Novel Tool Utilized as a Trigger for Advance Care Planning in Hospitalized Oncology Patients

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ADVANCE CARE PLANNING (ACP)

At Boston Medical Center (BMC), a 496-bed Academic Safety Net Medical Center, a 6-months retrospective readmissions study was performed in 2014 on the hematology-oncology inpatient population. Of this study population, 21% had a documented DNR order, 12% received a Palliative Care consult, and 17% had an end of life discussion, demonstrating that Advance Care Planning (ACP) discussions in seriously ill cancer patients have not been consistently occurring.

	Index Admission		First Readmission	
	Non-elective n=58	Elective n=10	Non-elective n=58	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%		

Figure 1: *Percent distribution of readmitted patients in 2014 who had Advance Care Planning.*

Patients with advanced disease and high symptom burden benefit from palliative care and Advance Care Planning. Twaddle *et.al* (2007) urges the development of systematic methods that identify seriously ill patients early in their admission to address goals of care and improve access to palliative care.

OBJECTIVES

- To standardize triggers for palliative care and/or ACP discussions in patients with advanced disease who are on the hematology-oncology inpatient service at BMC
- To standardize ACP documentation in the Electronic Medical Record (EMR) at BMC to facilitate communication amongst providers regarding patient/family goals.
- Propose interventions that will reduce oncology readmissions.

METHODS

- A novel Severity of Illness (SOI) tool was created and IRB approval was granted for its use.
- Hematology-oncology providers were educated about the intervention during their grand rounds.
- All patients admitted to the hematology-oncology service from January 4, 2016 through June 30, 2016 were scored during daily interdisciplinary rounds. ACP discussions and/or palliative care consults were indicated within 72 hours for those who score 4 or greater on the tool.
- Retrospective chart reviews determined whether the proposed interventions were completed.
- BMC providers created a new ACP documentation template in the electronic health record.

SEVERITY OF ILLNESS TOOL

Date: _____

Inpt attending: _____ Resident: _____

Outpt/primary oncologist: _____

DIAGNOSIS: _____

Place MRN sticker

Patient's Name: _____

Date of Birth: _____

Cancer Stage	Symptoms	Functional Status	
☐ Metastatic (2 points)	☐ Shortness of Breath at Rest (2 points)	☐ Recent Functional Decline in the last 2 months (1 point)	
OR	☐ Gastrointestinal: BMI < or = to 18.5 or unintended weight loss > 10% of TBW in the past 6 months (2 points)	☐ Dependent for ADLs (1 point)	
☐ Refractory Hematologic Malignancy (2 points)	☐ Pain: Reported or taking Opioid medications (1 point)		
	☐ Anxiety/Psychosocial Distress: Reported or observed (1 point)		
Points: _____	Points: _____	Points: _____	TOTAL POINTS: _____

☐ For score > or = to 4, please **consult Palliative care.**

OR

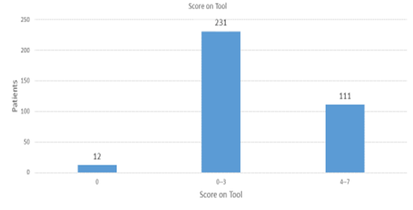
☐ If Palliative care deferred, please **arrange Advance Care Planning meeting within 72 hours.**

RESULTS

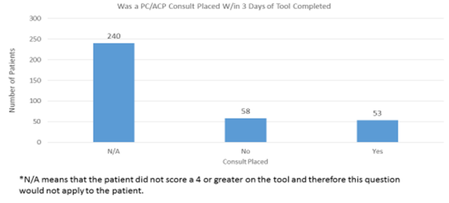
❑ 352 (96%) patients admitted to the Hematology/Oncology inpatient service were scored using the SOI tool.

- ❑ 111 (31.53 %) of these patients received a score of 4 or greater;
- ❑ 53 (47.74%) of this group received a palliative care consult and/or an ACP discussion.

What did they score on the Severity of Illness tool? 31% scored > or equal to 4



Was PC/ACP Consult placed w/in 3 days of completed tool? Yes on 48% of those scoring equal to or greater than 4 on tool.



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

CONCLUSIONS

- SOI tool promoted awareness among staff of the need for ACP discussions and/or palliative care involvement in identified patients.
- Although significantly increased from baseline, the tool alone did not translate into consistent application of these interventions.
- Barriers included:
  - Inconsistent communication amongst providers. Only the senior resident was present at multi-disciplinary rounds and thus, the inpatient and outpatient attending were not always aware of the patients' score on the tool.
  - The ACP documentation template was inconsistently utilized, creating ambiguity regarding previously held ACP discussions.
- There is a need for broader education about ACP practices and exploration of beliefs about ACP among hematology-oncology providers.
- The data highlights the need to validate the SOI tool and formalize its use in the EMR.

This research has the potential to improve the quality of care seriously ill cancer patients receive by early and consistent identification of patients who would benefit from ACP discussions and palliative care involvement.

NEXT STEPS

1.) Validate the Severity of Illness Novel Tool with a retrospective chart analysis performed on a subset of Hematology/Oncology Patients
Data points to be examined:

- ❑ Score on SOI Tool
- ❑ Age, Gender, Living situation
- ❑ Readmissions
- ❑ Advance Care Planning, Palliative Care consults
- ❑ Symptomatology, Cancer Type
- ❑ Admitting Diagnosis
- ❑ Days to Death

2.) Utilize an electronic objective SOI Tool to Identify Patients With Advanced Illness and to Trigger Advance Care Planning in the Inpatient Oncology Population at BMC

- ❑ Identify patient on admission
- ❑ Improve access to Palliative care
- ❑ Improve access to Complementary Therapy/Integrative

3.) Explore the attitudes and beliefs of the Hematology/Oncology medical team in regards to Advance Care Planning. Qualitative data will be collected via interviews to gain perspective on ways to positively impact culture and partnerships.

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