

# ASCO's Quality Training Program

**Project Title: Courageous Endeavor: Capturing Care Preferences for Late Stage Hematology Patients**

**Presenters' Names:**

**Team 7: Drs. William Dale and Finly Zachariah**

**Institution: City of Hope**

**Date: June 28, 2019**

# Institutional Overview

City of Hope is a designated Comprehensive Cancer Center located in Duarte, California. It is known for its research and treatment of cancer, diabetes and other serious diseases. There are more than 500 clinical trials enrolling more than 6,200 patients each year. Over 13,000 hematopoietic stem cell transplants have been performed with patient outcomes that exceed national averages.

It is ranked one of the nation's Best Cancer Hospitals by U.S. News and World Report.

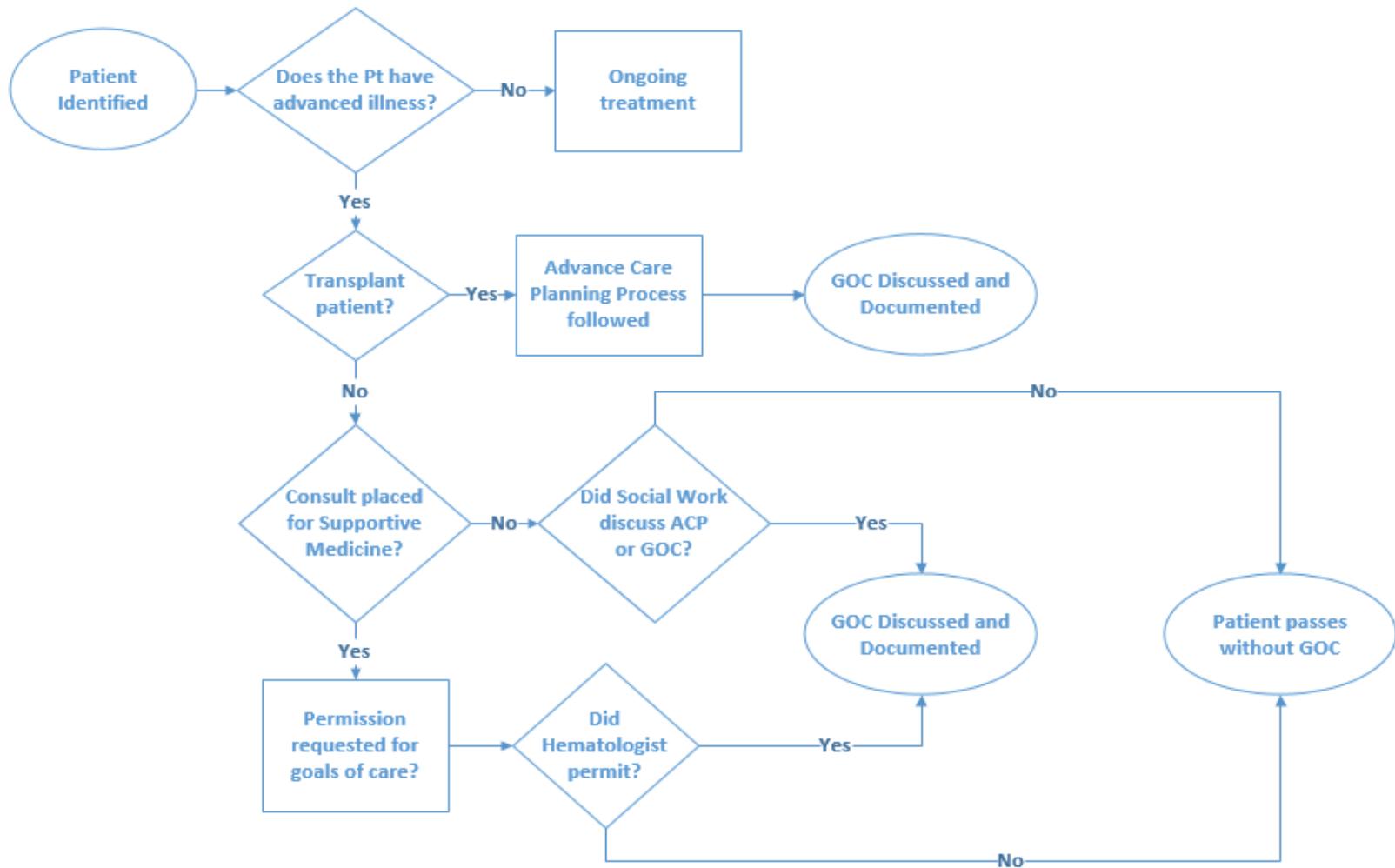
# Problem Statement

Only 31% of our deceased Hematology patients had a goals of care discussion documented greater than 7 days prior to death. This results in care that may not be aligned with patient and family preferences as well as inappropriately increasing healthcare costs.

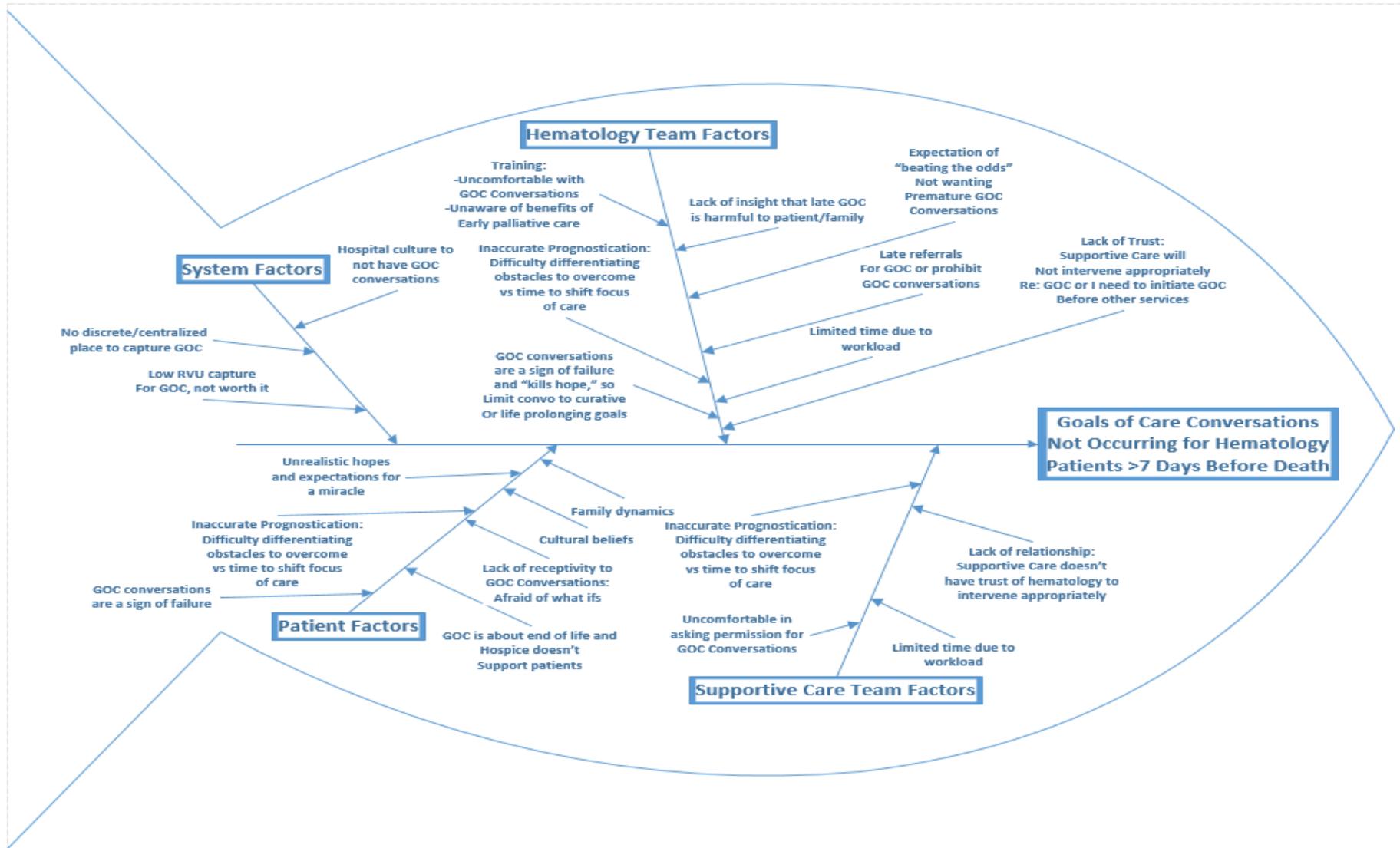
# Team Members

<i>Project Sponsor</i> <sup>#</sup>	Vince Jensen	SVP, Ambulatory & Foundation Ops
<i>Team Leader</i> <sup>†</sup>	William Dale, MD, PhD	Physician; Chair, Supportive Care Medicine
<i>Core Team Member</i> <sup>*</sup>	Finly Zachariah, MD	Physician; Director of Value-based Care, Supportive Care Medicine
<i>Core Team Member</i> <sup>*</sup>	Natalie Schnaitmann	Director of Operations, Dept of Supportive Care Medicine
<i>Core Team Member</i> <sup>*</sup>	Donna Ujiye, RN	Quality Specialist
<i>Other Team Member</i> <sup>^</sup>	Mohiddin Lone	Senior Transformation Specialist
<i>Other Team Member</i> <sup>^</sup>	Denise Morse, MBA	Sr Manager, Quality Analytics
<i>Other Team Member</i> <sup>^</sup>	Christine Glaser, MD	Physician
<i>Other Team Member</i> <sup>^</sup>	Priscilla Ohanesian, MHA, FACHE	Senior Director, Physician Services

# Process Map



# Cause & Effect Diagram



# Diagnostic Data

## Most Common Barriers Identified

1. Late Referrals to Supportive Care
2. Hematologist Perception of Supportive Care
3. Standardizing Location and Quality of Goals of Care Documentation
4. Engagement of all Clinical Staff Caring for the Patient to Assure Goals of Care Discussion Occurs

# Aim Statement

To increase, to 40%, the number of hematology patients that have a Goals of Care discussion documented more than 7 days prior to in-hospital death.

Our aim is to complete by June 7, 2019.

# Measures

- Measure: Documentation of Goals of Care
- Patient population: Hematology and HCT Patients
- Calculation methodology:
  - Numerator*: Number of Hematology patients with documentation of Goals of Care discussion in their electronic hospital record greater than 7 days prior death date.
  - Denominator*: All Hematology cases with a death date recorded in EPIC that was seen by the MD at least 2 times in the 9 months prior to death date
- Data source: Electronic Hospital Record, Manual Chart Audit
- Data collection frequency: Monthly
- Data quality (limitations):

# Baseline Data

Total cases reviewed – 110

Population – All Hematology cases with a death date recorded in EPIC that was seen by the MD at least 2 times in the 9 months prior to death date

Time Frame – May to October 2018

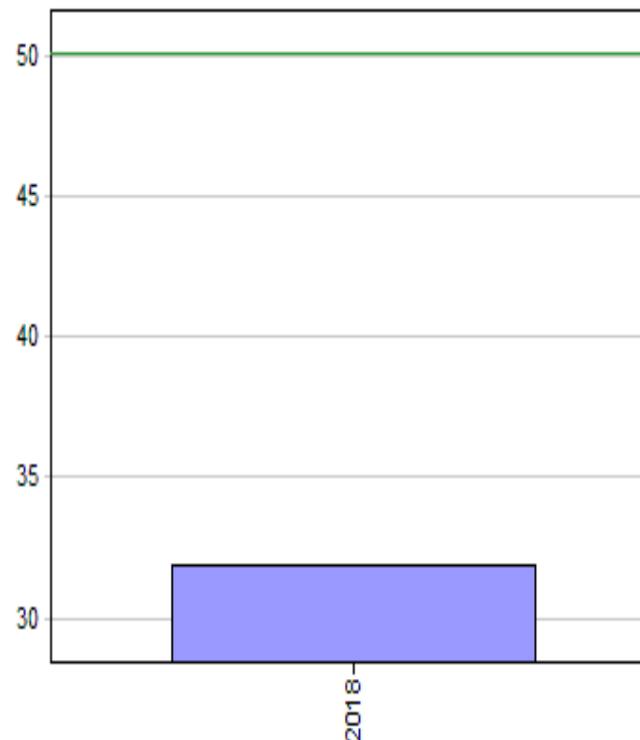
Avg = 31.82

## Goals of Care Consult

Provider = ALL

Bar Chart

+



Target

-

ASCO<sup>®</sup> Quality  
Training Program

# Root Causes to be Addressed

- Hematologist and patient misunderstanding of goals of care and the reason for the discussion
- Supportive care team's hesitation to be more forward in pursuing goals of care discussion
- No discrete/centralized location in Epic to document goals of care
- Patients with complex biopsychosocial and spiritual needs lack a multidisciplinary team approach to care

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

<b>Impact</b>	<b>High</b> <ul style="list-style-type: none"> <li>- Hematology rounds (Friday afternoons)</li> <li>- Integrated Care Service</li> <li>- Development of Advance Care Planning Note with smart phrases</li> </ul>	<ul style="list-style-type: none"> <li>- Utilization of Advance Care Planning Note with smart phrases enterprise-wide</li> </ul>
	<b>Low</b> <ul style="list-style-type: none"> <li>- Goals of Care Education:             <ul style="list-style-type: none"> <li>- Medical Staff presentation</li> <li>- Faculty Lecture</li> <li>- Hematology Staff Meeting</li> </ul> </li> </ul>	
	<b>Easy</b>	<b>Difficult</b>
	<b>Ease of Implementation</b>	

# PDSA Plan (Test of Change)

Date of PDSA Cycle	Description of Intervention	Results	Action Steps
Ongoing- every Friday	Hematology Rounds	Supportive Care integrated within rounds	Increasing confidence of supportive care medicine providers to advocate for goals of care
04/22	Education: Medical Staff Presentation- Goals of Care Faculty Lecture	Completed	Incorporate into ConnectHope training
06/01	Advance Care Planning note with smart phrases developed and pilot initiated with supportive care team	Completed	Finalization of discrete components of goals of care note
08/01	Enterprise-wide adoption of smart phrases/ advance care planning note	In-process	
On-going	Integrated Care Service	In-process	Expand services in line with staff recruitment

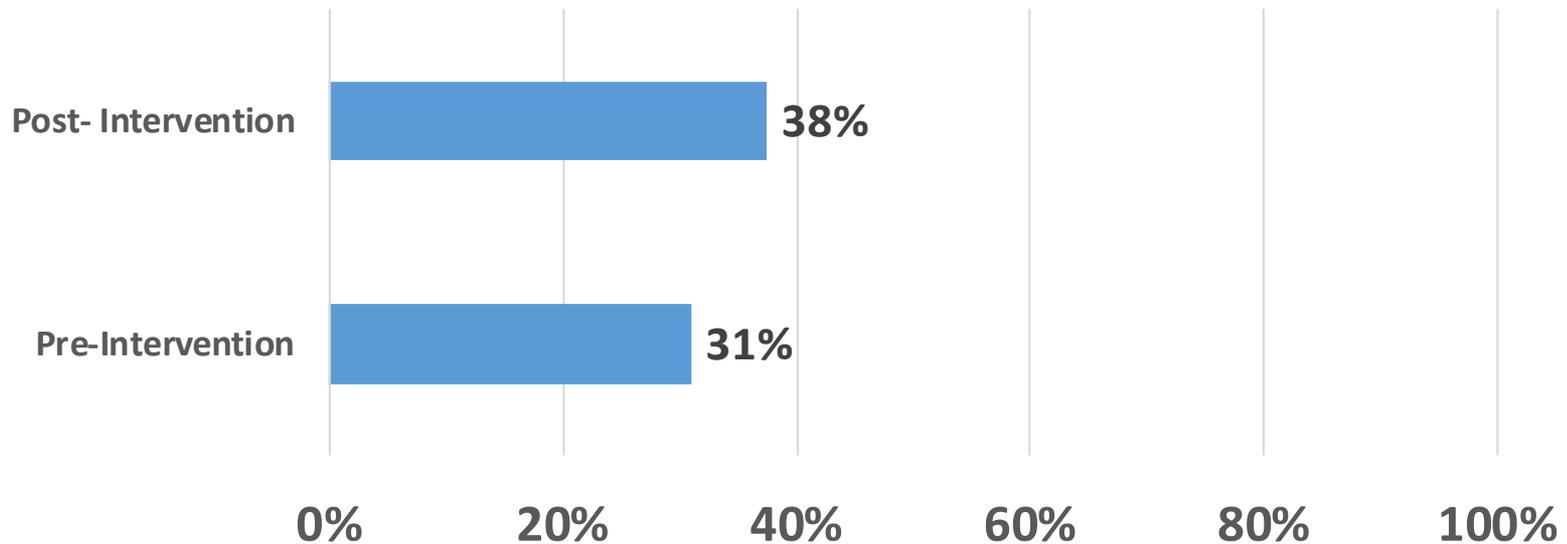
# Materials Developed

## Note Template Developed

- Right now, just free text to capture the fluid/narrative nature of goals of care conversations
  - Pulls all goals of care notes to a consolidated area of the chart
- Larger initiative to determine whether specific data elements are more suitable within the goals of care section of the note, or elsewhere including discussions with patient/family regarding:
  - Advance Directives/POLST
  - Code status
  - Prognostic awareness/uncertainty
  - Benefits and burdens of therapy
  - Hopes/worries
  - Short and long-term milestones
  - Goals, values, preferences aligned to therapeutic treatments/plan of care

# Change Data

## Goals of Care Discussion



Prior to our intervention, 31% of our deceased Hematology patients had a goals of care discussion documented greater than 7 days prior to death. Post intervention, review of inpatient charts revealed documentation in 38% of the patients.

*Initial baseline data was more restrictive given it was used for IIP; given the discussion happens within a care team, post-intervention calculation considered a broader denominator*

# Conclusions

- Enterprise-support and recognition of the need for improving the capture of goals of care for our patients and families
  - Further collaboration with all interdisciplinary care team members to facilitate advance care planning and goals of care
- Leverage technology
  - Need for automated data capture of discrete fields to measure our impact and improvement efforts
- Importance of teamwork and communication
- Room to grow and improve!

# Next Steps/Plan for Sustainability

- Continued visibility and monitoring into ICS/ end of life data by primary service line to be presented to key stakeholders across the institution
- Enterprise deployment and adoption of discrete goals of care note and advanced clinical decision support tools

## Courageous Endeavor: Capturing Care Preferences for Late Stage Hematology Patients

**AIM:** To increase, to 40%, the number of Hematology patients that have a Goals of Care discussion documented greater than 7 days prior to in-hospital death. Our aim is to complete by June 7, 2019.

### INTERVENTION:

- Collective Rounding on Hematology Patients with Hematology MD and Supportive Care MD
- Education to remove any misperceptions of goals of care
- Development of an advance care planning note with specific smart phrases
- Implementation of Integrated Care Service > complex patients directly admitted to supportive care

### TEAM:

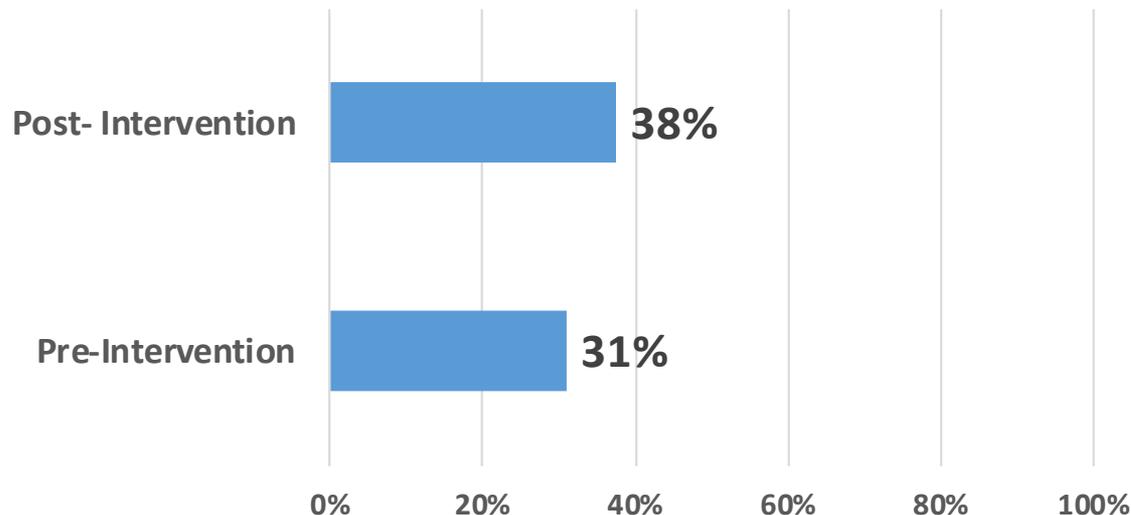
- Supportive Care:  
Natalie Schnaitmann
- Quality:  
Donna Ujiye  
Denise Morse
- Foundation:  
Priscilla Ohanesian

### PROJECT SPONSORS:

- Vince Jensen
- Vijay Trisal, MD

### RESULTS:

#### Hematology Goals of Care Discussion > 7 Days before Death



### CONCLUSIONS:

- Enterprise-support and recognition of the need for improving the capture of goals of care for our patients and families
- Leverage technology
- Importance of teamwork and communication
- Room to grow and improve!

### NEXT STEPS:

- Continued visibility and monitoring into ICS/ end of life data by primary service line to be presented to key stakeholders across the institution
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