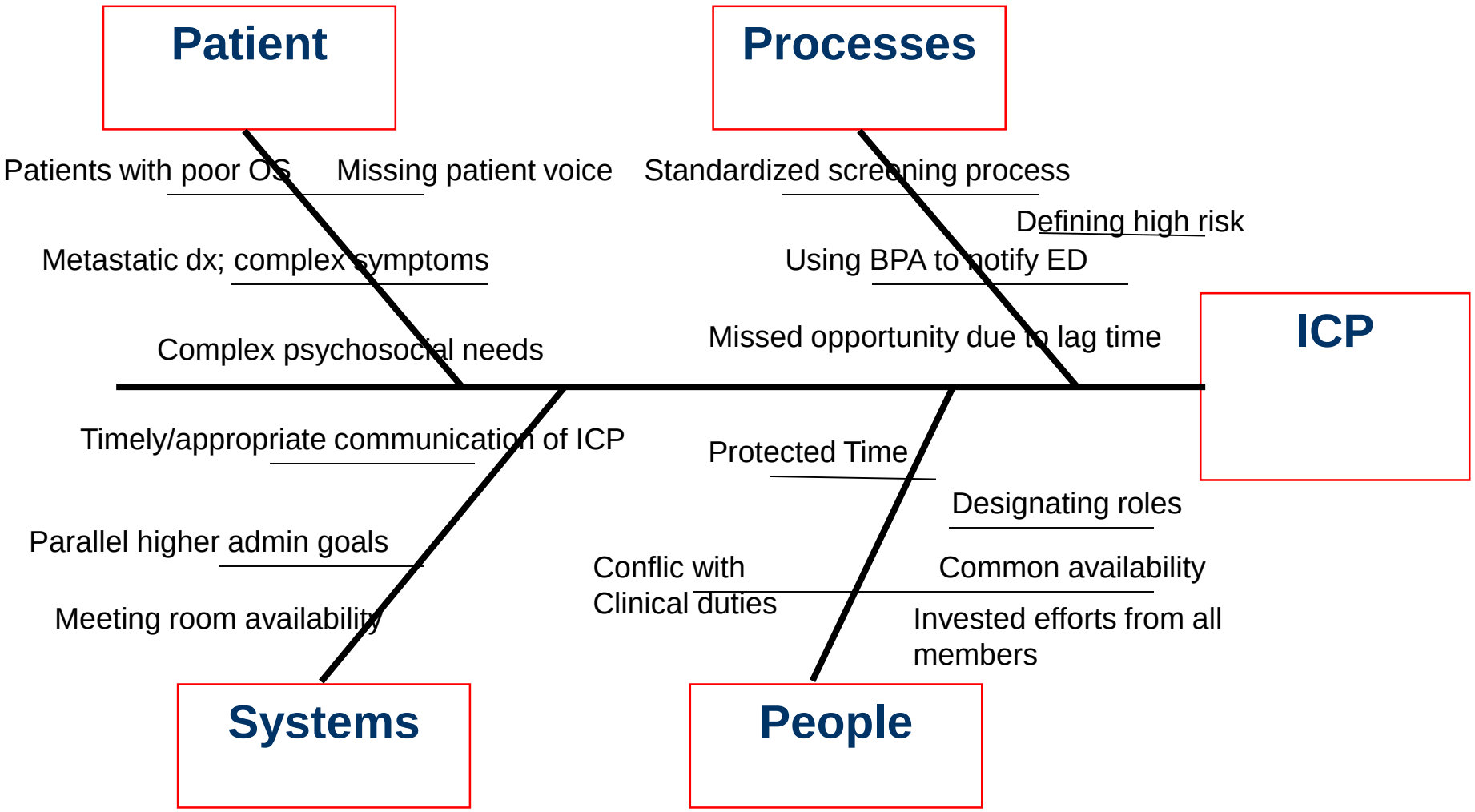
Cause and Effect Diagram



Diagnostic Data

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Aim Statement

- Reduce the cohort's total number of readmissions 10% by January 15, 2017. This will be accomplished by forming a cross functional care team that would discuss 10 individual patients, with 2 or more readmissions in the past 60 days, by creating individualized care plans to be communicated to primary oncology team and ED.

Measures

- **Measures:**
  - # of Individualized Care Plans created by the Cross Functional Team
  - # 30-60 Day Readmissions
  - # ED visits
  - Patient LOS (Days)
  - ICU admissions
  - Hospice referrals
  - # of outpatient visits
- **Patient Population:**
  - All patients discharged from the oncology units with 2 or more readmissions within the past 60 day period
- **Calculation Methodology**:
  - N of Readmissions / Total N of Discharges
- **Data Source:**
  - EHR
- **Data Collection Frequency:**
  - Ongoing, Bi-monthly review during intervention period: 10/1/17 – 1/15/17
- **Data Quality:**
  - Currently limited by manual review process of cohort patients with new care plans

Baseline Data

- In 2015, there were ~4000 discharges with overall readmission rate of 26%
- In 2015, 68% of all readmitted cancer patients had two or more readmissions within 6 months.
- In the 1st 6 months of 2016, that number was at 62%. The overall readmissions rate has increased to 28% in the 1st 6 months of 2016.
- 70% of the above readmissions were admitted through the ED at least once. 50% with at least two

Prioritized List of Changes (Priority/Pay –Off Matrix)

Impact	Easy	Difficult
High	Standardizing Discharge Process Multidisciplinary Rounds Moving Scheduler to Bedside	Same Day Access Individualized Care Plan Committee Social Work Inpatient/Outpatient Liaison
Low	Standardizing Post-Discharge Follow-up Appointment Process Follow-up Phone Calls	Palliative Medicine Home Visits

Ease of Implementation

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PDSA Plan (Test of Change)

Date of PDSA Cycle	Description of Intervention	Results	Action Steps
October 6th, 2016	Initial creation of multidisciplinary team	Creation of 4 ICPs per month	Supplement with patient input prior to ICP
December 1st, 2016	Communicate with outpatient care coordinator to seek patient input	TBD	Supplement with primary ambulatory team prior to ICP
February 2nd, 2017	Supplement with primary ambulatory team prior to ICP		

Materials Developed: ICP

PLAN IMPLEMENTATION DATE:

REASON(S) FOR ICP: Frequent hospital admissions for similar complaints

COMMON COMPLAINTS AND PRIOR EVALUATIONS:
1. ***

ICP COMMITTEE RECOMMENDATIONS:
1. ***

This consensus plan was developed by the group members of the Individual Care Plan committee which met in person on 10/20/2016.

SIGNATURE:
DATE:
TIME: xx:xx AM

PATIENT NAME: xxxxxxxx
MRN: xxxxxxxx

Interim Data

	Pre-ICP Data	Post-ICP Data
Average # Hospitalizations in 6 months prior to ICP	6.50	x
Average # Hospitalizations per month	1.08	0.23
ALOS for inpatient encounters	4.16 days	1.25 days
Average # ED visits in 6 months prior vs. post	4.25	0.75

- Notable decreases in # Hospitalizations and ALOS

Conclusions

- Creation of a cross functional care team with a wide spectrum of disciplines at a large academic center, focused to develop Individualized Care Plans, is feasible
- Most of ICPs were focused on patient's global needs rather than centered on disease biology.
- With the initiation of the above efforts, our interim data indicates a 3-5x decrease in overall number of hospitalizations, ED visits and average length of stay.
- Although current data suggests a great decrease in readmission rates, it is too early to draw that conclusion. However, current resource utilization by this cohort suggests we should surpass the target of 10% reduction rate in readmissions

Next Steps/Plan for Sustainability

- Continue Direct involvement of primary outpatient providers in the Cross Functional Care team discussions/review
- Streamline review process to determine preventability of hospitalizations by better allocation of roles within the CFC
- Create a model for predictors of readmissions that can be used to identify high risk patients on the front end
- Collaborate with enterprise efforts to create a predictive model to screen patients in real time during index admission

Girish Kunapareddy, MD, MBA Hematology/Oncology Fellow
Joseph Hooley, MBA, CPPS, Quality Director, Cancer

Cleveland Clinic

Creation of a Cross Functional Care Team to Develop Individualized Care Plans in High Utilizer Oncology Patients

AIM: **Reduce the cohort's total number of readmissions 10% by January 15, 2017. This will be accomplished by forming a cross functional care team that would discuss 10 individual patients, with 2 or more readmissions in the past 60 days, by creating individualized care plans to be communicated to primary oncology team and ED.**

INTERVENTION: Create cross functional care team, focused on creating care plans for patients readmitted 2 or more times during 60-day period to Cleveland Clinic facilities. Discuss an average of 2 cases per month with an action plan that is comprehensive and formulated by a multi-disciplinary group.

TEAM: Hematology/Oncology
Solid Tumor Oncology
Palliative Medicine
Nursing
Social Work
Care Coordinators
Case Management
APNs/PAs
Quality

PROJECT SPONSORS:
- Dr. Alberto Montero

RESULTS: Notable decreases in # Hospitalizations and ALOS

	Pre-ICP Data	Post-ICP Data
Average # Hospitalizations in 6 months prior to ICP	6.50	x
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CONCLUSIONS:
- **Preliminary data shows high impact on number admissions/ED visits and aLOS**
- **Although still early to determine if the aim of 10% reduction in overall readmissions is achieved, current data indicates that focusing on ICPs can help decrease overall readmissions**

NEXT STEPS:
- Identify predictors amongst the high risk population to better identify likelihood for readmission in real time.
- **Collaborate with enterprise efforts to identify prospectively**
- **Identify patients that may benefit from earlier hospice referrals to improve time of referral to death**
- **Above interventions will reduce the lag time from identification to our intervention time**