

# ASCO®

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



**Weill Cornell  
Medicine**

**NewYork-  
Presbyterian**

Christine A. Garcia, MD, MPH

June 18, 2021



**Weill Cornell  
Medicine**

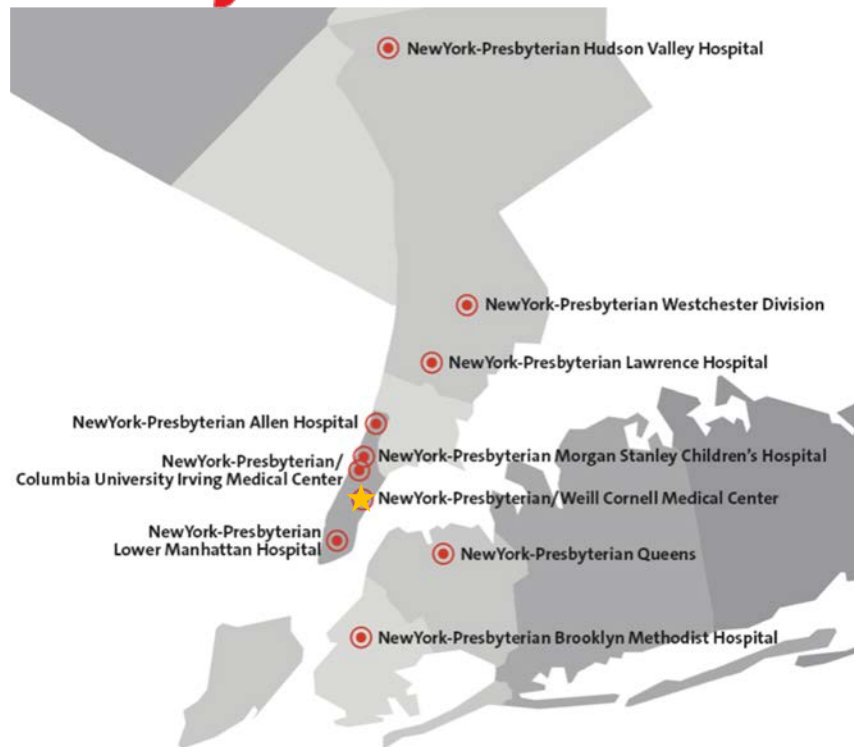
**NewYork-  
Presbyterian**

## 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.

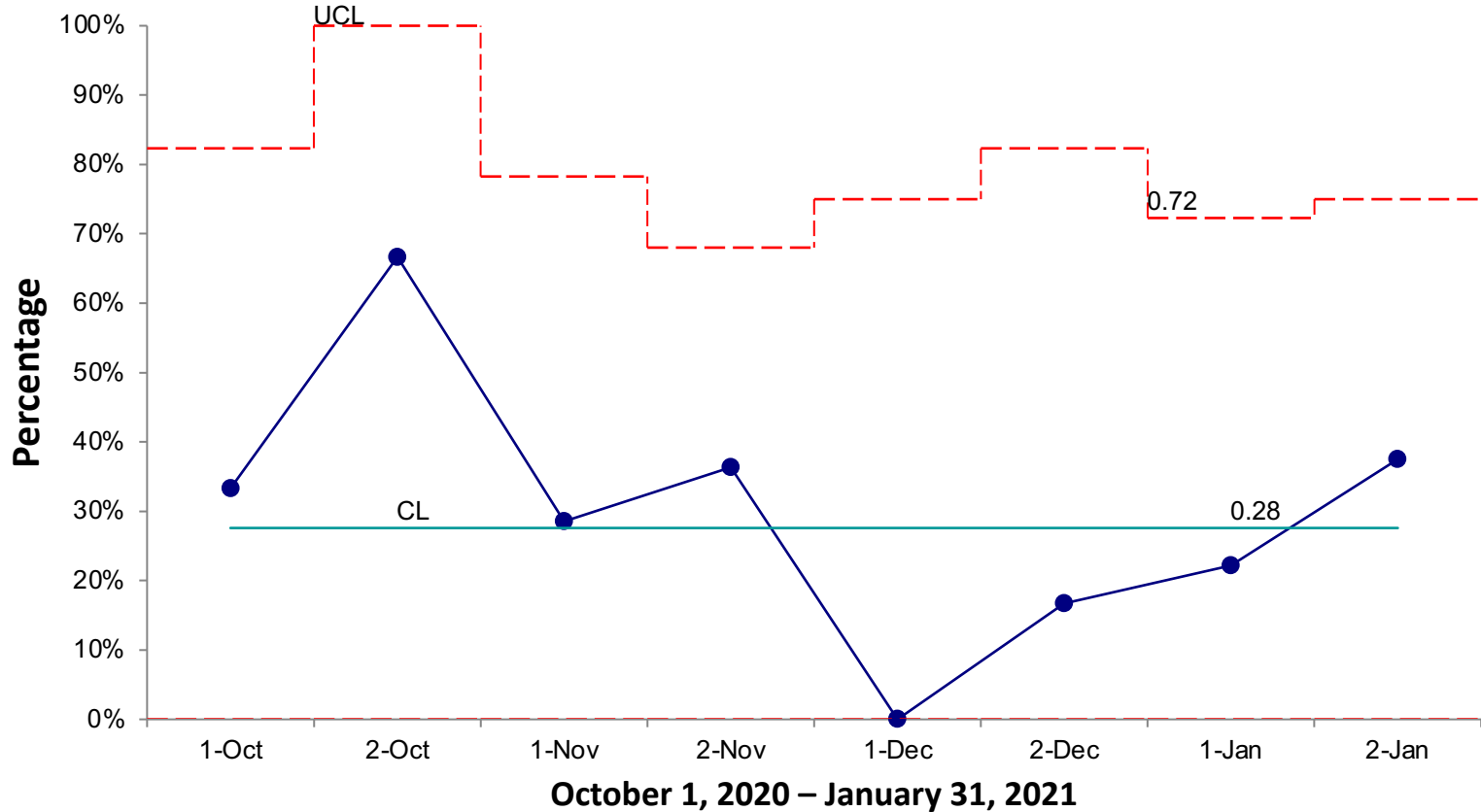
# Outcome Measure

## Baseline data summary

Item	Description
Measure:	Admitted patients discharged to hospice
Patient population:	Patients with (solid tumor) cancer diagnosis at the end of life (Excluding patients with heme malignancies)
Calculation methodology:	Numerator: Patients discharged to hospice 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)

p chart, 3 sigma





# 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

## Process/policy

- Discharge from inpt med to hospice
- Late consult
- Authorization time
- Weekend availability of hospice referral
- Delayed GOC bc wait for 1° onc to be present
- ACP/prognosis not addressed in outpt
- hospice billing and palliative tx

## Materials

### IT/EMR

- ACP not uniformly documented in EMR
- ACP tab not used

### Care Setting

- External hospice bed availability

## Communication

- Provider <-> patient/family
- Hospitalist <-> primary onc
- Med team <-> pallcare
- pt preferences not honored
- no treatment not offered as option or an alternative to tx

Cancer patients at end of life are underutilizing hospice

## Patient / Families

- Unclear/ inaccurate knowledge re: hospice
- Tx intent changes quickly 2/2 patient tolerance/health status
- Cultural beliefs
- Age

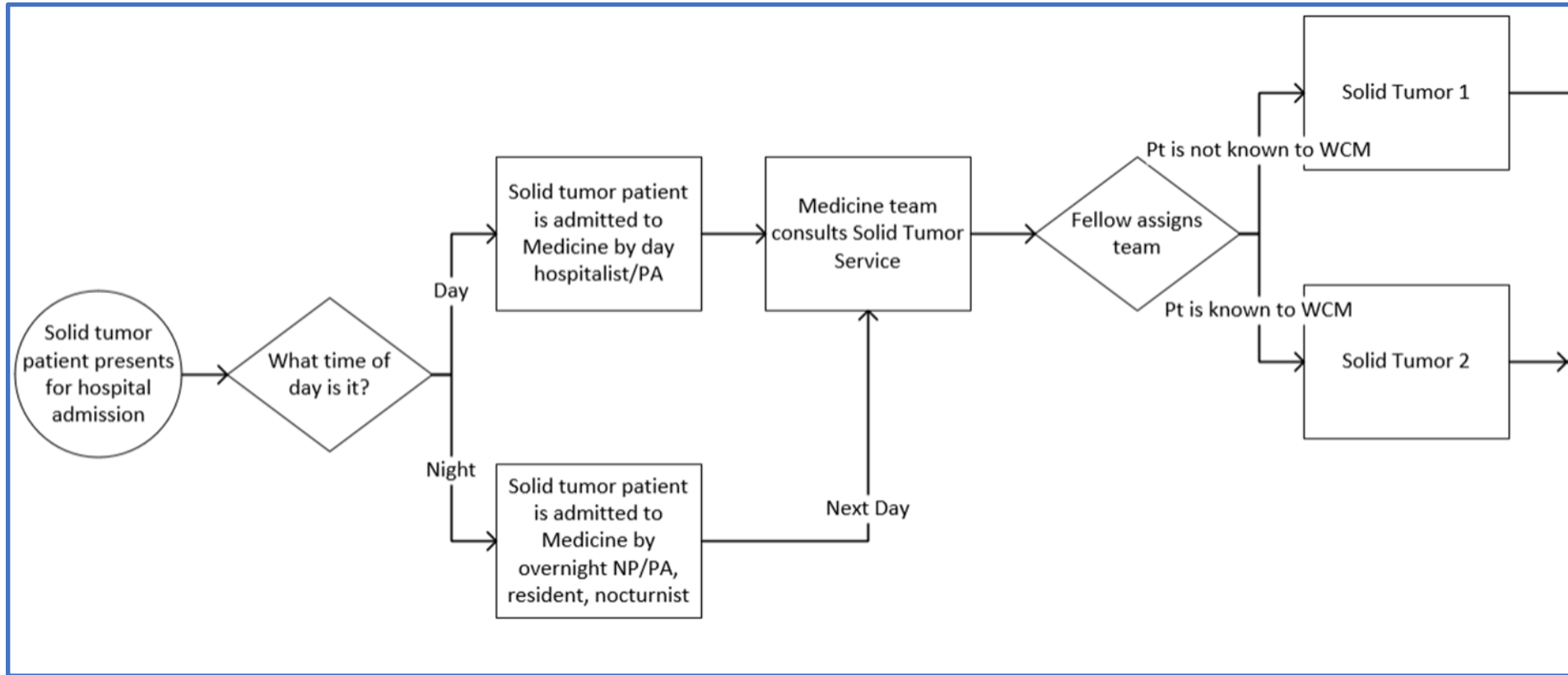
## Provider

- Inadequate knowledge of hospice rules/ benefits
- No formal training/ discomfort in GOC/hospice conversations
- Tx goal perceived to not be in line with hospice
- Pall care / SW may not be readily accessible
- Unclear roles - who's job to discuss
- Issues identifying end of life / prognosis
- 1° onc disagree with prognosis or pall care referral
- Unclear dying on pall vs dying on hospice
- lack of knowledge about scatter bed

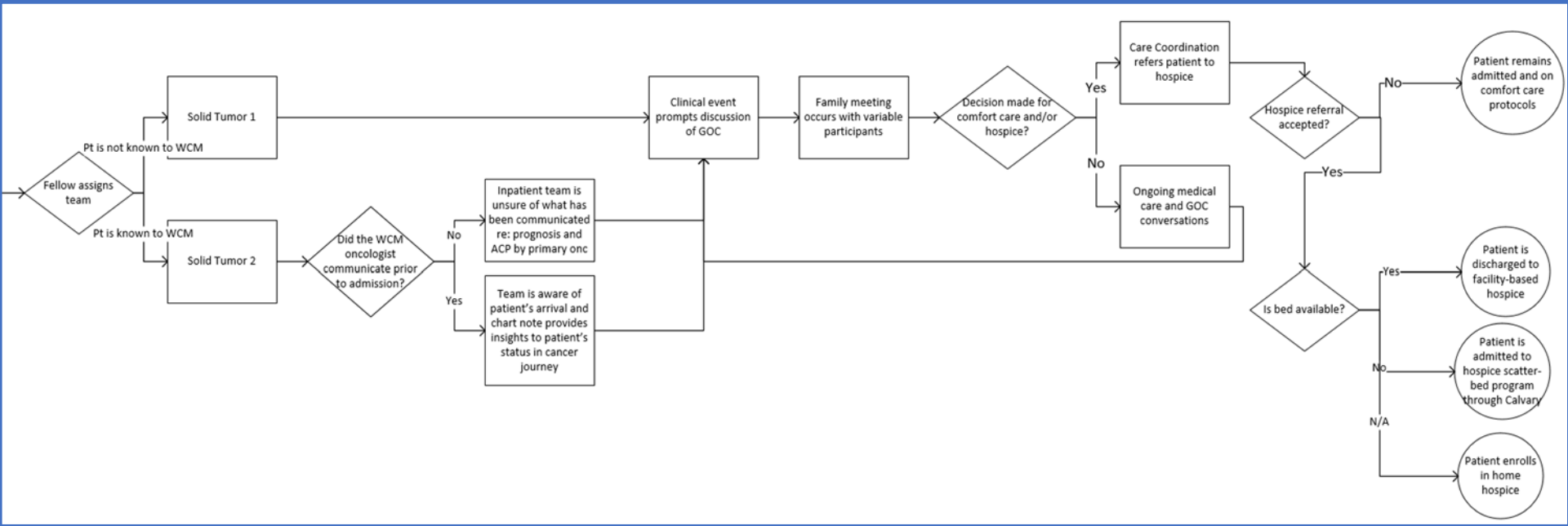
## Environment / Culture

- environment of heme malignancy
- misconceptions
- pandemic related issues

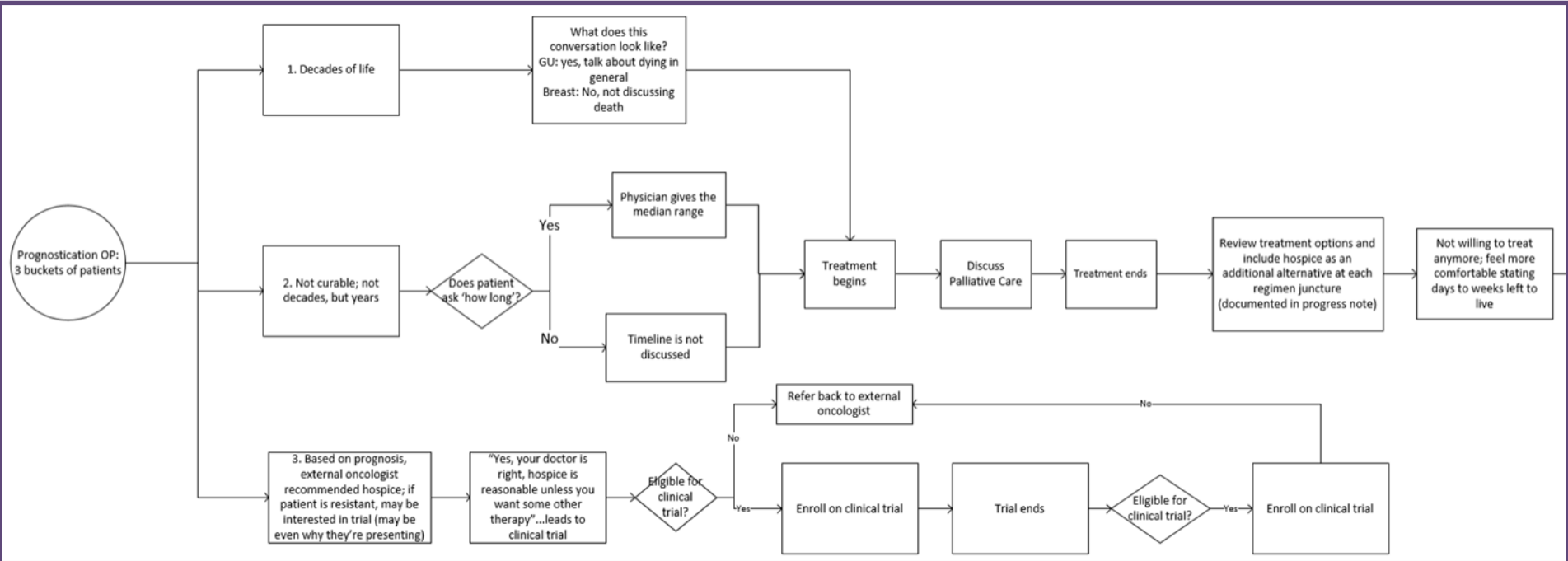
# Inpatient Process Map



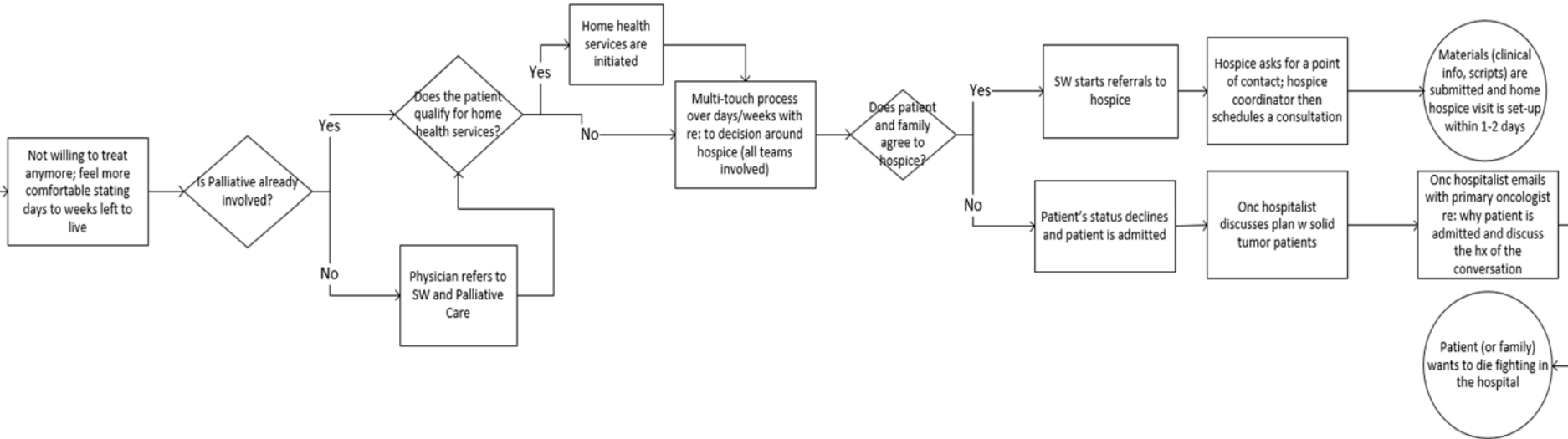
# Continuation of Inpatient Process Map



# Outpatient Process Map



# Continuation of Outpatient Process Map



# Priority / Pay-off Matrix Countermeasures

High	<ul style="list-style-type: none"> <li>• Mandatory ACP documentation for every oncology admission</li> <li>• Joint conference with Oncology and Hospital Medicine</li> </ul>	<ul style="list-style-type: none"> <li>• Palliative care trigger consult for advanced cancer patients with unplanned admissions</li> <li>• Palliative care NP inpatient co-management</li> <li>• GOC / prognosis communication training for MDs, APPs</li> <li>• ACT/CBT for HCPs when loved ones are at end of life (part of EMPOWER)</li> </ul>	
Impact	<ul style="list-style-type: none"> <li>• Decision Navigation services</li> <li>• Palliative care bridge program</li> </ul>		
Low	<ul style="list-style-type: none"> <li>• Education conference for oncologists on hospice benefits, scatter bed program and palliative outpatient programs</li> </ul>		
Easy	Ease of Implementation		Hard

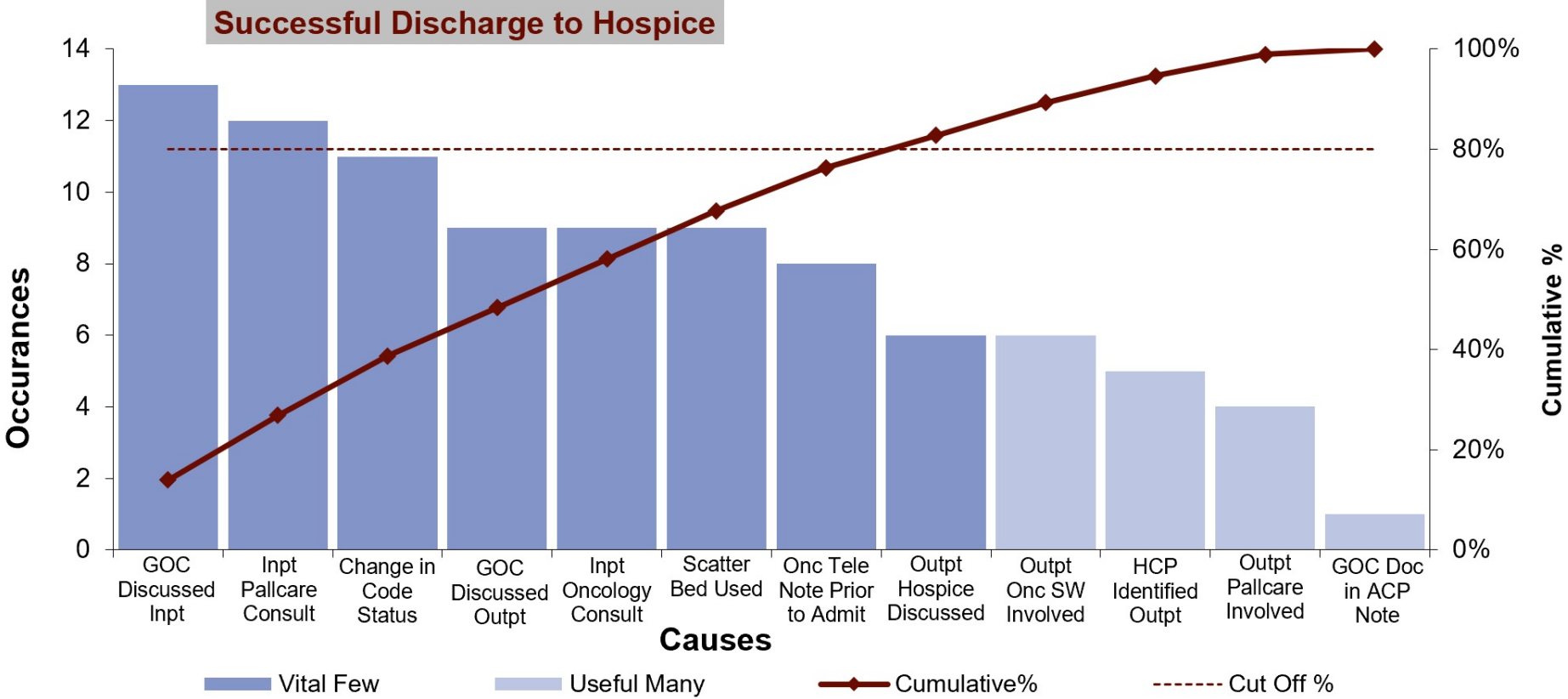
# Process Measure

## 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: <i>(if applicable)</i>	Retrospective, many things difficult to collect in chart due to non-documentation, variable use of advanced care planning tab



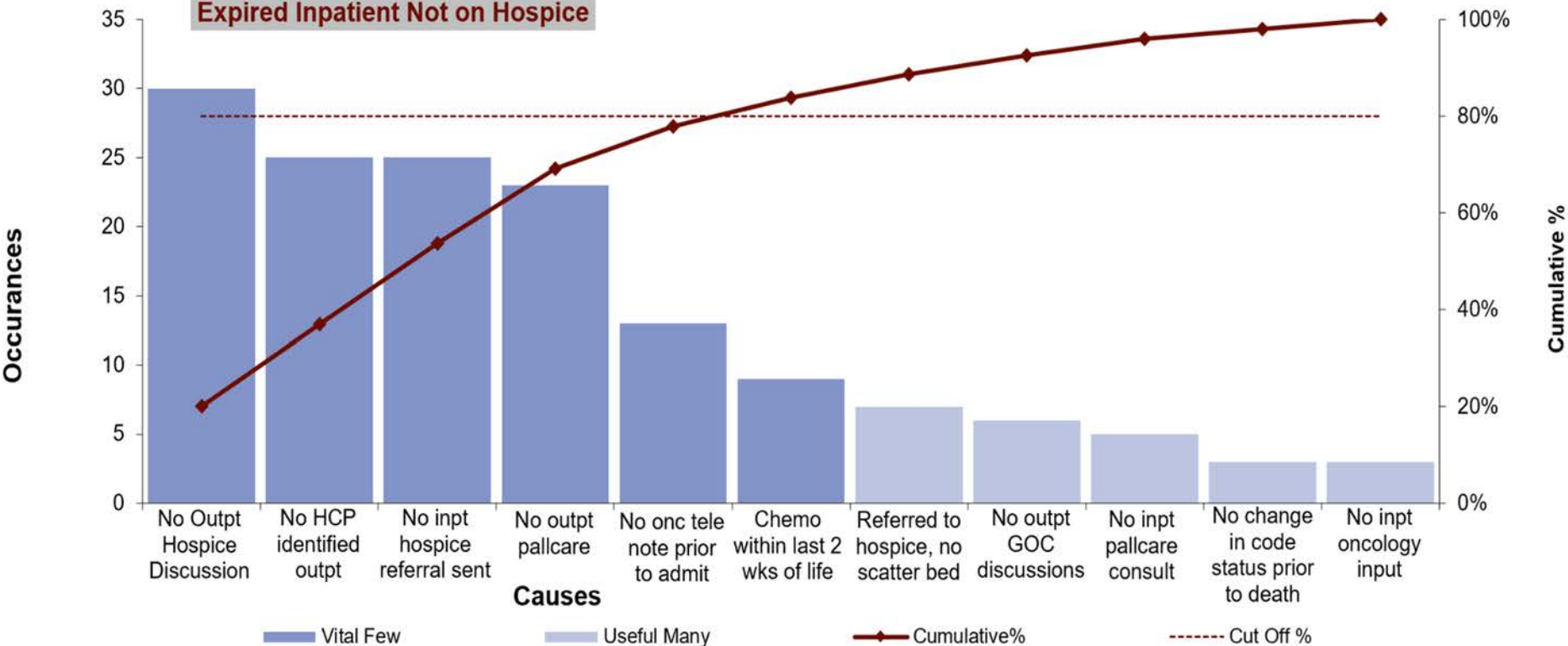
# Process Measure: Reverse Pareto



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

# Process Measure

Expired Inpatient Not on Hospice



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}

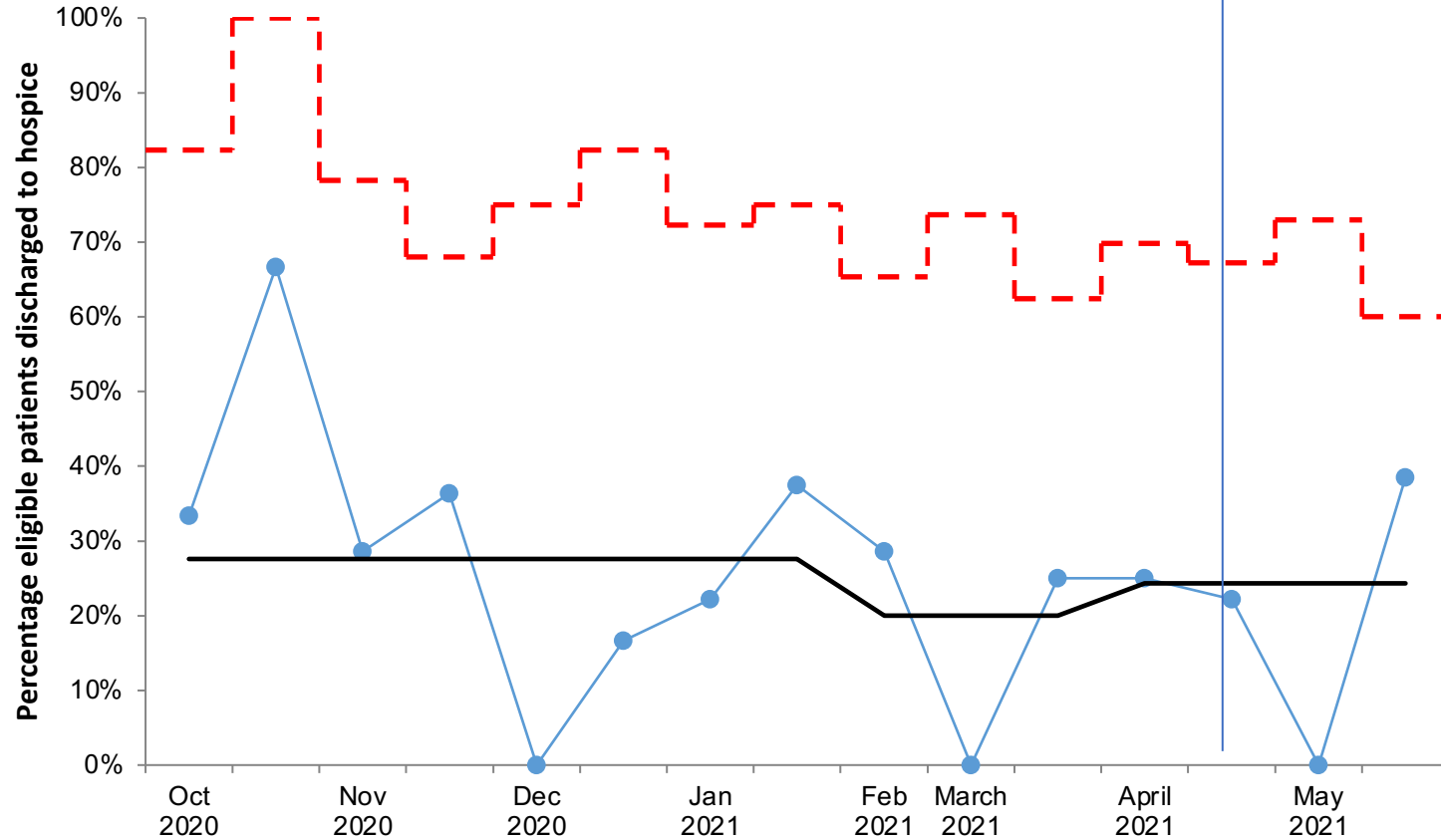
Was Palliative Care recommended in the outpatient setting: {YES/NO:60}

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

CODE STATUS: @CODESTATUS@

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

p chart, 3 sigma



# *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 smartphrase when providers admit patients without utilizing the smartphrase	Francie Emlen
Launch palliative care bridge pilot program with GI oncology	Christine Garcia Kelly Cummings
Standardize GOC documentation and advanced care planning documentation in EPIC organization-wide	Christine Garcia Kelly Cummings Org-wide QPS team

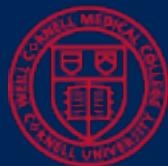
# Conclusions

- 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

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Thank you!



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