ASCO
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

# Improving utilization of hospice at the end of life for patients with advanced (solid tumor) cancer



Christine A. Garcia, MD, MPH

June 18, 2021

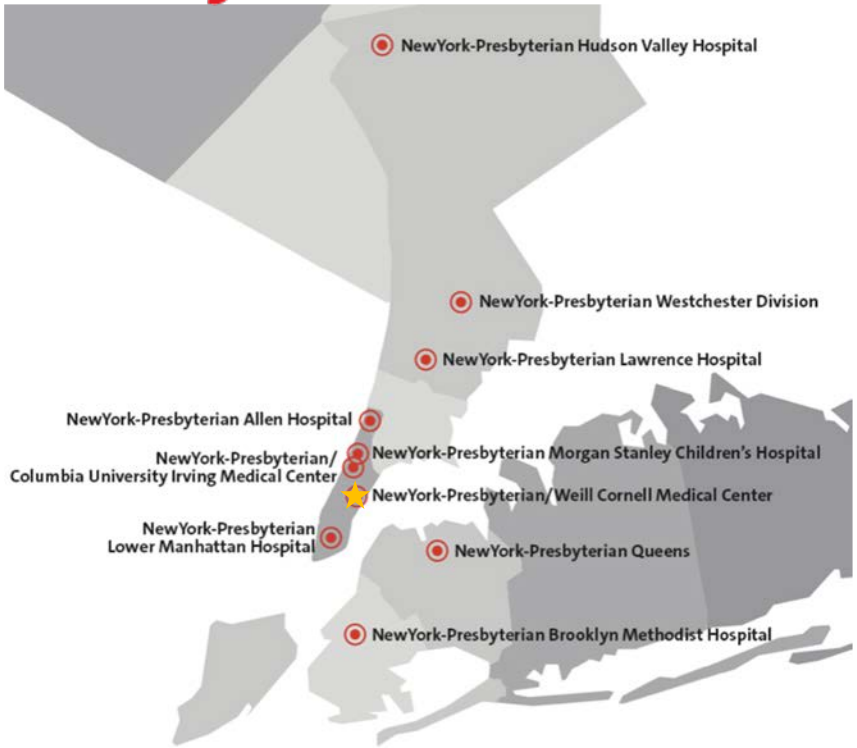
Weill Cornell Medicine | NewYork-Presbyterian

## Integrated, academic health system with two school partners

- 3.6 million patient visits in 2018
- 4,067 beds across 10 hospitals

## NYP/Weill Cornell Medical Center

- 47,532 hospital discharges in 2019
- 862 beds; 83 dedicated oncology bed for heme malignancies and transplant
- Inpatient solid tumor consult service follows patients on mostly hospitalist-led primary teams



Weill Cornell Medicine | NewYork-Presbyterian

## 5 Outpatient Hematology and Medical Oncology Practice Sites

- 5,356 new cancer patient visits in 2020
- ~4,700 analytic cases per year; 11,500 across system

## Providers

- 46 Physicians in Hematology & Medical Oncology (32 cFTEs)
- 41 Advanced Practice Providers (APPs)

## Supportive Medicine

- ~5 cFTE Palliative Care Physicians (not all dedicated to Onc)
- 8 OP Oncology Social Workers
- 1 IP Social Worker and 1 IP RN Care Coordinator per Unit
- 0.25 cFTE dedicated Psycho-Onc Psychiatry Support

# Team Members

- **Team Leaders**
  - Christine Garcia, MD, MPH - Oncology & Hematology
  - Francie Emlen, MBA, RN - Director of Oncology
  - Michelle Brody, MPH - Oncology Care Model Program Manager
  - Kelly Cummings, MD - Geriatrics

- **Project Sponsor**
  - Manuel Hidalgo Medina, MD, PhD- Chief of Oncology

- **Team Coach**
  - Amy Morris, Hematology/Oncology - Clinical Pharmacist, UVA Health System

# Team Members

- **Solid Tumor Oncologists**
  - Tessa Cigler, MD
  - Scott Tagawa, MD
  - Nevena Lucic, MD
- **Medicine Hospitalists**
  - Paul Martin, MD
  - Kimberly Bloom, MD
  - Laura Kolbe, MD

- Social Workers
- Patient Care Directors
- Physician Assistants/ Nurse Practitioners
- Nurses
- Palliative Care team
- Hospice partner, Calvary

# Problem Statement

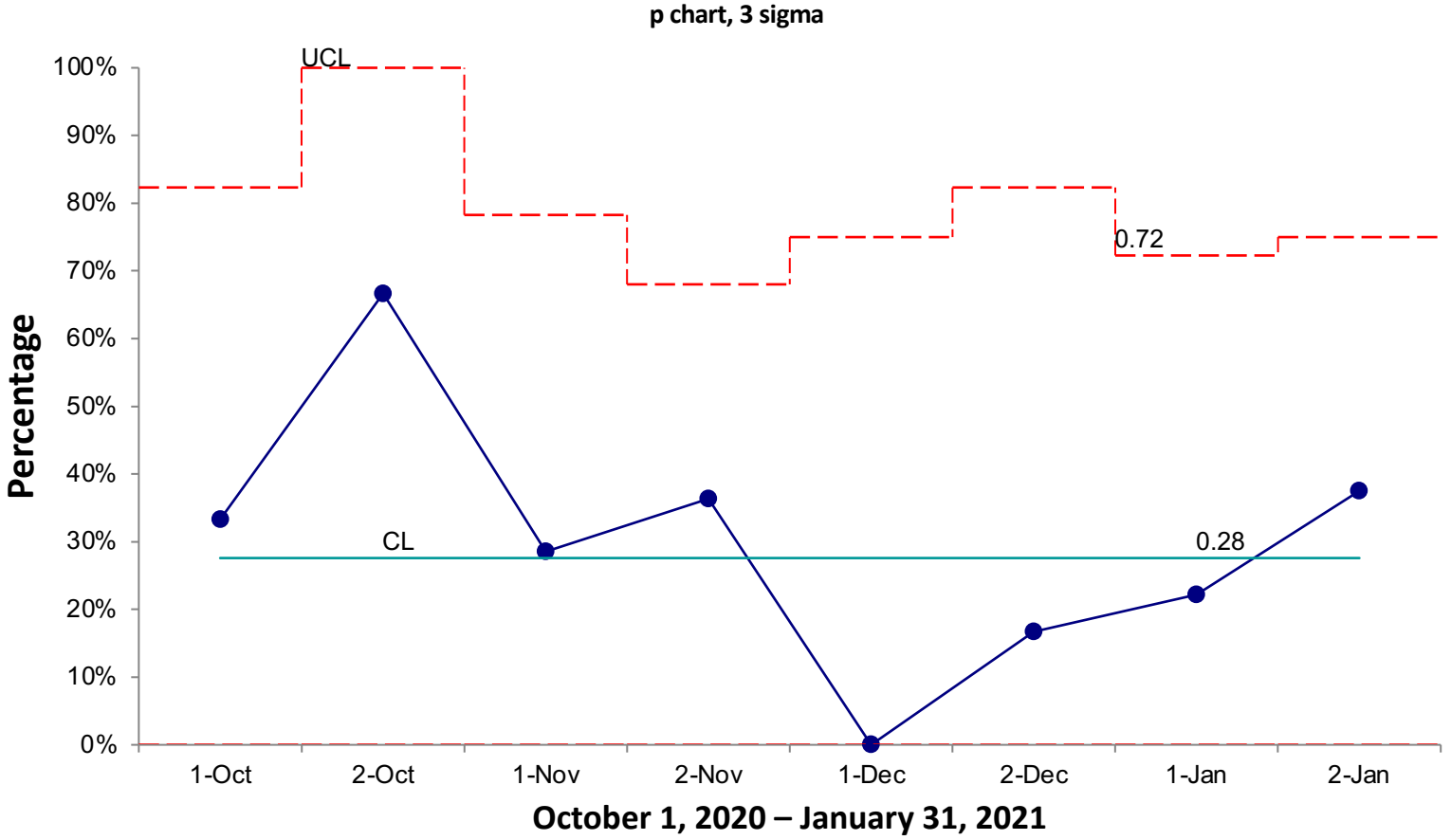
From October 1, 2020 to January 31, 2021, only 27% of patients with solid tumor cancer and an admission within 6 months prior at NYP/Weill Cornell Medicine utilized hospice services at end of life.

This can result in patients not being able to receive the full benefit of hospice at the end of life, significant distress to patients and families, and frustration among staff and caregivers.

# *Outcome Measure*
# Baseline data summary

| Item | Description |
|---|---|
| Measure: | Admitted patients discharged to hospice |
| Patient population: | Patients with (solid tumor) cancer diagnosis at the end of life<br>(Excluding patients with heme malignancies) |
| Calculation methodology: | Numerator: Patients discharged to hospice<br>Denominator: Sum of expired patients and patients discharged to hospice |
| Data source: | EPIC clinical data, Inpatient hospice data |
| Data collection frequency: | Weekly |
| Data limitations: | Timing (mortality data, dependent on documentation) |

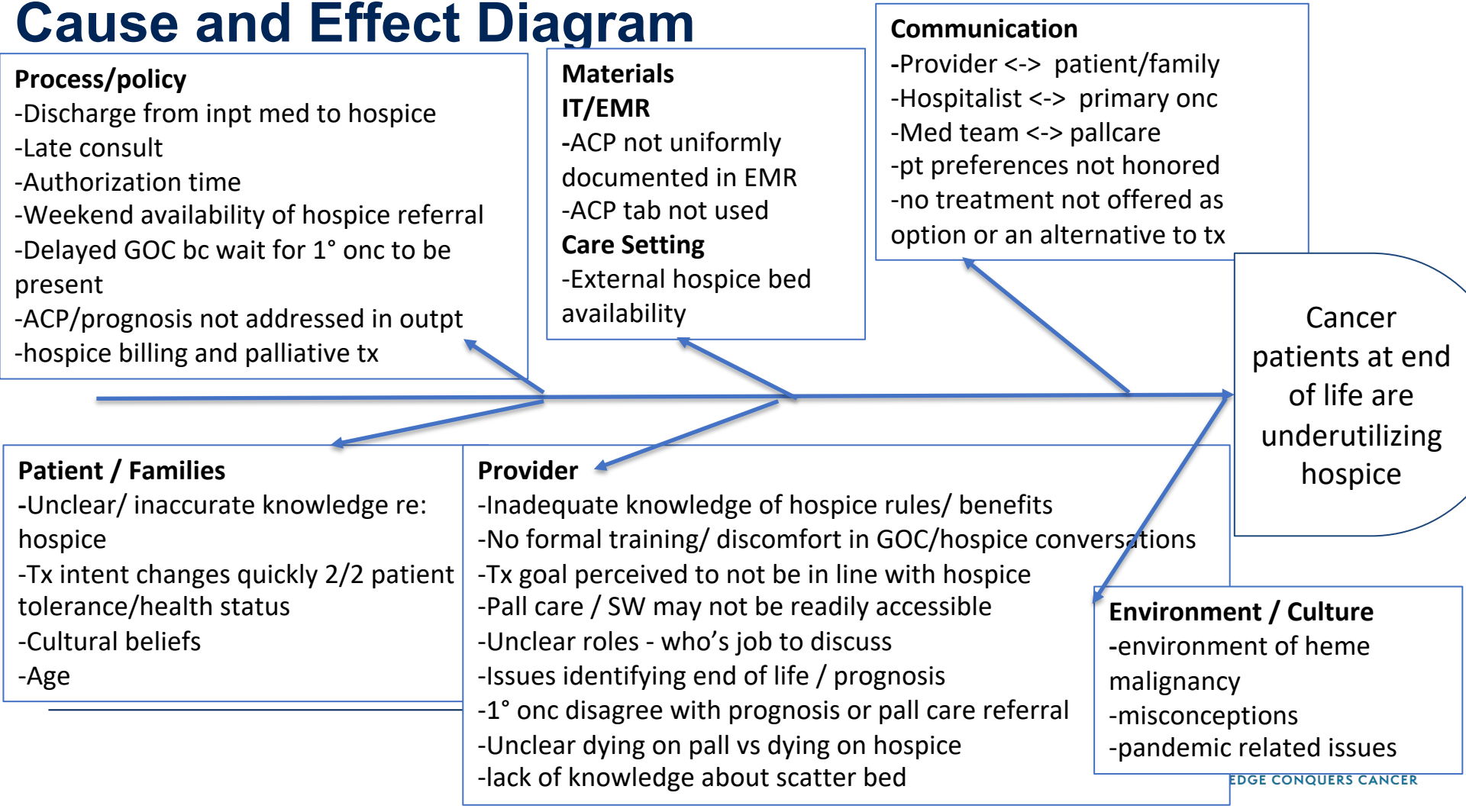
# Percentage of WCM hospice-eligible patients with advanced solid tumor cancer discharged to hospice (baseline 10/2020- 1/31/2021)



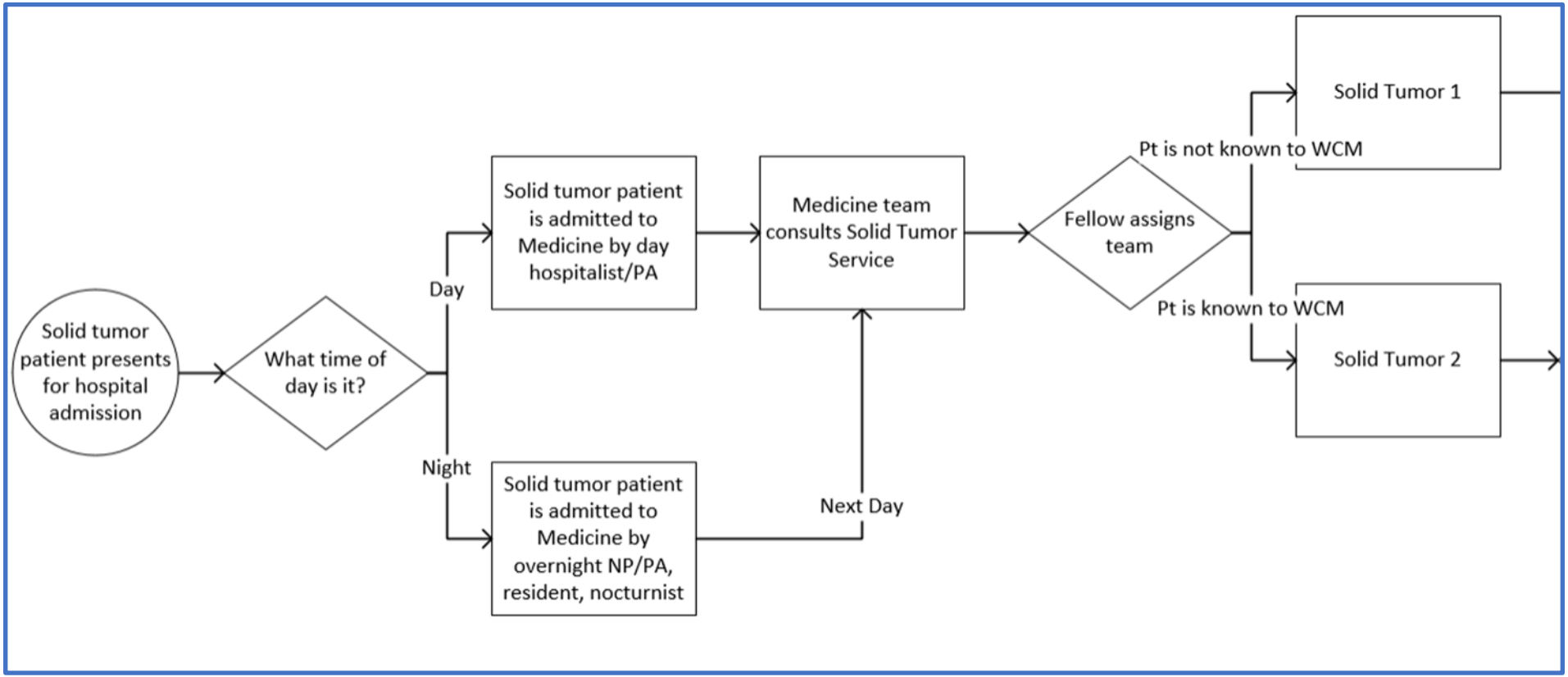
# Aim Statement

To increase the volume of hospitalized patients with diagnosis of solid tumor cancer at the end of life discharged to hospice by 10% from 3/1/2021 to 6/30/2021.

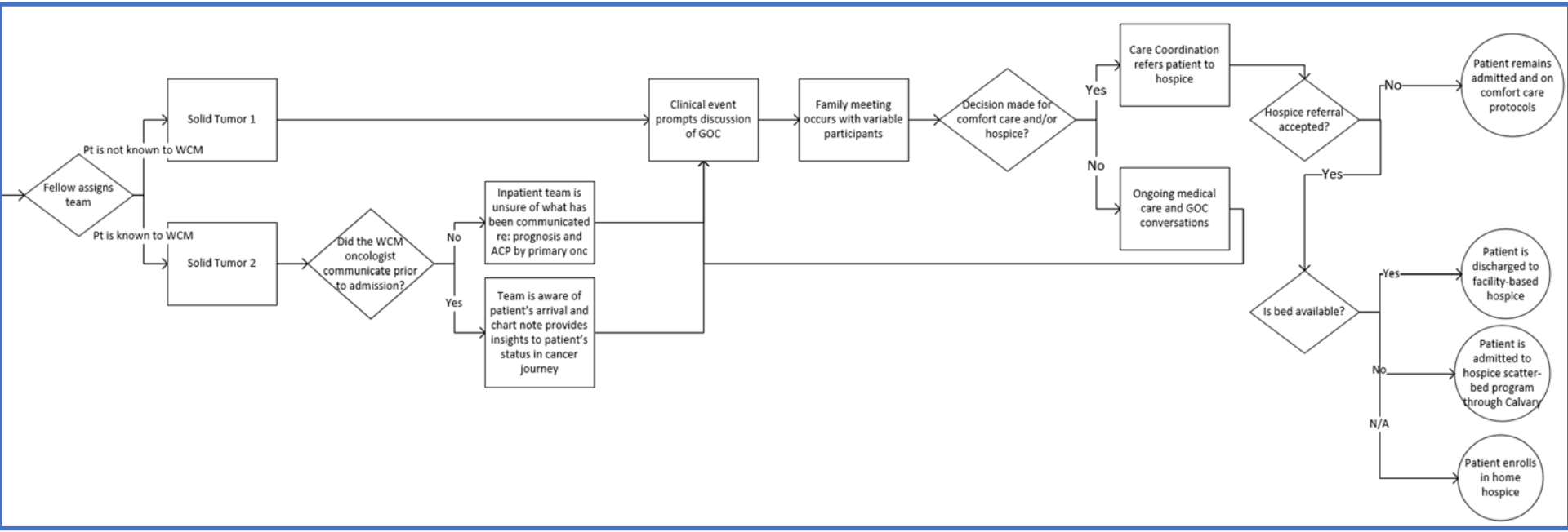
# Cause and Effect Diagram



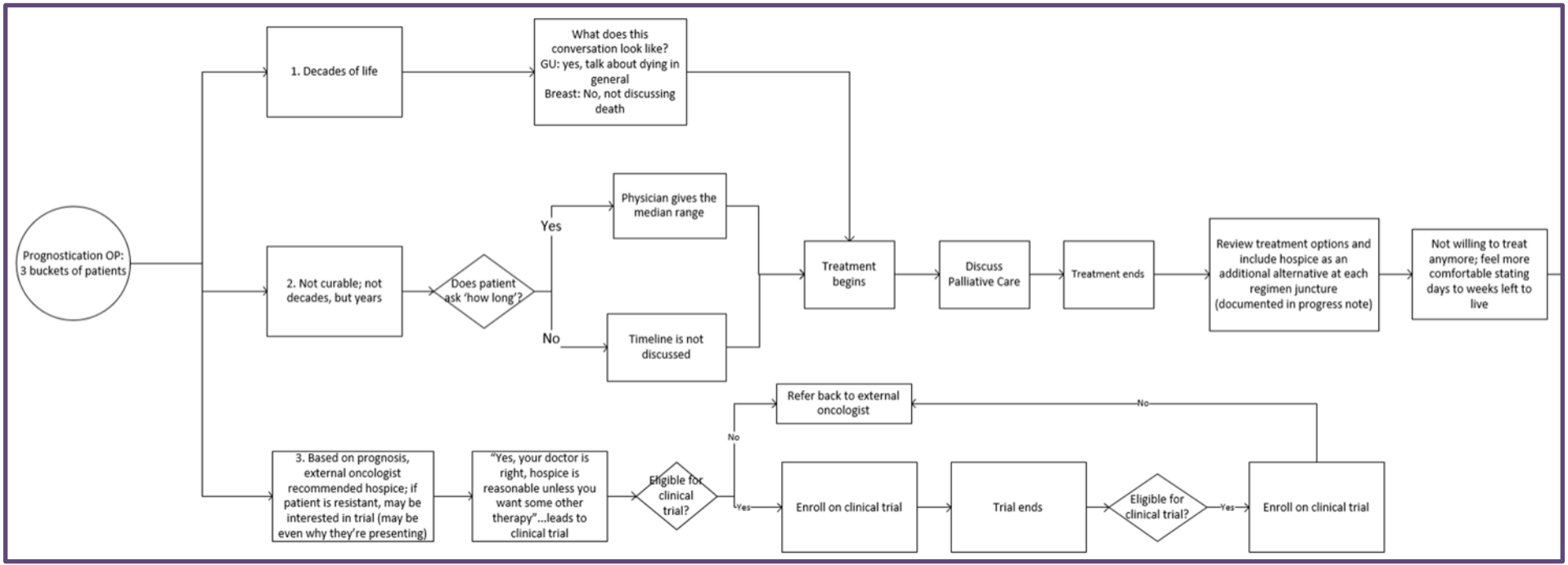
# Inpatient Process Map



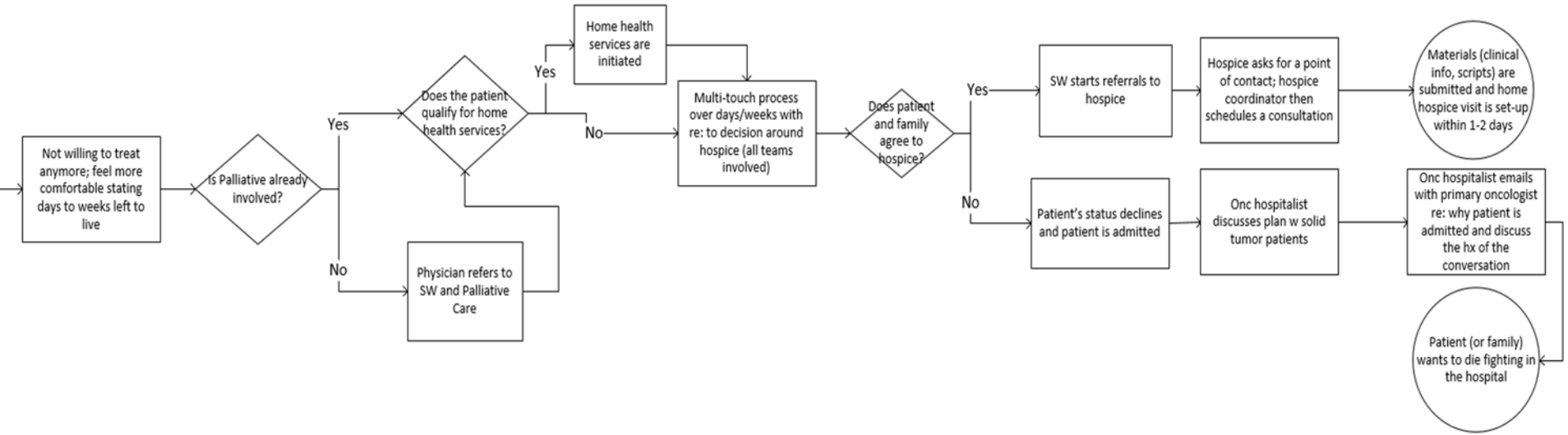
# Continuation of Inpatient Process Map



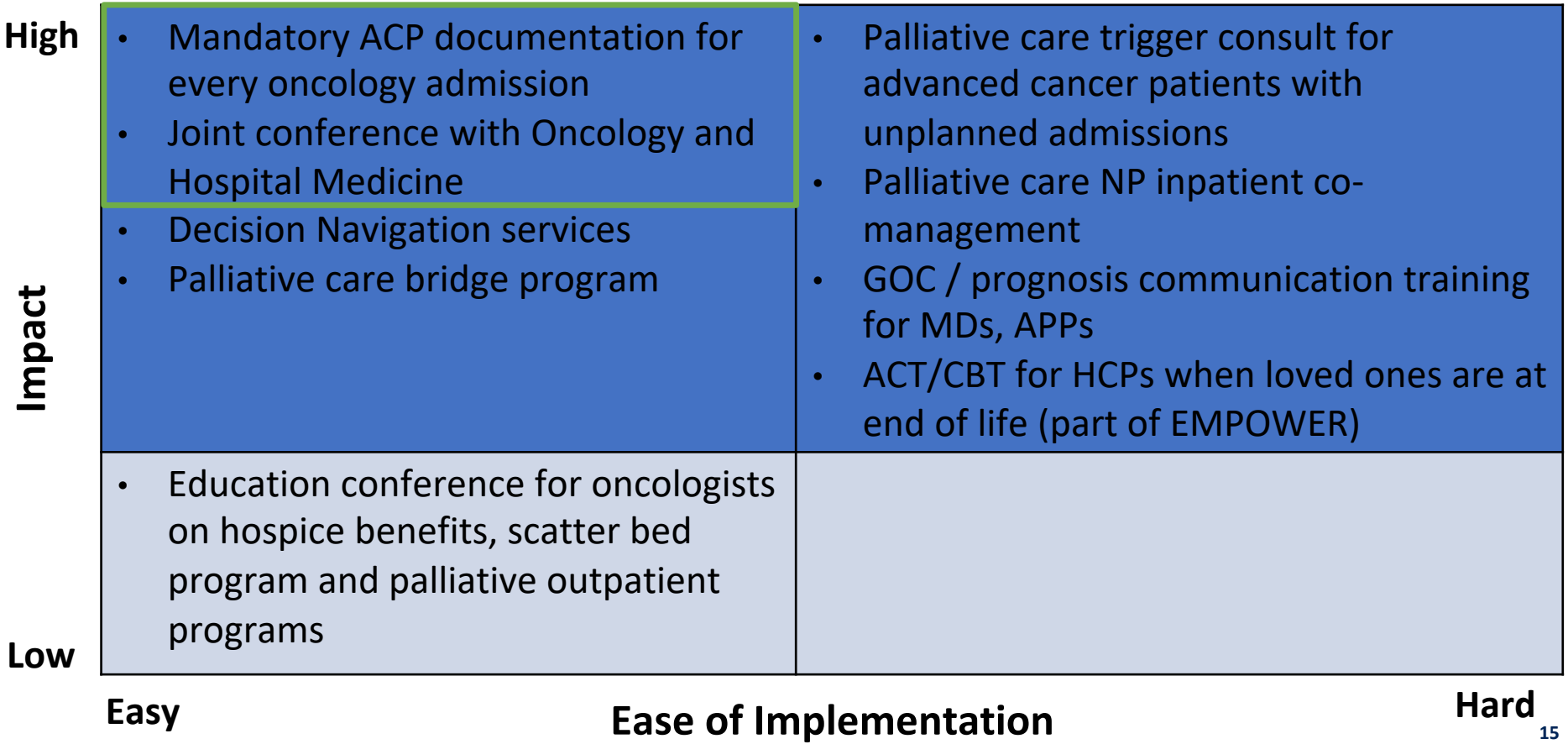
# Outpatient Process Map



# Continuation of Outpatient Process Map



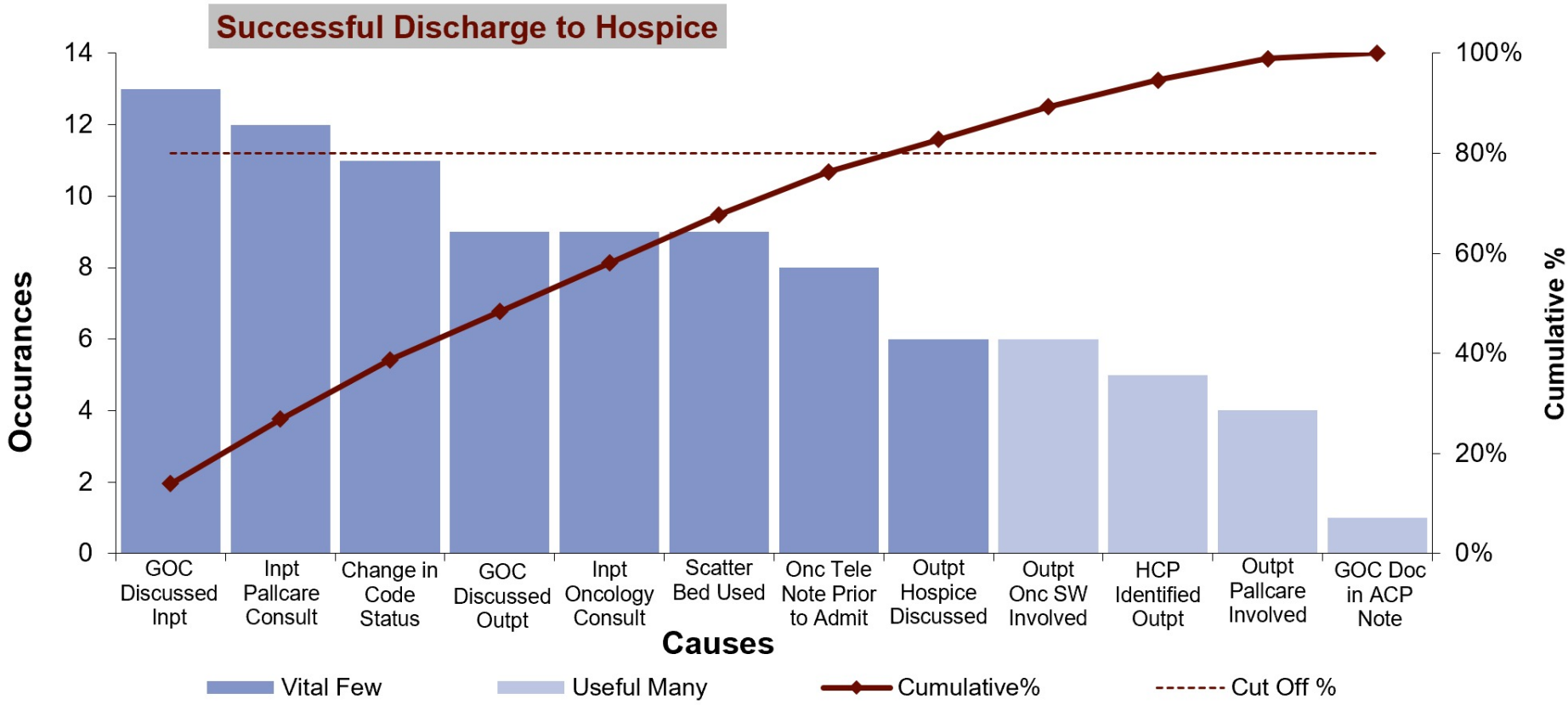
# *Priority / Pay-off Matrix*
# Countermeasures



# *Process Measure*
# Diagnostic Data summary

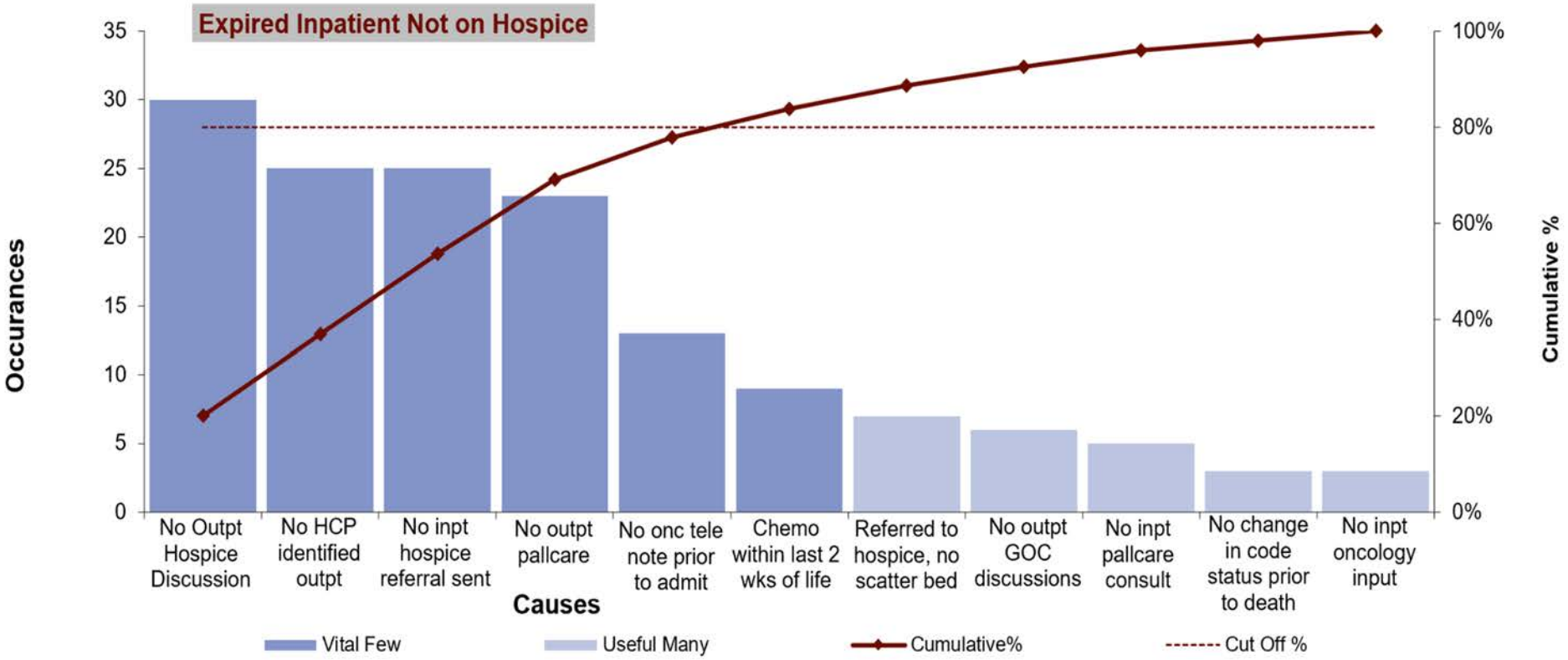
| Item | Description |
|---|---|
| Measure: | Use oncology admit note (with GOC documented) |
| Patient population: | Solid tumor oncology patients (known to WCM oncology) |
| Calculation methodology: | EPIC report, chart review |
| Data source: | EPIC |
| Data collection frequency: | Weekly |
| Data limitations: *(if applicable)* | Retrospective, many things difficult to collect in chart due to non-documentation, variable use of advanced care planning tab |

# Process Measure: Reverse Pareto




**The first 8 Causes cover 82.8 % of the Total Occurances**

# Process Measure




The first 6 Causes cover 83.89% of the Total Occurances

# *Test of Change*
# PDSA Plan

| Date | PDSA Description | Result |
|---|---|---|
| 02/01/2021-04/20/2021 | Increase awareness through multidisciplinary root cause analysis and process map discussions | Key stakeholders/ champions identified on all teams to participate in RCAs and process map discussions |
| 04/01/2021-12/01/2021 | Mandatory oncology admission template to include GOC | Increased GOC documents using smart phrase template for admit note and in referral to ER notes, but uptake has been slow and inconsistent |
| | Joint oncology & hospital medicine conferences | Ongoing post-joint conference survey for feedback |
| 06/01/2021-07/2021 | Evaluate reasons for non-compliance with oncology admission templates, identify all areas where GOC documents live with goal to standardize | |
| 07/01/2021-12/31/2021 | Palliative care “bridge” outpatient program for specific disease areas | |
| | Decision navigation at time of referral to palliative RT inpatient | |

# Oncology Admission Template

**Oncology Inpatient Admission Handoff**

Primary Oncologist: ***

Preferred way to communicate with Oncologist: {JMPREFERREDCOMMUNICATION:5

Diagnosis: ***

Stage: ***

Treatment Details:

Name of Most Recent Treatment: ***

Last Treatment Date: ***

Type: {JMCHEMOTHERAPY:51378}

*** line treatment

Treatment goal: {JMTREATMENTGOAL:51377}

Prior Treatment Summary:

***

Other Consults to be Placed:

Pain Management: {YES/NO:60}

Palliative Care: {YES/NO:60}

Radiation Oncology: {YES/NO:60}

Nutrition: {YES/NO:60}

Other Pertinent Medical Issues:

***

Advanced Care Planning:

Was ACP completed in the outpatient setting: {YES/NO:60}

Identified HCP: ***

Most recent GOC discussion (Date and Details):
Date: ***
Details: ***

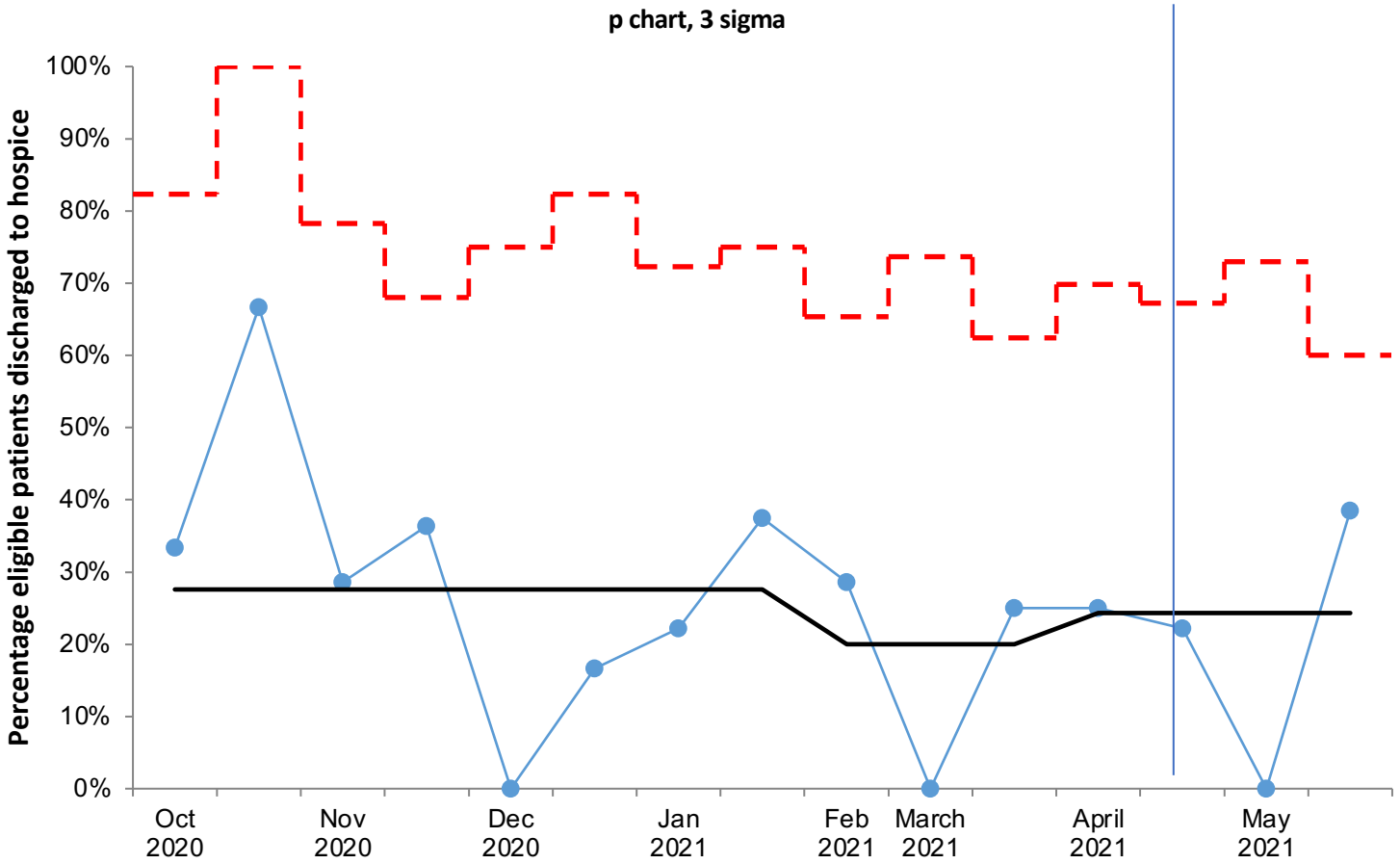
Have there been any prior hospice discussions: {YES/NO:60}
If yes, summary of previous discussion: ***

Is Palliative Care already involved in the outpatient setting: {YES/NO:60}
Was Palliative Care recommended in the outpatient setting: {YES/NO:60}

Is Social Work involved: {YES/NO:60}

CODE STATUS: @CODESTATUS@

# Percentage of WCM hospice-eligible patients with advanced solid tumor cancer discharged to hospice



# *Next steps*
# Sustainability Plan

| Next Steps | Owner |
|---|---|
| Run report weekly, calculate outcome measure, and distribute | Michelle Potash-Brody |
| Send gentle reminders to provider teams re: the .oncadmit smartphase when providers admit patients without utilizing the smartphrase | Francie Emlen |
| Launch palliative care bridge pilot program with GI oncology | Christine Garcia<br>Kelly Cummings |
| Standardize GOC documentation and advanced care planning documentation in EPIC organization-wide | Christine Garcia<br>Kelly Cummings<br>Org-wide QPS team |

# Conclusions

- Consider culture around communicating advanced disease and poor prognosis
- Importance of aligning with organization/ campus-wide goals
- Need for standardization of ACP documentation across all disciplines
- Collaboration is key –
  - Palliative care and hospice partnerships for “bridge” type services
  - Radiation therapy nurses to help with decision navigation
  - GI PEG “time out”
  - Palliative care social work champions
  - Pain management

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

# Thank you!

Weill Cornell Medicine | NewYork-Presbyterian