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Novel Tool as A Trigger for Advanced Care Planning (ACP) in Hospitalized Oncology Patients

Boston Medical Center

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Advocate Boston Medical Center (BMC)

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Advocate Boston Medical Center (BMC)

315,000 MEMBER HEALTH PLAN	MORE THAN 5,000 EMPLOYEES	NETWORK OF 14 COMMUNITY HEALTH CENTERS
482 BED TEACHING HOSPITAL	BOSTON MEDICAL	LARGEST PROVIDER OF TRAUMA AND EMERGENCY SERVICES IN NEW ENGLAND
860,000 OUTPATIENT VISITS PER YEAR	PRIMARY TEACHING HOSPITAL OF B.U. SCHOOL OF MEDICINE	NEW ENGLAND'S LARGEST SAFETY-NET HOSPITAL

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Objectives

1. Discuss ACP and improving access to earlier consults for palliative, hospice, spiritual, and integrative care
2. Discuss pilot implementation of a novel tool to trigger ACP in an inpatient hematology/oncology setting
3. Evaluate patient and staff outcomes from the study and lessons learned

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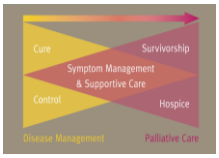
ACP

1. ACP is an important component of person centered care
2. ACP improves alignment of care with patient wishes and reduces intensive treatments and hospitalizations at the end of life
3. Results in earlier and increased referrals to hospice care, spiritual care, integrative therapies
4. Increases patient and family quality of life and satisfaction with care



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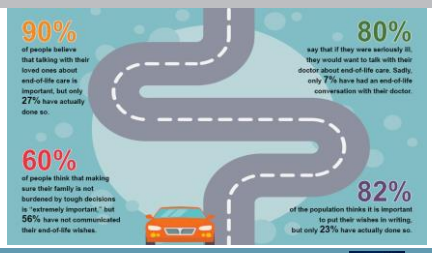

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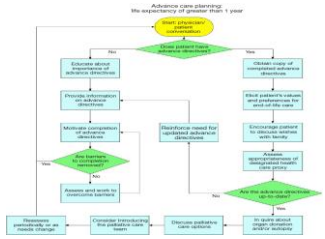

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Advance Care Planning discussions

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Preliminary Study

January -June 2014 a retrospective review of all readmitted patients from the hematology and oncology service

Mortality rate within 1 year of discharge: **32.8%**

Mean days to death from readmission discharge: **65 days** (range 0-252)

84.2% of those who died had metastatic cancer in index admission

Only **37%** ever had a palliative care consult placed (all on readmit)

Only **17%** had a documented EOL discussion on index admission

	Index Admission		First Readmission	
	Non-elective n=58	Elective n=10	Non-elective n=68	Elective n=10
Metastatic CA*	53%	30%		
DNR/DNI	21%	10%	33%	10%
Palliative Care Consult	12%	0%	21%	0%
End of Life Discussion	17%	10%	33%	10%
Health Care Proxy	67%	80%	74%	90%
Spiritual Consult	12%	0%		

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Severity of Illness Scales

- Nord (2012)- 8 point scale of severity and functional status: equal intervals in terms of value to the individuals whose functional status is being described to objectify & standardize assessment and inter-rater reliability.
- Frost et al. (2009)- Meta-Analysis: the risk of readmission to ICU increased by 43% with each standard of deviation in severity of illness score.
  - Acute Physiology and Chronic Health, APACHE II, APACHE III, SAPS, SAPS II

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Novel Tool


Place MRN sticker

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AIM

- To standardize the trigger for Palliative Care consults and ACP discussions at BMC
- To determine if the addition of the trigger led to earlier ACP discussions and improved patient access to palliative care
- Improve quality of life/death for patients

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Methods

- A novel Severity of Illness (SOI) tool was created by the interdisciplinary team
- ACP discussions and/or palliative care consults were indicated within 72 hours for those who score 4 or greater on the tool.
- Hematology-oncology providers were educated about the intervention during grand rounds, at team meetings and during huddles on the unit.
- All patients admitted to the hematology-oncology service from January 4, 2016 through June 30, 2016 were scored during daily interdisciplinary rounds.
- Retrospective chart reviews determined whether the proposed interventions were completed and documented.
- BMC providers created a new ACP documentation template in the electronic health record.
- Mortality outcomes of study participants will be followed for 1 year post-completion of the study

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Results

1. Standardizing the trigger to initiate ACP discussions and access to Palliative Care in the oncology inpatient population was beneficial to improving communication for the team and patients.
2. Even with the SOI there was a communication gap amongst with primary oncologist in regards to ACP at this institution
3. SOI Tool was administered at daily rounds to inpatients admitted to the Hematology/Oncology Service January 4, 2016-June 30, 2016
4. 96% of patients admitted to the Hematology/Oncology service had the SOI completed
5. 48% of patients that scored in with 4 or greater on SOI had an ACP discussion with either Palliative Care or primary team.

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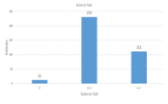
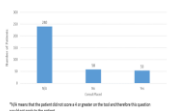
Results

What did they score on the Severity of Illness tool?



Was PC/ACP Consult placed w/in 3 days of completed tool?



*SOI means that the patient did not score a 4 or greater on the tool and therefore this question would not apply to the patient.

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Barriers SOI Tool

1. Attending physicians were not present at interdisciplinary rounds where SOI tool was scored, residents may have been hesitant to place consult or have ACP discussion
2. Was on paper not yet hardwired in computer
3. Attitudes and beliefs of hematology/oncology physicians about ACP
4. Lack of education about ACP discussions, documentation template
5. Lack of education about when to consult Palliative Care

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Qualitative Results Survey of Attending MDs: Barriers to ACP

1. Perceived patient/family lack of readiness to discuss (83%)
2. Provider discomfort (33%)
3. Difficulty with care coordination with primary hematology or oncology provider (50%)
4. Lack of time/resources (50%)
5. Lack of education (29%)

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Conclusions

1. This work suggests more investigation is needed to identify specific communication and organizational barriers to ACP discussions and services such as palliative care, spiritual care, integrative care, hospice.
2. SOI tools can provide value to a busy interdisciplinary team as a trigger for ACP (57%/MDs).

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Next-Steps

1. Improve care coordination with ambulatory settings
2. Establish electronic trigger (Possibly BMC SOI Tool) to be utilized in ambulatory clinics/various inpatient settings
3. Expand Palliative Care service
4. Offer high-fidelity ACP simulation team training sessions for the interdisciplinary team
5. Increase nursing involvement in the ACP process

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Thank you!! Feel free to contact -Nicole.lincoln@bmc.org

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