

ASCO Quality Training Program

Improving End of Life Care with Advance Care Planning



Institutional Overview



- Located in Rock Springs, WY (Population: 43,534, Service area: 75,000)
- Only comprehensive cancer center in the area, some patients travel ~200 miles roundtrip to SRCC to receive treatment.
- We are defined as frontier rather than rural due to our low population density and large geographic footprint.
- Nearest major city is Salt Lake City, 180 miles to the West.
- Highly skilled and compassionate team, cutting edge radiation oncology equipment and multidisciplinary navigation team.
- We have a shortage of subspecialty providers, few social resources, little foundation support and a patient population that is frequently underinsured or uninsured.

Team members

| Role | Name | Job Function |
|---------------------------------|-------------------------------------|---|
| Project Sponsor | Kari Quickenden, PharmD, MHSA | Chief Clinical Officer |
| Team Leader | Banu Symington, MD, MACP | Medical Director & Hematologist/Oncologist |
| Core Team Member | Jackie Barnhart, MSN, MSB, FNP-C | Nurse Practitioner |
| Core Team Member | Stacy Wells, BSN, RN, OCN | Clinical Coordinator |
| Facilitator/Core Team Member | Tasha Harris, MS, CMD, RTT | Cancer Center Director & Dosimetrist |
| Other Team Member | June Ledger | Receptionist |
| QTP Improvement Coach | Valorie Harvey, BSN, MBA | Provides remote support to the team. |

Problem Statement

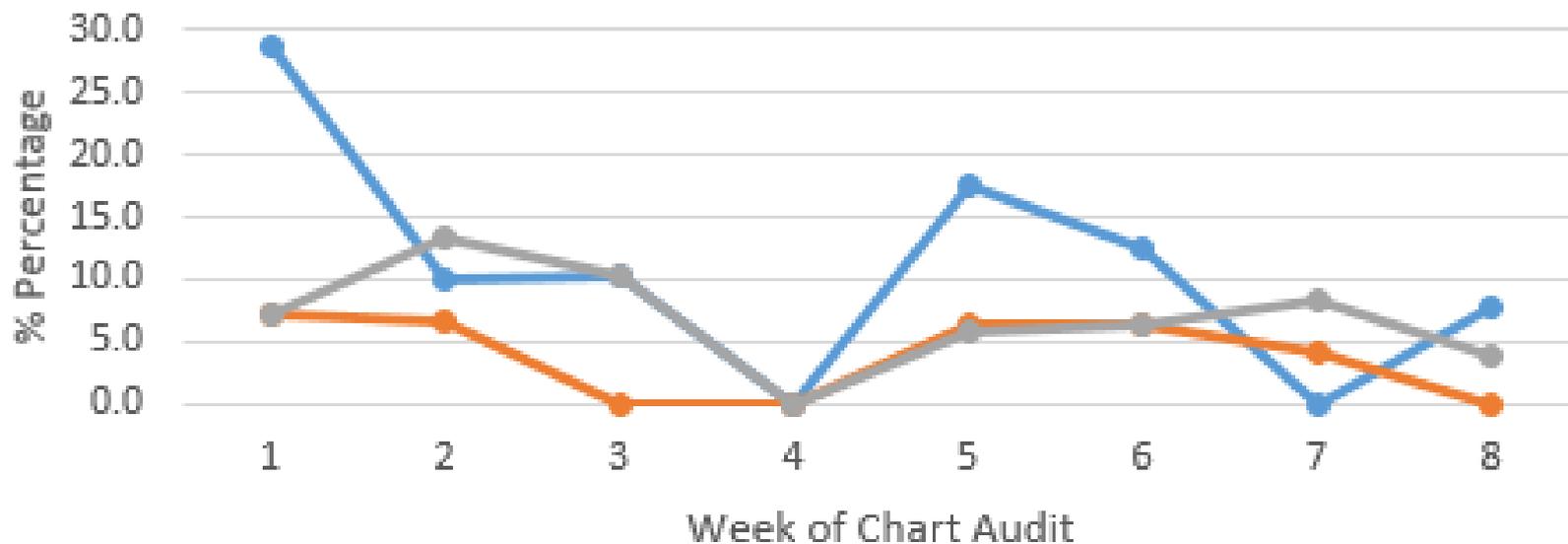
Between December 2019-January 2020, five of our patients were admitted to the hospital, four were discharged to hospice and died within a week. None of those patients had advance directives. In November and December 2019, all oncology patient charts were reviewed and only 7% (12/174) had advance directives. We believe an established advance directive could have helped avoid unnecessary hospitalization, improved end of life care and reduced wasteful health care costs.

Baseline data summary

| Item | Description |
|---|--|
| Measure: | Percentage of patients screened, educated and/or completed an advanced directive scanned into medical record |
| Patient population: <i>(Exclusions, if any)</i> | All medical oncology and malignant hematology patients seen in clinic in November and December 2019 |
| Calculation methodology: <i>(i.e. numerator & denominator)</i> | Medical record review Numerator: # of patients screened, educated and/or completed AD scanned into medical record Denominator: All November and December oncology patients |
| Data source: | eMDs, Quadramed, Phreesia, paper chart |
| Data collection frequency: | One-time data collection on qualifying patient charts from November-December 2019 |
| Data limitations: <i>(if applicable)</i> | Multiple data sources |

Baseline data

Run Chart of Advanced Care Planning Nov/Dec 2019

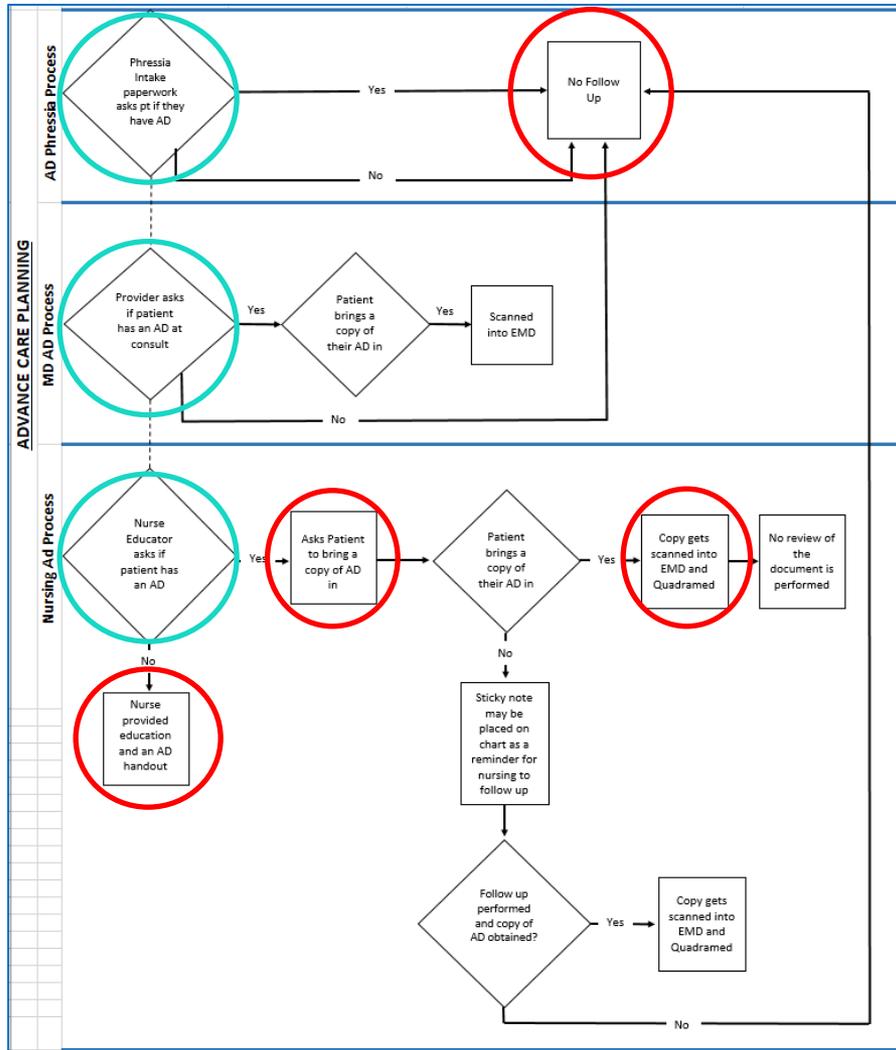


- Percentage of patients screened per week
- Percentage of patients educated per week
- Percentage of patients with completed AD per week

Aim Statement

By August 28, 2020, the goal is 30% of all new oncology patients will have documentation of a completed advance directive. From June 8, 2020-August 28, 2020 we will offer advance care planning (including screening, education, follow-up and documentation of an advance directive) to all new oncology patients.

Process map

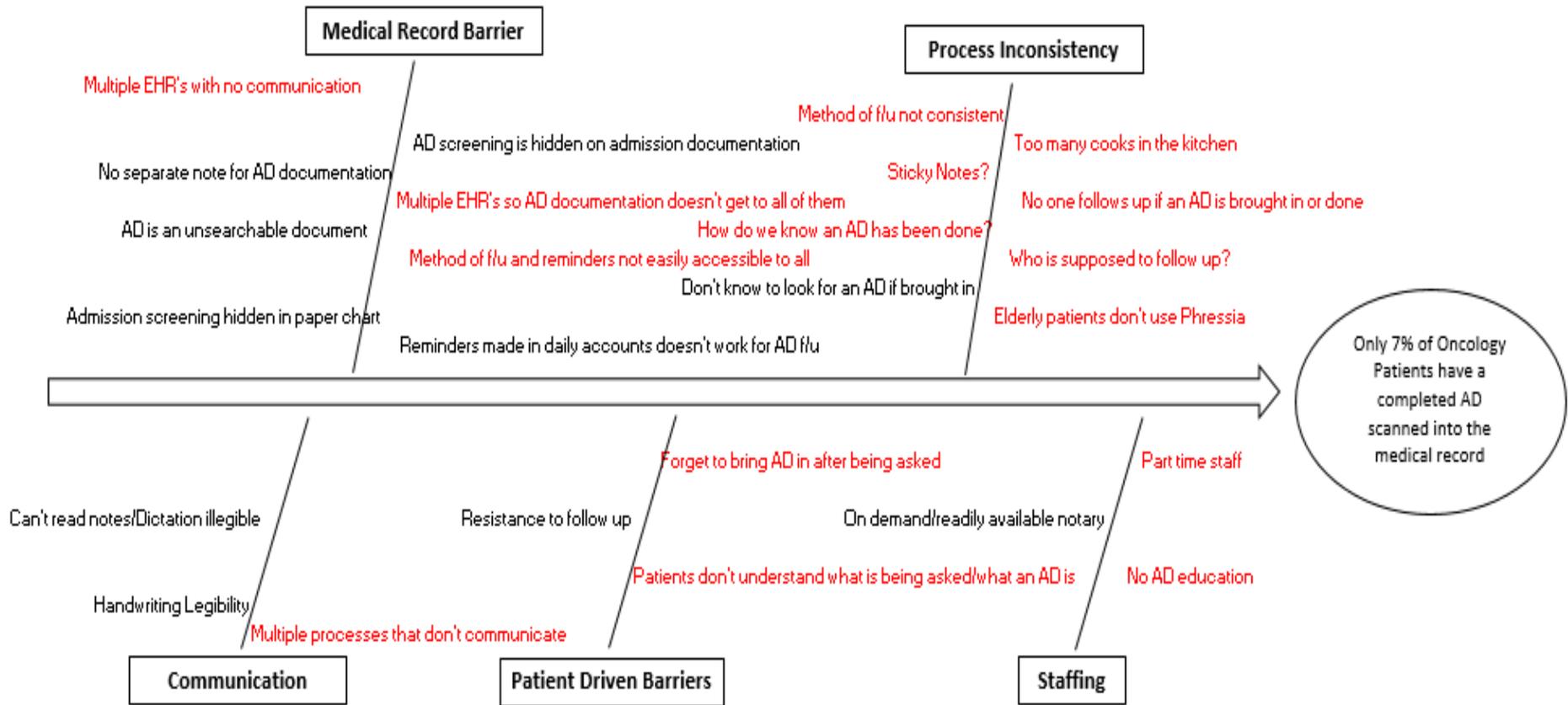


All processes lacked follow-up

No one had ownership of making sure AD was obtained

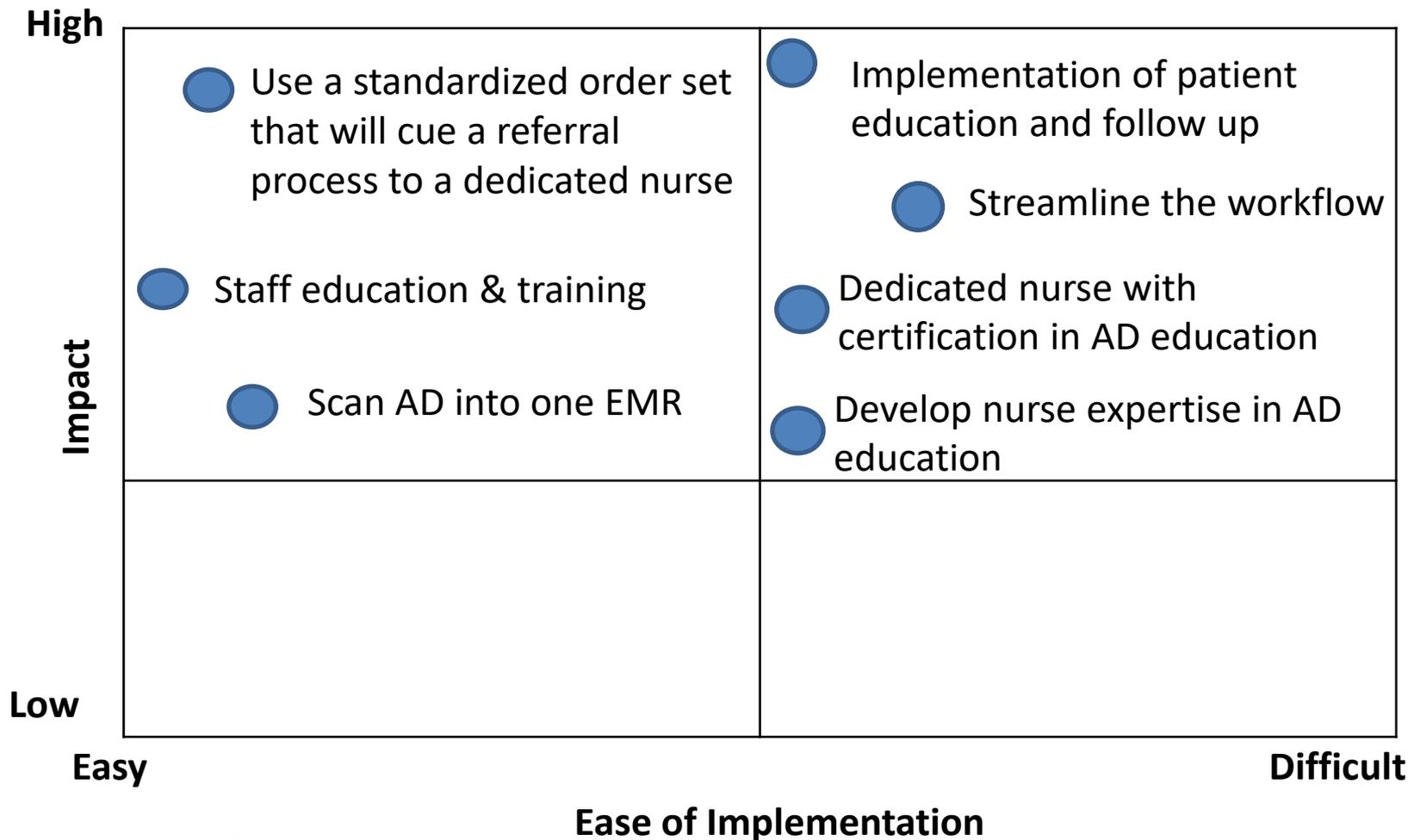
We realized how many redundant and ineffective processes were already in place. There were 11 steps in the process, 6 hand-offs, 9 people involved in the process and 9 decision points.

Cause and Effect Diagram



We knew that having multiple EMR's was a barrier and a challenge, however we quickly realized that process inconsistency was nearly an equal challenge. Patient driven barriers had less of an impact than we had assumed.

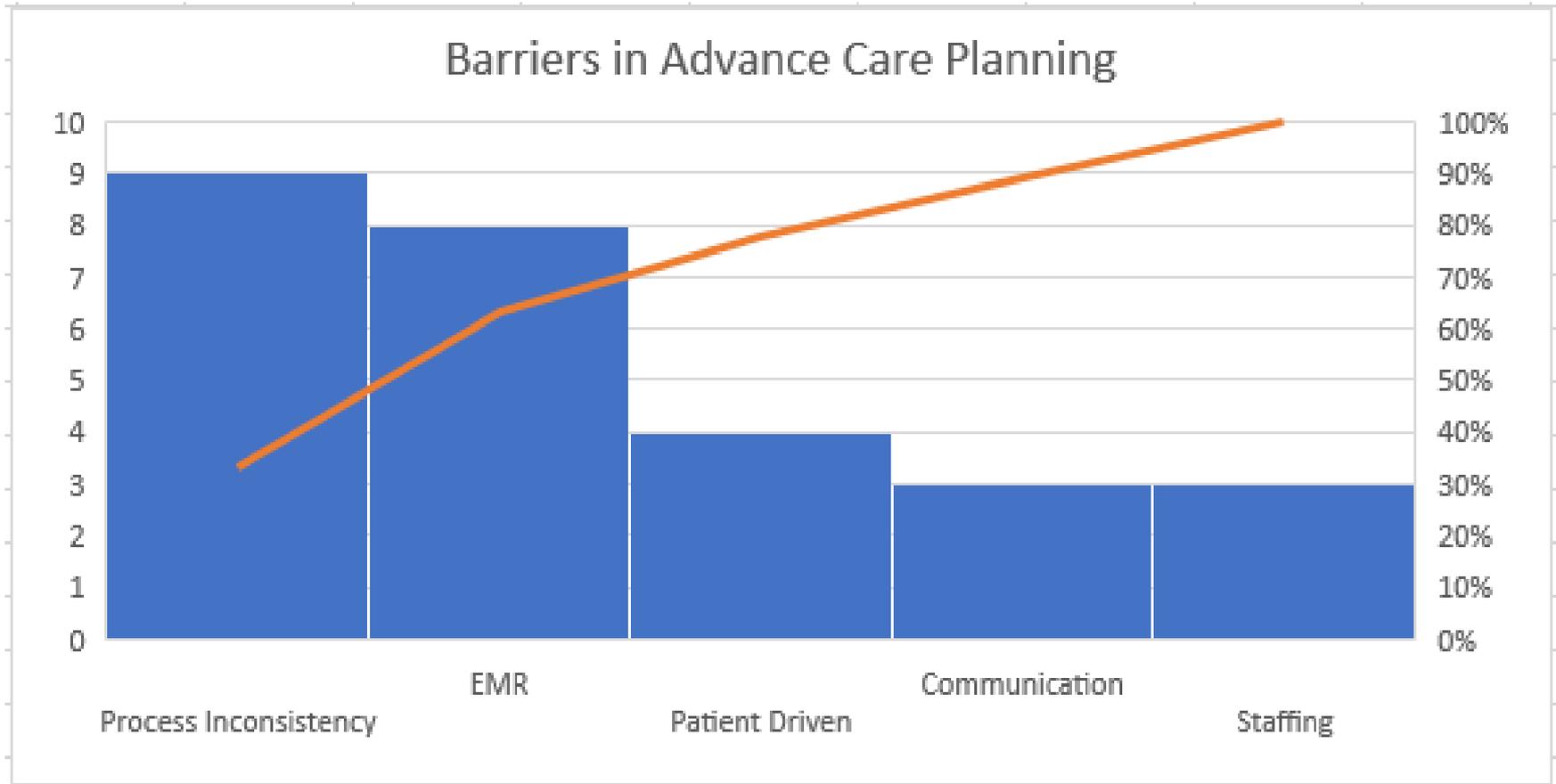
Countermeasures



Diagnostic Data summary

| Item | Description |
|---|---|
| Measure: | Percentage of patients who have a completed advanced directive scanned into medical record |
| Patient population: <i>(Exclusions, if any)</i> | All new oncology patients |
| Calculation methodology: <i>(i.e. numerator & denominator)</i> | Medical record review Numerator: # of patients with a completed AD and scanned into medical record Denominator: All new oncology patients in the clinic June 8th-August 28th 2020 |
| Data source: | eMD |
| Data collection frequency: | Monthly: June 8th-August 28th 2020 |
| Data limitations: <i>(if applicable)</i> | Smaller sample size |

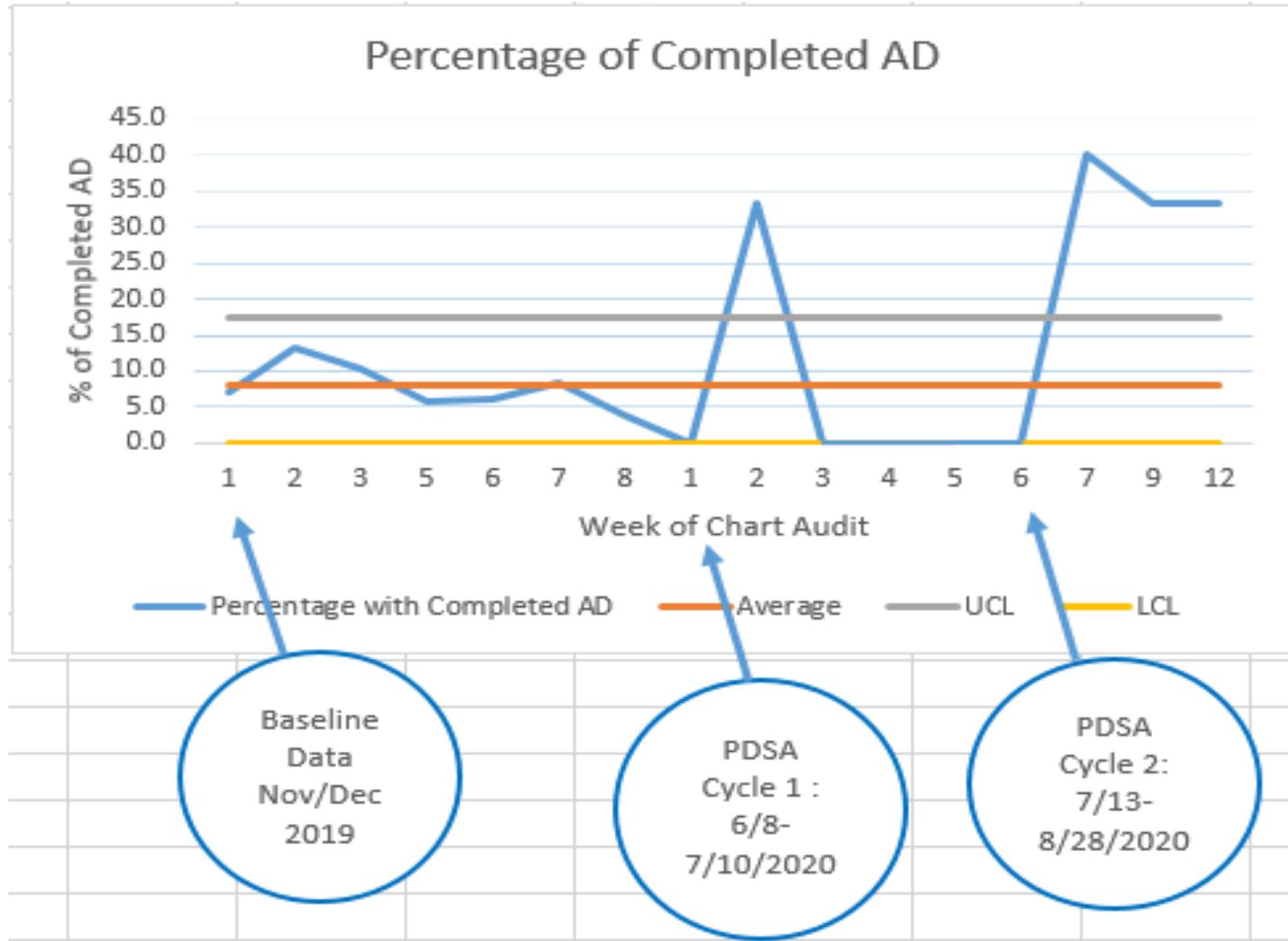
Diagnostic Data



PDSA Plan

| Date | PDSA Description | Result |
|--------------------------------|--|---|
| 6/8/2020-7/12/2020 Cycle 1 | <ul style="list-style-type: none">• Assign a dedicated advance directive nurse• AD nurse training & certification• Staff education | <ul style="list-style-type: none">• Certification obtained• 6% AD completion |
| 7/13/2020-8/28/2020 Cycle 2 | <ul style="list-style-type: none">• Establish a standardized order set that will cue a referral process to the dedicated AD nurse• Standardize patient education and follow-up processes by the AD nurse• Establish one consistent EMR (eMD) to scan in AD | <ul style="list-style-type: none">• 36% AD completion and scanned into medical record |

Outcome Measure Change Data



Next steps

Sustainability Plan

| Next Steps | Owner |
|--|--|
| Staffing: Establish the value of a permanent role for AD nurse and maintain certification. Appoint staff to cross train to cover for AD nurse. | AD Nurse/ Clinical Coordinator |
| Budget Analysis: May need to increase the annual staffing budget to allow the AD nurse to work more hours or bring in a PRN nurse when needed. | Cancer Center Director |
| Stakeholder Communication: Communicate project needs, aims and outcomes to support sustainability. | Cancer Center Director |
| Data Collection: Continue to pull AD data and conduct random annual chart audits. Report data quarterly to Performance Improvement and Patient Safety Committee. Survey patients and families to assess impact. | Receptionist/ Clinical Coordinator |
| Project expansion: Expand referral and AD education to all oncology outpatients, help expand the project to the entire hospital. | QTP Team |

Conclusion

- Communication failings and process inconsistencies created significant barriers.
- Creating a position dedicated to AD was not in itself sufficient to lead to a change in completion rates.
- Adding a consistent process and formal communication to the dedicated AD nurse led to improvements.
- We now have a process to make sure that the completed AD is in the chart or the patient's refusal is documented.
- More time is needed to ensure the new system is sufficient to meet our goals consistently.
- We will need to come up with a plan to address advance directives in established patients.

Improving End of Life Care With Advance Care Planning

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INTERVENTIONS:

- Assign a dedicated advance directive nurse with certification in advance care planning
- Educate staff on the new process
- Include advance directives on the standardized order set that will cue a referral process to the dedicated AD nurse
- Implement patient education and follow-up by the AD nurse
- Completed AD scanned into one consistent EMR (eMD)

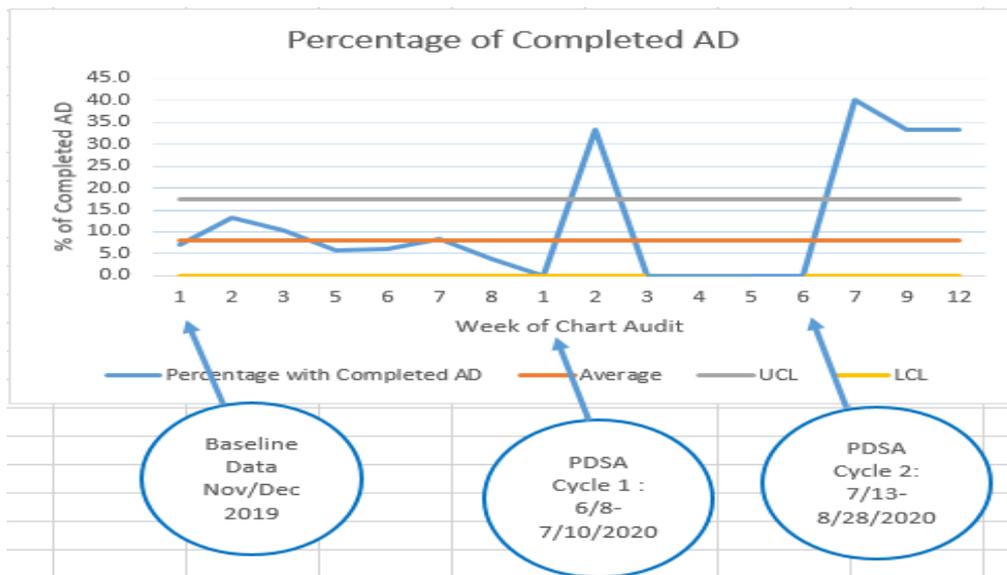
TEAM:

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- Valorie Harvey, BSN, MBA

PROJECT SPONSORS:

- Kari Quickenden, PharmD, MHSA

RESULTS: Our baseline data showed that we had a 7% AD completion rate. By the end of PDSA Cycle 2, our AD completion rate had increased to 36%



CONCLUSIONS:

- Prior to our interventions, communication failings and process inconsistencies led to poor AD completion rates
- Implementing a consistent process, assigning a dedicated AD nurse and formal communication resulted in a significant increase in AD completion rates and helped us meet our AIM

NEXT STEPS:

- Appoint staff to cross train as AD nurse
- Continue to pull data monthly
- Report our data quarterly to the Performance Improvement and Patient Safety Committee



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— REGIONAL CANCER CENTER —

Thank you!



SRCC Team: Dr. Banu Symington, Jackie Barnhart, Tasha Harris, Stacy Wells