Partnership and Empowerment Program: A Model for Patient-Centered, Comprehensive, and Cost-Effective Care

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The Partnership and Empowerment Program model offers a comprehensive, patient-centered, and cost-effective template for coordinating care for underinsured and uninsured patients with cancer. Attention to effective coordination, including use of internal and external resources, may result in decreased costs of care and improved patient compliance and health outcomes.

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The Partnership and Empowerment Program (PADP) in the fall of 2003. The PADP was designed to reduce the financial burden in treating uninsured and underinsured patients receiving chemotherapy by applying drug assistance programs on behalf of the patient. The PADP was highly successful in mitigating financial strain on the hospital and led to the creation of a full-time position dedicated to the PADP known as oncology care coordinator (OCC) (Borsellino, 2006).

After introducing the PADP, the staff at the hospital’s Day Treatment Center (DTC)—an outpatient infusion center that provides chemotherapy and supportive therapy to patients with cancer who are uninsured or underinsured—recognized that an exclusively financial approach was inadequate because many other variables were affecting patients’ treatment plans. In an effort to maximize efficiency and effectiveness, the PADP was expanded to include a pretreatment appointment prior to the initiation of chemotherapy. Those present at the appointment include the patient, the OCC, an oncology social worker (OSW), and an oncology pharmacist. The PADP has evolved into what is now called the Partnership and Empowerment Program.

Program Development

The Partnership and Empowerment Program builds on the PADP to include elements of patient navigation (Paskett, Harrop, & Wells, 2011), and fosters cooperation between the patient and the Partnership and Empowerment Program team from the point where treatment begins through the end of treatment. The Partnership and Empowerment Program is not a traditional linear model. Instead, it has a circular, ongoing flow that assumes patient needs are constantly changing (see Figure 1).

The pretreatment appointment is the first step of the process. In it, the patient is assessed by the Partnership and Empowerment Program team prior to initiation of therapy. The patient and the program team work collaboratively to identify and address patient needs through efficient coordination of care, education regarding treatment, psychosocial support, and resource referrals (Institute of Medicine, 2008; Watson, 2006). The program team was able to expand the scope of available professional services by focusing on internal and external resources (see Figure 2).

Active patient participation results from patient empowerment to engage in self-care and plan of care development while adapting to the cancer diagnosis, treatment, and the medical environment. As a result, the patient is more informed, expectations of the patient and the program team are clearer, and the patient is better equipped to adhere to the care plan. The Partnership and Empowerment Program is a mission-based service that links well with the hospital’s mission and vision by emphasizing quality and efficiency.

The hospital continues to support the Partnership and Empowerment Program because the proactive interventions are economically advantageous: Patients appreciate the financial benefit from linking them with patient-assistance funding, and the patient and team collaboration substantially reduces the financial losses typically seen in this population, including unnecessary emergency room and acute inpatient visits. For scheduled patient visits, nursing productivity is maximized because patients come to scheduled visits prepared (e.g., with laboratory work results, necessary home prescriptions) and chemotherapy orders have been reviewed for questions.

Limited resource coordination in the private office setting is related to the lack of a billing structure to support preventive coordination of those resources. Because the hospital will be caring for the patients regardless of insurance status, the Partnership and Empowerment Program helps to minimize the institution’s financial losses.
Oncology care

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cancer, experiencing nausea and vomit

Laboratory work was obtained. She

grew

Note: All supporting agencies work in collaboration with each other as guided by the patient’s needs assessment.

FIGURE 1. Partnership and Empowerment Program Model of Care

Referral to Partnership and Empowerment

L.J. presented to the emergency room, was admitted to the hospital, and was diagnosed with stage IV lung cancer. The oncologist discussed her treatment options and L.J. chose chemotherapy. She was uninsured, had limited resources, and was referred to the local health department for follow-up with a participating oncologist. L.J. was to be monitored and treated by DTC and her oncologist consulted the Partnership and Empowerment Program for assistance.

Patient referrals to the Partnership and Empowerment Program must be formally made by the oncologist to ensure commitment by all parties involved. However, participants may be recommended to oncologists for inclusion in the program, based on financial eligibility, from multiple sites, including the emergency care center and inpatient and outpatient settings.

Pretreatment Appointment

L.J. and her husband arrived at the DTC for her pretreatment appointment with the Partnership and Empowerment Program team. L.J.'s pretherapy assessment and laboratory work was obtained. She was anxious and concerned about having cancer, experiencing nausea and vomiting, and losing her hair, and was unsure how to tell her children that she had cancer. L.J. also was concerned about her finances and how to pay for her treatment. L.J. and her husband were provided with options for financial assistance, obtaining prescriptions, managing chemotherapy side effects, and suggestions on how to talk with their children. L.J. and her husband actively assisted in creating the plan of care and stated their commitment. She was given an individualized folder that contained information about chemotherapy medication, side effects, smoking cessation, and community resource information. All information was reviewed and discussed with L.J. and her husband. She was given support and encouraged to contact the program team with any needs throughout the process. L.J. scheduled her treatment appointment and was asked to bring her education folder to each treatment for review and discussion with her nurse.

At the pretreatment appointment, the patient is encouraged to actively contribute to the treatment plan and to seek clarification for optimal understanding. The OCC completes the admission assessment profile and baseline measures (including laboratory work); reviews central line information; pursues PADP eligibility and applications; assesses for additional services that might be helpful, such as low-cost pharmacy programs, cancer support, and spiritual or nutrition services; screens the patient for any missing prescriptions, such as antiepilics or anxiolytics; coordinates follow-up with the physician; and collaborates with the pharmacist to provide treatment-specific medication and side effect education to the patient. The pharmacist reviews patient home medications for potential interactions with chemotherapy and discusses use of over-the-counter medications, supplements, and herbs. The OSW provides psychosocial counseling and recommends appropriate local cancer care coalition support and other needed resources.

Initial Treatment Appointment

L.J. arrived at the DTC for the first day of chemotherapy visibly anxious and quiet. The nurse introduced himself to L.J., and reviewed the physician’s orders and plan of care for the day. L.J. was encouraged to discuss any questions or concerns prior to the initiation of and throughout therapy. She was later visited by an OSW for follow-up.

During the initial treatment visit, the staff oncology nurse is responsible for reinforcing the drug information and patient education received during the pretreatment appointment. That visit allows follow-up by the program team for any unresolved pretreatment topics. The OSW continues to meet with the patient regularly to assess for psychosocial distress and overall adjustment to the

FIGURE 2. Examples of Commonly Used Internal and External Resources

<table>
<thead>
<tr>
<th>Internal Resources</th>
<th>External Resources</th>
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<tbody>
<tr>
<td>Patient financial services</td>
<td>Nutrition</td>
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<tr>
<td>Pharmacy</td>
<td>Community medical clinic</td>
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<tr>
<td>Spiritual services</td>
<td>Behavioral health</td>
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<tr>
<td>Transportation services</td>
<td>Prescription options</td>
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<td>Financial services</td>
<td>Social Security</td>
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<tr>
<td>Department of Children and families</td>
<td>Co-pay assistance programs</td>
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<tr>
<td>Financial assistance programs</td>
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<tr>
<td>Cancer survivorship</td>
<td>Cancer site-specific</td>
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<tr>
<td>Fertility</td>
<td>Patient advocacy</td>
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<td>Cancer survivorship</td>
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cancer diagnosis and treatment plan. The OSW provides resource information and supportive counseling, which includes ongoing discussion about effective and holistic coping strategies (Association of Oncology Social Workers, 1998; Gordon & Edwards, 2005).

Therapy Continuation and End Point

L.J. continued her scheduled treatment during the next several months, including chemotherapy administration, supportive therapy, and laboratory work. During each visit, L.J., her nurse, and the OSW discussed emerging or unmet needs and updated the plan of care as needed. As months progressed, L.J. had fewer needs and anxiety and increased autonomy evidenced by sharing follow-up actions for her needs and their related outcomes. By the end of her treatment, L.J. was more communicative with DTC staff and voiced hope about her treatment’s effectiveness. L.J. successfully completed her therapy and expressed gratitude to DTC staff and the Partnership and Empowerment Program team for support and encouragement during the experience.

During each visit, the nurse reinforces patient education. The nurse and the OSW also screen the patient for needs requiring additional follow-up, and coordinate any needed consultations (i.e., OCC, pharmacy, nutrition, spiritual care, or transportation) (Holland & Bultz, 2007; National Comprehensive Cancer Network, 2011). Patients who begin treatment at DTC may complete treatment at DTC, as illustrated in the case study. However, many patients who begin treatment at DTC are then transferred to the oncologist’s office mid-treatment if a satisfactory payor source is established. When treated in the oncologist’s office, the patient is no longer under the care of DTC staff or enrolled in the Partnership and Empowerment Program. Anecdotally, many patients would prefer to stay with the Partnership and Empowerment Program because the new healthcare system, community resources, and understand how to navigate this. About 445 patients have been served by the program since 2004. In addition, the program offers of end-life care (non-hospice palliative and hospice care) through internal and external resources.

Figure 3 includes suggestions for other healthcare settings to begin developing a Partnership and Empowerment Program team. The main limitation for the Partnership and Empowerment Program is the absence of a survivorship program. The hospital is exploring that and, once a program is developed, the Partnership and Empowerment Program will be able to use it for continued support along the care continuum (Schlairet, Heddon, & Griffis, 2010; Washam, 2011).

Conclusion

The purpose of sharing the Partnership and Empowerment Program model was to offer a comprehensive, patient-centered, cost-effective template for coordinating care for underinsured and uninsured patients with cancer. Through deliberate coordination and use of resources, decreased costs of care and improved patient adherence and health outcomes can be positively influenced. The patient who is proactively assessed and linked with resources at the initiation of therapy may experience more favorable treatment outcomes, fewer adverse treatment events and delays, decreased psychosocial distress, and improved patient satisfaction (Holland & Alici, 2010; Holland et al., 2010).

References


FIGURE 3. Elements of Partnership and Empowerment Program Development