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Early Specialty Palliative Care for High Mortality Cancers

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Section I: Abstract

Problem: Patients with stage IV cancer have a high mortality rate. Evidence shows that patients have a better quality of life when they receive specialty palliative care (SPC) services. In the microsystem of focus for this project, referrals to SPC are not automatic, and there are no triggers to help the oncologist decide when to refer during a patient's terminal illness trajectory. Siloes between oncology and SPC exist, which leads to a lack of communication and coordination of care, ultimately affecting patient access to support services from SPC.

Context: A multi-disciplinary SPC clinic and a referring oncologist within the same facility partnered to improve early SPC among patients with certain high mortality cancers.

Intervention: A weekly oncology/palliative care team huddle was instituted to improve communication and proactively refer, discuss, and plan patient coordination of care. Communication tools were created to enhance patient education and team communication.

Measures: Pilot goal was to increase SPC consultation and ongoing follow-up support for stage IV gastrointestinal cancer patients by 20% from a baseline of 37% from February 2021 to 57% by June 31, 2021, for one participating oncologist patient panel.

Results: At baseline, 37% (20 out of 54) of patients received SPC consultation and ongoing support. After the huddle interventions, scripted introduction, and direct bookable appointments, 68% (52 out of 76) of patients received SPC consultation and ongoing support. Of the nine patients who died during the project, six died at home with hospice support and three died in the hospital on comfort-only orders.

Conclusion: A collaborative and coordinated huddle with oncology resulted in improved consultation and ongoing routine follow up, which benefited the patient and the family by having a peaceful and dignified death concordant with their goals and wishes. The organization benefited by having terminal patients expire with support from hospice or expire without receiving aggressive or ineffective treatment.

Keywords: Palliative Care; specialty palliative care; GI cancer; gastrointestinal cancer; stage IV cancer; end-of-Life, advance care planning; concordant care

Section II: Introduction

Patients who experience a cancer diagnosis often have significant physical, emotional, and psychological burdens and are faced with having to make complicated healthcare decisions that can evoke fear and anxiety (Hui et al., 2018). Aggressive forms of cancer continue to exist despite advances in medical treatment, with some cancers having less than a 5-year survival rate (American Society of Clinical Oncology, 2021; McGuigan et al., 2018). Rapid physical decline and increased symptom burdens can limit the time a patient and their family have to cope, comprehend, and plan for medical treatment preferences, including end-of-life care.

Specialty palliative care (SPC) is a supportive care service made up of professional disciplines (physicians, nurses, social workers, and chaplains) who are expert in “symptom management, psychosocial and spiritual care, caregiver support, patient-clinician communication, complex decision making, and end-of-life care” (Hui et al., 2018, p. 357), particularly skilled at supporting the person who is living with a terminal or life-limiting illness. SPC has several components to its mission as a specialty service, focusing on an integrated teamwork approach to treating patients based on a holistic view—the patient and their family as one unit and supporting them through different stages of their illness. Management of pain and symptom burdens is a primary goal of all healthcare; however, SPC concerns itself with complex or refractory symptom burdens. Caring and compassion by all members of the team are expertly administered to patients who may manifest their physical and emotional burdens in various ways. The team often focuses on eliciting information from the patient and their family about what they wish and hope for as they face their illness. Working together, the team aligns medical treatment preferences so that care is medically appropriate, culturally sensitive, and consistent with patient wishes, with a goal of helping to achieve optimal quality of life and a dignified peaceful death.

SPC trained professionals are also expert facilitators at helping patients and their families plan for end-of-life healthcare decisions.

The trained physician has a deep understanding of many life-limiting illnesses, including cancer, and how they manifest clinically to prepare the patient and prevent suffering to the highest extent possible. They are experts at treating refractory pain and other physical burdens, such as nausea, vomiting, fear, and anxiety. Specialty-trained palliative care physicians are often hospice physicians who possess expert knowledge to determine hospice eligibility. Nurses trained in SPC provide expert clinical triage and assessment to guide the patient or family through the complexities of the healthcare system. They frequently monitor a patient's response to pain medication regimen and provide emotional support. The palliative care team of nurses, social workers, and chaplain engage in compassionate conversations with patients and their families, often without the assistance of a physician. The medical social worker regularly provides a myriad of resources to help the patient and family survive financial setbacks and provide additional caregiver resources while addressing emotional and existential burdens. The chaplain is particularly skilled at connecting on a spiritual and emotional level with patients and their families. They offer spiritual guidance and help the patient and family draw from their own religious or non-religious faiths to cope, adjust, gain acceptance, and find peace, which can ultimately improve their quality of life.

Despite all the beneficial services that SPC provides, the World Health Organization (WHO, 2020) estimates that only 14% of people who need palliative care actually receive it. Palliative care is, unfortunately, often misunderstood and underutilized (Hawley, 2017).

In the clinic setting, a referral to SPC is usually at the discretion of the oncologist or primary care physician. However, an automated, population-based method of clinical diagnosis codes and other clinical criteria found in the electronic health record is often used to identify patients who may benefit from SPC. An automated referral system removes the ambivalence or emotional aspects of making the referral and provides consistency and objectivity to process. As of January 2021, 659 patients were identified as having a cancer diagnosis through the identification system. These patients are presumed to have significant illness burden and have been enlisted in the Supportive Care Services-Specialty Palliative Care Cancer Registry. Of those patients, only 26% (171 patients) have received a SPC consultation and ongoing support (see Appendix A). Technological limitations and a lack of widespread workflows create a lack of awareness for the referring physician regarding which patient is included in the SPC cancer registry, therefore hindering the referral process.

In a recent study, Schenker et al. (2018) cited common misperceptions by oncology physicians about palliative care as one major barrier for early referrals to palliative care for patients with advanced pancreatic cancer. Sullivan et al. (2019) noted, “Despite its potential association with positive outcomes, palliative care is often underused or delivered too late in the disease trajectory to provide meaningful benefit” (p. 1703). Another reason cited in the evidence is a reluctance to refer due to fear of upsetting the patient or making them feel abandoned. Not understanding the benefits of palliative care or feeling as though they somehow failed the patient were also cited as barriers (Hawley, 2017). According to Hawley (2017), patients and their families resist palliative care and associate it with end of life, hospice, or a substitution for dying. This hesitancy or avoidance is often based on cultural taboos or societal norms that prohibit openly discussing one’s mortality. Additionally, fear of others losing hope in them or loosing medical services were also valid points found in the evidence.

In preparation for the project, manual chart review of the patient panel for the participating oncologist found that out of 54 patients diagnosed with high mortality (stage IV gastric, esophageal, hepatic, biliary, pancreatic, and late-stage colon) cancer, only 20 patients had received ongoing palliative care support, with a resulting 37% supportive care rate at baseline (see Appendix B). These data suggest that opportunity exists for providing coordinated cancer care with integrated support by SPC at the appropriate intervals during the disease trajectory.

SPC services were first instituted at the participating medical center over a decade ago to align patient-centered goals with complex treatment options for patients living with serious or life-limiting illness. There are several organizational priorities linked to optimal palliative care delivery. Hospitals across the nation are focused on decreasing or eliminating unnecessary spending, particularly on ineffective treatment that may harm the patient or avoidable hospital readmissions. A study by Cherlin et al. (2016) found that patients who were at end of life, as evidenced by frequent readmissions, were likely to benefit from palliative care or hospice. Furthermore, advanced care planning for patients with serious illness, through life care planning, improving patient quality of life, patient satisfaction, and providing early hospice support, are metrics that align with the project and garnered considerable support.

Available Knowledge

PICO Question

The PICO question used for the literature search and synthesis of evidence for early SPC asked: In patients newly diagnosed with stage IV (gastric, esophageal, hepatobiliary, and pancreatic) cancer (P), does early referral to specialty palliative care (I), compared to standard referral process (C), lead to improved concordance of care with documented treatment preferences in the last 3 to 6 months of life (O)?

Literature Review

The following databases were used in the literature search: CINHAL, PubMed, and Joanna Briggs. Data were collected and synthesized using the following key words and phrases: *early palliative care, oncology, cancer, specialty palliative care, palliative medicine, end-of-life,* and *metastatic cancer*. A comprehensive literature search resulted in 10 academic journal articles from around the world, with an emphasis on five articles (see Appendix C). The five relevant journal articles were evaluated and rated using the Johns Hopkins Evidence-Based Practice Research Evidence Appraisal tool (Dang & Dearholt, 2017).

Two large retrospective cohort studies, appraised as Level III A, found that patients who received early SPC services had significantly less hospital-based deaths and significantly more community deaths, as compared to patients who received late or no SPC (Qureshi et al., 2018; Sullivan et al., 2019). These studies were helpful in understanding the impact of early palliative care interventions on quality-of-life and end-of-life care wishes and the financial impact of patients who choose conservative treatment at end of life.

Schenker et al.'s (2018) randomized controlled trial (RCT) was appraised at Level IB. In this study, patients who participated in the palliative care arm of the study experienced positive perceptions of emotional support and symptom management. Negative perceptions were noted by participants as palliative care services were inconvenient and services were not tailored to the needs of the patient and caregiver specifically (Schenker et al., 2018). This study was useful in providing recommendations for a patient- and caregiver-centered approach to SPC.

Warth et al.'s (2019) systematic literature review and mixed effects meta-analysis was analyzed and appraised at Level IIIA. Warth et al. found that psychosocial interventions on patients facing terminal illness had improved quality of life and significant reduction in existential suffering. This study is relevant to the project in demonstrating the impact of providing the patient and family with grief support.

Temel et al.’s (2010) landmark study was appraised as Level IA. This was a non-blinded RCT that demonstrated that early palliative care improved quality of life, decreased depression, reduced aggressive care at end of life, and surprisingly, improved survival. Temel et al.’s study is a landmark study and is helpful in understanding that consulting with palliative care does not hasten end-of-life decisions, but rather improves quality of life and in some cases increased life span, therefore, evident and helpful in dispelling many of the misconceptions, fears, and anxiety related to accepting palliative care services.

Overall, the body of evidence demonstrates that SPC services overwhelmingly benefit the patient and family by improving quality of life, while decreasing the associated cost of ineffective healthcare treatments. Therefore, the goal of the project is to improve communication with the referring oncologist to increase referrals and consultations to SPC for patients with high mortality cancer. Having early palliative care services, normalized by the oncology team and in coordination and conjunction with oncological treatment, will greatly support patient symptom burdens as their incurable disease progresses to help improve quality of life.

Rationale

The conceptual framework used to drive the project is Kotter’s 8-step change model, which describes the steps needed to establish a permanent and sustained change process (King et al., 2019; see Appendix D):

1. Establish a sense of urgency
2. Create the guiding coalition
3. Develop a vision and strategy

4. Communicate the change vision
5. Empower broad-based action
6. Generate short-term wins
7. Consolidate gains and produce more change
8. Anchor new approaches in the culture

Step 1 of Kotter's change model describes a need to establish a sense of urgency in order to mobilize people and organizations toward change. In the initial phase of the project, discussions with the outpatient palliative care staff were centered around challenges associated with patients declining SPC services and the inability to establish care with patients before they experienced significant and debilitating symptoms, often resulting in hospitalization without significant support and advanced care planning. The team was receptive and understood the urgency early on.

Step 2 is to create a guiding coalition of early adopters. Project discussions were initially met with resistance and fear related to increased workload or inadequate support but providing volume data and scope of the project helped to decrease anxieties. Our SPC nurses who manage the bulk of our palliative care referrals were early adopters and helped to get the rest of the team to buy into the project.

Step 3, develop a vision and strategy, required a prior in-depth microsystem analysis and identification of current practice. In subsequent meetings, the team was approached and asked to consider proposed workflow and vision for the project. The team was engaged and provided feedback that was used to improve the workflow.

Step 4 is to communicate the vision for the change. This occurred over several meetings, individually with the SPC team and collectively with the oncology team. The vision and proposed workflows were developed, and the team was encouraged to provide their feedback. The team worked to address concerns and moved forward with several pilots, including the weekly oncology/palliative care huddle and script creation.

Step 5 is to empower action. In this phase of the project, the team was empowered to provide their input and alternative ways to implement the proposed changes. The team was adaptive to the changes and communicated effectively with the oncology case manager to make patient care coordination.

In Step 6, create quick wins, the team got a sense of accomplishment during the first two huddles and seemed to enjoy the process, as exhibited by an increase in engagement and collaboration. The physicians and other members of the team authentically participated by listening to each other and respectfully engaged in opposing views. As the project matures and data collection continues, small wins will be continually shared with the entire team to increase team satisfaction with the process.

Step 7 is to consolidate gains and to produce more change. The future plans of the project are to expand to the other oncologists. As the interventions associated with the project mature and solidify, there will be expected emergence inherent to the dynamic changes.

Step 8 is considered the sustainability step of any change project (Aziz, 2017). As previously mentioned, the ultimate goal will be to spread the project to the other oncologists and support each other in our quest for optimal care delivery. One way this can be done is to invite all the facility oncologists to a weekly or monthly meeting to discuss their patients who are diagnosed with high mortality cancers or in need of support.

Specific Project Aim

The specific aim of this project is to increase the number of SPC consults and goals-of-care discussions for patients newly diagnosed with metastatic stage IV gastric, esophageal, hepatic, biliary, pancreatic, and end-stage colon cancer from 37% to 57%, a 20% increase from February 19 to June 31, 2021 (see Project Charter. Appendix E).

Section III: Methods

Context

Healthcare systems have become much broader and more complicated. As a consequence, there are opportunities for process improvement at every level of an organization. In order to embark on any performance improvement project, the clinical nurse leader (CNL) must understand the complexities within the microsystem, the people involved, how the project relates to the meso and macro systems, and the goals the project is set to achieve (King et al., 2019). Utilizing a systematic approach can provide the framework necessary to obtain a comprehensive assessment of the microsystem. The 5P model is the framework used by CNLs to assess a clinical setting in anticipation of process improvement (Gerard, 2016). This microsystem was assessed using the IHI microsystem assessment tool, which incorporates the 5P assessments (purpose, patient, professionals, processes, patterns, and metrics that matter) and the specialty care practice profile worksheet from the Dartmouth Institute (see Appendix F).

SPC services were first instituted at this medical center over a decade ago to align patient-centered goals with complex treatment options for patients living with serious or life-limiting illness. At the meso and macro level, the goal of palliative care is to decrease utilization of unnecessary healthcare services and avoidable spending that is incongruent with patient goals and wishes. At the micro level, staff work directly with patients and their families to support their physical, mental, and spiritual health. Clinicians assist in illness education, support, and coordination of care that is in alignment with patient and family goals and wishes.

Patients are referred to SPC at all stages of their illness and “are generally characterized as complex, with multiple symptoms, psychological, existential and social concerns” (Pask et al., 2018, p. 1079). They may have a life expectancy of years, months, weeks, or mere days. Patients with metastatic cancer, end-stage heart failure, and renal or pulmonary disease make up the bulk of the referrals. Those who are referred early are usually diagnosed with progressive diseases, such as dementia, amyotrophic lateral sclerosis, Parkinson’s, or Huntington’s disease. Palliative care services are provided holistically to patients of all ages and their families. The majority of patients are elderly, with an estimated 70% over the age of 65 (see Appendix F). A holistic team approach is the philosophy of palliative care.

The team is comprised of one full-time and two part-time physicians who provide prognostic information, medications to treat refractory symptoms, and physical assessments. Two full-time registered nurses (RNs) provide clinical assessments, symptom management, and goals-of-care discussions. Two full-time masters-prepared medical social workers provide psychosocial support and resource guidance. Spiritual care and grief support are provided by a masters-prepared chaplain. The team is cohesive and communicates effectively with each other and with other disciplines.

SPC is a referral and outreach program. Patients are referred by primary care physicians or other specialists through an electronic system. Patients are telephonically outreached by the triage RN and scheduled for an in-person, telephonic, video, or home visit, depending on the needs of the patient. Unique to palliative care, the visit is patient-centered, holistic, and primarily patient-driven. The palliative care team members anticipate patient needs based on diagnosis, chart review, and pertinent information provided by the referring physician and often by patient families. The consults focus on assessing coping, understanding of the illness, symptom burdens, prognosis, and eliciting patient/family goals and wishes to improve quality of life.

The majority of SPC referrals are for patients living with cancer. Referrals to SPC are usually due to refractory pain or other frequent ailments, such as anorexia, nausea, and vomiting.

Often these referrals are late in the disease trajectory, and patients may have exhausted all treatment options and are nearing end of life. According to Gaertner et al. (2013), “Patients with advanced cancer often suffer from burdensome symptoms that affect their quality of life and are a cause for suffering” (p. 343). Late-stage referrals perpetuate the belief that palliative care is solely concerned with end-of-life care. Patients who are consulted and receive ongoing support by SPC are more likely to forgo aggressive and ineffective treatments that can cause harm at end of life (Sullivan et al., 2019).

End-of-life care is only one component of palliative care. Evidence shows that oncologists and other physicians often hesitate to give bad news for fear of destroying hope (Gaertner et al., 2013). This anxiety or fear can perpetuate delays or referral avoidance for patients to palliative care. Furthermore, as studies suggest, physicians lack education about the benefits of palliative care and may have difficulty introducing the service or answering questions from the patient or family. As a result, patients lack an understanding of the benefits of SPC and frequently decline services. Early palliative care addresses the need for early support of physical and emotional burdens, advanced care planning, and cooperation and coordination among the healthcare team. Therefore, the project aims to improve the early palliative care referral process and increase the number of consultations, while supporting and educating the oncology team.

Intervention

Several interventions were constructed to launch the project toward increasing and improving early referrals for patients living with aggressive and high mortality gastrointestinal stage IV cancer. Addressing the need to remove siloes between the team and to improve communication was the fundamental provision of the project.

The first intervention was the creation of the huddle between the participating oncologist and the palliative care team. The palliative care physician leaders, the participating oncologist, and this author met and came to consensus about when the huddle would be conducted, the agenda for the huddle, who would participate, and how much the time would be allocated. Access to the participating oncologist's patient panel was granted and a thorough chart review was conducted of all patients with pancreatic, biliary, hepatic, gastric, and colon stage IV cancer. A gap analysis was prepared from the chart reviews and entered into an excel spreadsheet. The spreadsheet was prepared with the following columns: patient's first and last name, medical record number, age, diagnosis, current participation in palliative care services, date of prior consultation or outreach, inclusion in the palliative care registry, current plan, code status, completion of a POLST (physician order for life-sustaining treatment), participation in prior life care planning conversation, prior completion of an advance directive, number of hospital admissions in the last 6 months, hospice enrollment, and quality of death (see Appendix G). The spreadsheet was maintained over the course of the project and updated as each new patient was identified and with each weekly huddle. Plan of action, outreach response, and clinical information was updated, and the spreadsheet was sent to all project participants, which served as a communication tool.

The project was initiated on February 19, 2021, with a staff meeting, where a call to action was presented, evidence to support the project was presented, and the conceptual workflow details were provided. The team participated in the creation of the workflow process (see Appendix H), and approvals from clinic leaders were obtained to reduce clinic schedules to facilitate huddle participation. Pre-huddle preparations were done by completing weekly thorough chart reviews and by establishing baseline clinical understandings and future patient follow-up appointments. A 30 minute huddle was conducted every Friday afternoon, with participation from the triage nurse, palliative care physician, oncologist, oncology case manager nurse, and this author. The main discussion points were patient clinical situation, cancer type, response to treatment, prognosis, and expert opinion of future anticipated burdens. The palliative care team provided feedback about patient/family response to palliative care, overall updates, patient coping, psychosocial insight, and any identified barriers or challenges to patient care. Palliative care team participants reported back on any patients who declined SPC services and discussed any barriers or concerns. The team collectively decided on a plan of action tailored specifically for each patient. A post-huddle debrief was completed among the palliative care team participants to elicit feedback for huddle improvements and conclusion of plans made.

Establishing a format and agenda for huddle promoted efficiency and effectiveness. Pre-huddle communication of patients to be discussed allowed the team to prepare a succinct synopsis of the patient condition and recommended treatment plan. Newly diagnosed patients were identified by the oncologist as benefitting from palliative care and a plan formulated for introduction of SPC services and outreach. A referral in the form of an e-consult is submitted electronically after the oncologist has introduced palliative care to the patient/family, with rationale and importance for SPC follow up.

The intervention for direct bookable appointments was initiated to provide a coordinated and seamless transition between the two teams, while removing the need to further outreach the patient. Work was initiated between the palliative care physician and the information technology personnel. This intervention required several plan-do-study-act (PDSA) cycles to ensure that the system was both usable and accurate. In the PDSA cycle, “The goal is for all staff to contribute to problem solving and to collaborate in designing improvements to add value as defined by the client" (King et al., 2019, p. 11). Giving the oncology nurse the authorization to direct book with SPC demonstrates an integrated program to the patient/family and eliminates outreach duplication of work by the SPC nurse. The oncology physician or oncology nurse would introduce and encourage the patient/family to consult with palliative care, answer any questions or concerns, and upon leaving the oncology visit, they would have their SPC appointment. Challenges faced were patients being able to direct book, leading to scheduling errors, and the use of inappropriate time slots and technical difficulties, prohibiting the oncology nurse from direct booking.

To ensure that the oncologist and the oncology nurse manager introduced SPC accurately and effectively, a scripted introduction was created by the SPC team as another intervention to the project (see Appendix I). The creation of the script was started by the SPC nurses and then sent via email to the rest of the team for additions or edits. Once completed, it was sent to the oncology team for final review and utilization. The script made it easy for the oncology team to use when introducing and describing the benefit of SPC, rather than rely on their misconceptions or misinformation.

To decrease confusion and improve collaboration between the two teams, a service agreement was discussed in the early phases of the project. The oncologist decided that patients with chemotherapy initiation and other treatment burdens would be managed by the oncology team. Refractory or late-stage symptom burdens would be consulted by the SPC team and handed back to oncology for maintenance, if actively receiving chemotherapy treatments. Patients who would no longer benefit from oncological treatments would have their symptom burdens treated by SPC primarily, who would continue working with the patients and their families as they neared end of life and hospice eligibility.

Study of the Intervention

Implementation of the interventions was not without challenges or barriers. In the initial phases of the huddle intervention, there was staff resistance, confusion, and a lack of trust in the process. Staff verbalized concerns that the huddle would add responsibilities to their already busy schedules, with the perception of little to no value added to patient care. A PowerPoint presentation with baseline data, evidence-based information, and several one-on-one discussions helped get buy-in from the staff and decrease concerns about the time investment.

The huddle was intentionally set as a small test of change limited to four huddles, with the plan to reassess its longevity and usefulness. The huddle intervention progressed with multiple revisions through the PDSA process. The first huddle was awkward, uncoordinated, and lacked timeliness; yet it was also positive, engaging, and exciting to have a platform for patient care discussion, while developing a superior partnership. Therefore, the huddle intervention went through a series of PDSA cycles to improve the structure, time efficiency, and content for discussion. With the recognition of being concise and prepared for the Friday huddles, a pre-huddle discussion via email was initiated to provide opportunity for preparation, and the huddle agenda was established. The spreadsheet served as a repository for information discussed, which was used in future huddles, plans of action, and communication with other team members.

The huddle was found to bring significant value and was extended beyond June 31, 2021. Future plans to spread to other oncologists is being decided upon as part of the sustainability plan. Some circulating ideas is to expand the time of huddle to perhaps 2 hours, with several oncologists participating. Through several PDSA cycles and feedback from staff, the huddle eventually came together nicely. Time spent was efficient, coordinated, and effective and resulted in reducing the frequency to every other week in the month of May. Ultimately, the team, including the oncologist, verbalized great appreciation in the new partnership and for improving communication and coordination of care.

The intervention for scripting was less challenging. Palliative care staff volunteered to draft the initial script, and the draft was circulated among the staff who edited along the way. The final draft was sent to oncology, who began using the script, with positive results from patients in the form of referral acceptance to palliative care. The script was created to help the oncology team normalize and describe palliative care services to patients; however, the biggest unintended benefit of the scripting intervention was with the oncology physician and nurse verbalized feeling more at ease when introducing palliative care services.

Given the effectiveness of oncology introductions, the intervention to provide direct bookable appointments was made to eliminate the added step of calling the patient for an appointment. The oncology nurse was authorized to book directly onto the SPC appointment schedule. This intervention gave the patient the perspective of a coordinated and seamless transition between oncology and SPC services. This intervention required several PDSA cycles to ensure that the system was both usable and accurate before adopting the change. Challenges faced were patients being able to direct book, leading to scheduling of inappropriate time slots. Additionally, several technological issues prohibited the oncology nurse from being able to direct book. Once the technical challenges were overcome, the system worked appropriately.

The ultimate goal of the project was to make a positive difference in the lives of patients who are suffering from stage IV gastrointestinal cancer (gastric, esophageal, hepatic, biliary, pancreatic, and colon cancer). Success for the project is based on the ability to connect with the patient and family, build rapport and trust, determine how to best support them, and intervene where possible in the quest for quality-of-life improvement, as evidenced by ongoing follow up and completing goals-of-care discussions. The landmark study by Temel et al. (2010) found that patients who received SPC had improved quality of life, lived longer, and had less distress and symptom burdens. Given the overwhelming evidence that patients benefit from palliative care service, the project goal is to increase access to palliative care services for patients with high mortality gastrointestinal cancer. From a quality perspective, the premise is that effective palliative care support, education, and alignment of patient goals with treatment preferences would result in less aggressive utilization of ineffective treatment at end of life, as the evidence suggests (Sullivan et al., 2019).

Measures

All process improvement efforts require the collection of data and periodic monitoring throughout the project timeline. The project to improve early SPC among stage IV gastrointestinal cancer patients had multiple measurements, with the vast majority of the data collected through manual chart abstraction due to propriety limitations. Outcome, process, and balancing measures were collected at the start and at the end of the project timeline. Outcome measures are based on evidence-based practice to improve quality of care. Process measures are used to monitor throughout the project to ensure that the interventions were resulting in small improvements toward the targeted goal. Finally, the balancing measures are used to ensure that the interventions toward process improvement did not have unanticipated negative consequences.

Two outcome measures were identified for the project: the percent of patients who received a SPC consult from February 19, 2021, through June 31, 2021, and the quality of death for those who expired during the project timeline. Baseline denominator data were collected by identifying the patients with stage IV gastrointestinal cancer for the participating oncologist at the beginning of the project (before February 19, 2021). Patients who had a consultation and ongoing follow-up appointments were collected in the numerator. These numbers were calculated for the percentage of integrated oncology and palliative care. Patients who were previously consulted but were not receiving ongoing palliative care support were not included in the numerator. Post-intervention results were calculated by collecting the number of patients who were consulted and received ongoing support during the project February 19, 2021, thru June 31, 2021. Patients who were referred, not referred, or declined SPC services were also noted and calculated before the project and after the project timeline.

The other outcome measure that was important to the global aim of the project was examining and measuring the manner and quality of death of those who died during the project timeline. A *good death* for the project purposes was a death of a patient who did not experience aggressive or ineffective treatment, but rather a peaceful and dignified death with the aid of hospice or comfort measures. The reviews of the medical record looked for documentation regarding goals of care and whether the death was concordant with patient goals and wishes. The organization metric that mattered to this project was the rate of consultation for patients in the Supportive Care Service-Palliative Care Cancer Registry. January 2021 baseline data were at 26% for consultation or follow up among the 659 patients identified with a qualifying cancer diagnosis (gastrointestinal stage IV patients included; see Appendix J). Patients who received an SPC consultation were calculated into the numerator, contributing toward the overall organizational improvement goal of 20% increase.

Process measures included the number of referrals and the number of huddle interventions. The referrals were calculated as an overall rate, with referred patients in the numerator over all identified gastrointestinal cancer patients, which were calculated as the denominator.

The rate of referrals declined, both at baseline and during the project period, served as the balancing measure. This was an important metric to monitor to ensure that our early referral intervention did not have a negative consequence with more patients declining SPC services.

Ethical Considerations

There are several ethical considerations related to palliative care and the goal of increasing consultations. The concept of autonomy is frequently misunderstood or over simplified. According to literature, healthcare professionals often think that as long as a patient possesses the capacity to make medical decisions, then they have the right to make bad decisions or refuse any aspects of medical care, including palliative care. However, according to Grace (2017), "Honoring autonomy means that the professional is responsible for evaluating what the person needs in the way of information and assisting the person to interpret all available knowledge in light of his or her own projects and desires" (p. 19). Individuals, including healthcare professionals, often misunderstand and, therefore, fear palliative care, and as a consequence, often decline outreach efforts. Working with referring physicians, patients, and their families to improve education, communication, and timeliness about the benefits of palliative care is ethically responsible and relevant, despite initial patient refusals.

Improving access to SPC for patients who have been diagnosed with stage IV gastrointestinal cancer implies that this patient population should be prioritized to some degree over others. The concept of prioritizing one patient over another can conjure a series of ethical considerations. As SPC continues to grow, the demands for services are outpacing the availability of resources (Philip et al., 2019). In order to maintain some form of equity, patients are prioritized by employing the role of triage. Triage in healthcare is well established and is particularly important when allocating a scarce resource by distributing the resource in a just manner based on a series of criteria.

The performance improvement project prioritized one participating oncologist and his patients, while all other referrals were handled in the traditional way. Patients were contacted by the triage nurse, who performed an in-depth assessment of the medical condition, latest test results, and recent medical visits prior to contacting the patient to determine who should be prioritized for the available appointments. However, there is evidence that patients who have physical pain are often prioritized over other patients who may have anxiety or distress, leading to the ethical question: Who is more important? Oncology patients who have an acute process may be prioritized over patients who exhibit chronic issues.

With improvement in communication and collaboration based on the weekly huddle between oncology and SPC, the team has become much more unified, and patients are being prioritized potentially over other physician patients. It will be important to build effective relationships with all oncology physicians as the project moves to sustainability and spread. Philip et al. (2019) noted, “Relationships with colleagues within the health service system were considered important to maintain the network of care for current and future patients and ensure patient flow across the healthcare system” (p. 580).

Section IV: Results

Overall, this project, early palliative care for patients with high mortality gastrointestinal cancer, has been widely successful. Over the last 5 months, the huddle, script introduction of palliative care by the oncology team, and the direct booking of SPC appointment have become standard and routine practice. Communication among the team members has improved considerably, and huddle discussions have become significantly more authentic and relevant, evolving into a safe zone where the participating members, particularly the oncologist, can share their fears related to patient condition, concern for future response to treatment, or disease progression. Patients are being monitored through periodic chart reviews and proper timing within the patient's disease trajectory for SPC referral optimization.

The goal for the project was to increase the consultation and ongoing follow up for patients with high mortality stage IV gastrointestinal cancers (gastric, esophageal, hepatic, biliary, pancreatic, and colon cancer) and to determine if palliative care consultations contributed toward end-of-life decisions. Baseline data, collected through chart reviews, found that of the 54 patients diagnosed with high morality stage IV gastrointestinal cancer, 20 patients were receiving ongoing palliative care support and 13 were never referred. At the end of the project timeframe, the number of patients who received consultations and ongoing support by SPC rose from 37% (20 out 54) to 68% (52 out of 76), an increase of 31%, which greatly surpassed the goal of 20%. The balancing measure was the rate of refused SPC consultations, which went from 13% (7 out 54) to 12% (9 out of 76). Finally, during the project, nine patients died. All nine patients had received a palliative care consult and ongoing support during their disease trajectory, with the exception of one patient. Six out of the nine patients who died at home enrolled in hospice, and the other three died in the hospital and shortly after admission converted to comfort measures only (see Appendix J for project intervention results).

Section V: Discussion

Summary

Overwhelming, evidence demonstrates that early SPC consultation and ongoing support can have significant positive effects on a patient's quality of life and death, communication and collaboration is enhanced between the medical teams, and organizations benefit from decreasing medically ineffective treatment at end of life.

Patients who are diagnosed with a terminal cancer may have many physical, emotional, and existential burdens, which can decrease quality of life and effect medical treatment choices that are too often, incongruent with their overall goals and wishes. When cancer is particularly aggressive and prognosis is poor, patients and their families need emotional support combined with realistic and compassionate goals-of-care discussions to ensure concordant care.   As their disease progresses, they may need access to resources, disease trajectory education, and authentic expectations as their disease advances. Goals-of-care discussions, most importantly, provides the patient and their family with an opportunity to share what's important to them as they near end of life.

The oncology care physician and their patients often build strong and trusting relationships which often span many years and their influence over the patient and their family cannot be underestimated. The concept of SPC in the physician-patient relationship is multi-faceted and dynamic. Extending support to the oncology team through enhanced communication and collaboration with SPC ultimately benefits the patient and fortifies the professional relationship across the entire medical team.   Through the huddle intervention the oncology team ultimately gained confidence and knowledge related to SPC services which improved identification for the optimal timing of SPC introduction and referral submission.

As our society ages and medical technology advances, our ability to prolong suffering is also magnified. As healthcare professionals and as future CNLs, it is imperative that patient advocacy remains at the forefront. Early intervention and ongoing effective collaboration with the oncology team will lead to improved working relationships that will benefit the patient. Having a forum for oncology physicians and nurses to discuss cancer patients with palliative care colleagues provides reassurance, validation, and peer support. The organization benefits from peer support, judicious use of resources, and improved patient outcomes.

Lessons Learned

There were many lessons learned throughout the project of early palliative care for stage IV gastrointestinal cancer. Patient's response to treatment and level of symptom burden helped to gage the optimal time for referral to palliative care. Patients who were starting to experience symptom burdens were much more receptive to a palliative care referral, as opposed to outreach, based on an automated referral on diagnosis alone. Therefore, tailored patient care that meets them where they are in their illness journey generated better consultation and ongoing acceptance rates. Patient outreach or direct booking by the oncology team, along with proper explanation and introduction of palliative care services, also had positive results toward acceptance of the SPC referral and attending the consult.

Oncology and palliative care were able to formulate a plan of care as patient condition progressively declined, which helped the patient and family understand and process consistent medical information. The respective team was able to use the information and plan of action shared in huddle to increase confidence about how to support the patient/family. The palliative care team benefited by being supported by the patient's oncologist and by creating outreach efficiencies.

Conclusion

As society ages and the cost of healthcare continues to soar, the need for palliative care will continue to grow and gain more prominence (Roberts et al., 2018). Through SPC, patients and their families receive education, support, and guidance toward treatment preferences that are realistic and in alignment with improved quality of life and death. Coordination and collaboration between SPC and other medical teams can forge superior partnerships that enhance patient lives, decreases provider distress, and eliminates misconceptions about the role of SPC to pave the way for patient centered care that embraces concordant medical treatment.

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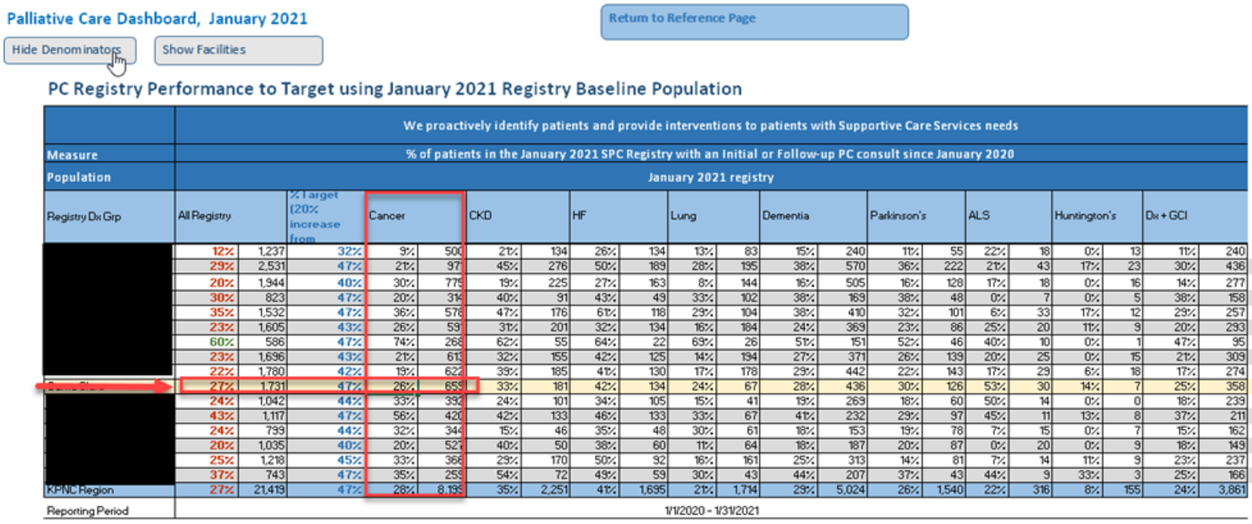
Section VII: Appendices

Appendix A. Palliative Care Registry

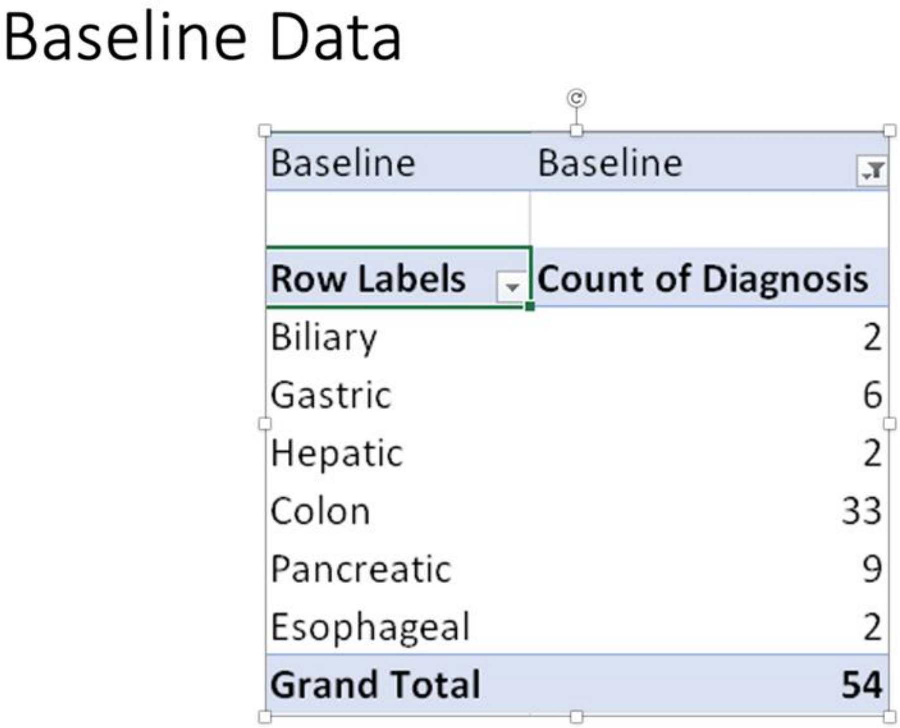


Palliative Care Dashboard, January 2021

PC Registry Performance to Target using January 2021 Registry Baseline Population

	We proactively identify patients and provide interventions to patients with Supportive Care Services needs																		
Measure	% of patients in the January 2021 SPC Registry with an Initial or Follow-up PC consult since January 2020																		
Population	January 2021 registry																		
Registry Dx Grp	All Registry		%Target (20% increase from	Cancer		CKD		HF		Lung		Dementia		Parkinson's		ALS		Huntington's		Dx + GCI
[redacted]	12%	1,237	32%	9%	500	21%	134	26%	134	13%	83	15%	240	11%	55	22%	18	0%	13	11%	240
[redacted]	29%	2,531	47%	21%	971	45%	276	50%	189	28%	195	38%	570	36%	222	21%	43	17%	23	30%	436
[redacted]	20%	1,944	40%	30%	779	19%	225	27%	163	8%	144	16%	505	16%	128	17%	18	0%	16	14%	277
[redacted]	30%	823	47%	20%	314	40%	91	43%	49	33%	102	38%	169	38%	48	0%	7	0%	5	38%	158
[redacted]	35%	1,532	47%	36%	578	47%	176	61%	118	29%	104	38%	410	32%	101	6%	33	17%	12	29%	257
[redacted]	23%	1,605	43%	26%	591	31%	201	32%	134	16%	184	24%	369	23%	86	25%	20	11%	9	20%	293
[redacted]	60%	586	47%	74%	268	62%	55	64%	22	69%	26	51%	151	52%	46	40%	10	0%	1	47%	95
[redacted]	23%	1,696	43%	21%	613	32%	155	42%	125	14%	194	27%	371	26%	139	20%	25	0%	15	21%	309
[redacted]	22%	1,780	42%	19%	622	39%	185	41%	130	17%	178	29%	442	22%	143	17%	29	6%	18	17%	274
[redacted]	27%	1,731	47%	26%	659	33%	181	42%	134	24%	67	28%	436	30%	126	53%	30	14%	7	25%	358
[redacted]	24%	1,042	44%	33%	392	24%	101	34%	105	15%	41	19%	269	18%	60	50%	14	0%	0	18%	239
[redacted]	43%	1,117	47%	56%	420	42%	133	46%	133	33%	67	41%	232	29%	97	45%	11	13%	8	37%	211
[redacted]	24%	799	44%	32%	344	15%	46	35%	48	30%	61	18%	153	19%	78	7%	15	0%	7	15%	162
[redacted]	20%	1,035	40%	20%	527	40%	50	38%	60	11%	64	18%	187	20%	87	0%	20	0%	9	18%	149
[redacted]	25%	1,218	45%	33%	366	29%	170	50%	92	16%	161	25%	313	14%	81	7%	14	11%	9	23%	237
[redacted]	37%	743	47%	35%	259	54%	72	49%	59	30%	43	44%	207	37%	43	44%	9	33%	3	25%	166
KPNC Region	27%	21,419	47%	28%	8,199	35%	2,251	41%	1,695	21%	1,714	29%	5,024	26%	1,540	22%	316	8%	155	24%	3,861
Reporting Period	1/1/2020 - 1/31/2021																				

Appendix B. Baseline Data



Baseline Data

Baseline	Baseline
Row Labels	**Count of Diagnosis**
Biliary	2
Gastric	6
Hepatic	2
Colon	33
Pancreatic	9
Esophageal	2
Grand Total	**54**

Appendix C. Evaluation Table

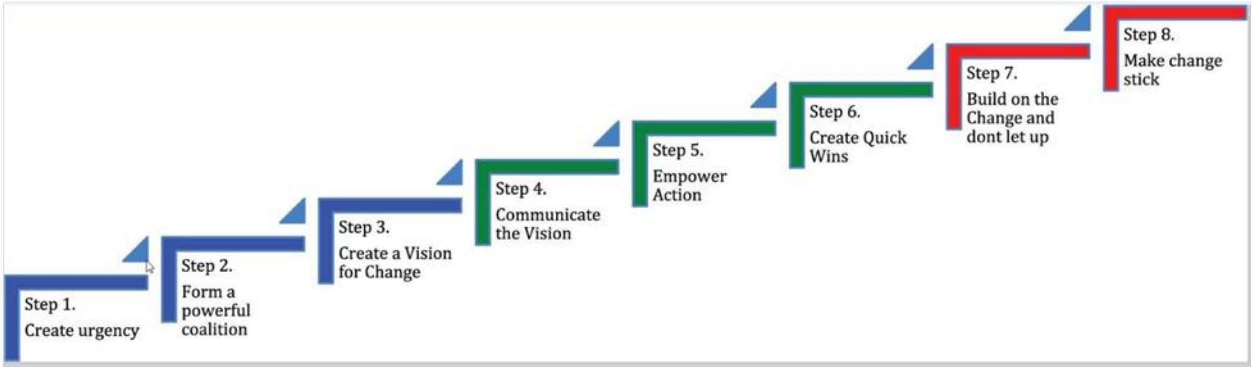
PICO Question: In (P) patients newly diagnosed with stage IV (gastro-esophageal, hepatobiliary, and pancreatic) cancer does (I) early referral to specialty palliative care as (C) compared to standard referral process, lead to (O) improved documentation of end-of-life care treatment preferences in last 3 to 6 months of life.

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
Qureshi, D., Tanuseputro, P., Perez, R., Pond, G. R., & Seow, H.-Y. (2018). Early initiation of palliative care is associated with reduced late-life acute-hospital use: A population-based retrospective cohort study. *Palliative Medicine*, *33*(2), 150–159. https://doi.org/10.1177/0269216318815794	Retrospective population-based cohort study of cancer and non-cancer patients	Retrospective review of 230,921 decedents age 18 years and older between April 1, 2010 and December 31, 2012 in Ontario, Canada	**Outcome:** Patients who received early palliative care services had significantly less hospital-based deaths and significantly more community deaths, as compared to patients who received late palliative care referrals. **Feasibility:** Useful in understanding the impact of early palliative care interventions on end-of-life care wishes.	Level III-A
Schenker, Y., Bahary, N., Claxton, R., Childers, J., Chu, E., Kavalieratos, D., King, L., Lembersky, B., Tiver, G., & Arnold, R. M. (2018). A pilot trial of early specialty palliative care for patients with advanced pancreatic cancer: Challenges encountered and lessons learned. *Journal of Palliative Medicine*, *21*(1), 28–36. https://doi.org/10.1089/jpm.2017.0113	Randomized controlled trial	30 patient-caregiver pairs with advanced pancreatic cancer at the University of Pittsburgh Cancer Institute	**Outcome:** Patients who participated in the palliative care arm of the study found positive perceptions of emotional support and symptom management. Negative perceptions were inconvenience and services not tailored to the needs of patient/caregiver. **Feasibility:** The study gives useful recommendations for patient/caregiver centered approach to specialty palliative care.	Level I-B
Sullivan, D. R., Chan, B., Lapidus, J. A., Ganzini, L., Hansen, L., Carney, P. A., Fromme, E. K., Marino, M.,	Retrospective population-based cohort study	23,154 patients with advanced lung cancer (stage IIIB	**Outcome:** Study found that patients who received palliative care in acute or non-acute	Level III-A

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
Golden, S. E., Vranas, K. C., & Slatore, C. G. (2019). Association of early palliative care use with survival and place of death among patients with advanced lung cancer receiving care in the Veterans Health Administration. *JAMA Oncology*, *5*(12), 1702. https://doi.org/10.1001/jamaoncol.2019.3105		and stage IV) who received care in the Veterans Affairs healthcare system from January 1, 2007 to December 31, 2013	settings were less likely to die in acute care settings as compared to patients who did not receive palliative care. **Feasibility:** Useful study demonstrating the impact of palliative care on patient quality of life, particularly when consulted early.	
Warth, M., Kessler, J., Koeher, F., Aguilar-Raab, C., Bardenheuer, H. J., & Ditzen, B. (2019). Brief psychosocial interventions improve quality of life of patients receiving palliative care: A systematic review and meta-analysis. *Palliative Medicine*, *33*(3), 332–345. https://doi.org/10.1177/0269216318818011	Systematic literature review and mixed effects meta-analysis	50 randomized and non-randomized controlled were reviewed and 15 were included in the analysis	**Outcome:** Analysis found that psychosocial interventions on patients facing terminal illness improved quality of life and significantly reduced existential suffering. **Feasibility:** Useful study demonstrating the impact of providing patients with grief support as part of palliative care support.	Level III-A
Temel, J. S., Greer, J. A., Muzikansky, A., Gallagher, E. R., Admane, S., Jackson, V. A., Dahlin, C. M., Blinderman, C. D., Jacobsen, J., Pirl, W. F., Billings, J., & Lynch, T. J. (2010). Early palliative care in non–small-cell lung cancer. *New England Journal of Medicine*, *363*(23), 2263–2265. https://doi.org/10.1056/nejmc1010529	Landmark study Non-blinded randomized controlled trial	151 patients newly diagnosed with metastatic non-small cell lung cancer at Massachusetts General Hospital, Boston	**Outcome:** Landmark study in which results demonstrated that early palliative care improved quality of life, decreased depression, reduced aggressive care at end of life, and improved survival. **Feasibility:** Evidence can be shared with referring providers and patients who may be skeptical or fearful in accepting palliative care services.	Level I-A

Appendix D. Kotter’s 8-Step Change Model

Kotter’s 8-Step Change Model.



Aziz, A.-M. (2017). A change management approach to improving safety and preventing needle stick injuries. *Journal of Infection Prevention, 18*(5), 257–262. https://doi.org/10.1177/1757177416687829

Appendix E. Project Charter

Project Charter: Improving referral process for specialty palliative care in patients with stage IV gastric, esophageal, hepatobiliary, pancreatic, and colon cancer.

Global Aim: To reduce patient suffering and improve quality of life and death through palliative care consultation and ongoing support.

Specific Aim: To increase the number of specialty palliative care consults and support for patients diagnosed with stage IV GI cancer (esophageal, gastric, hepatic, biliary, pancreatic, and colon) from 37% to 57% by June 31, 2021.

Background:

There exists opportunity for improving communication and coordination of care between palliative care and oncology. Palliative care is underutilized and misunderstood by healthcare providers and patient populations. Palliative care is able to support patients with serious illness and their families through consultations with physicians, nurses, social workers, and chaplains. Early specialty palliative care integrated within oncology services has been found to reduce burdens, improve patient's quality of life, and increase survival (Temel et al., 2010). The overarching purpose of the project is to improve and increase the referral process for specialty palliative care in high mortality cancers, such as gastric, esophageal, hepato-biliary, and pancreatic, to reduce unnecessary suffering and symptom burden.

Sponsors

Assistant Physician in Chief	Dr. D.C.
Continuum Administrator	G.S.
Assistant Medical Group Administrator	R.P.
Physician Lead	Dr. S.G.
Chief Division of Oncology/Hematology	Dr. M.P.

Goals:

To standardize collaboration and communication among team members in specialty palliative care (SPC) and oncology by the following interventions:

1. Improve communication among the oncology and specialty palliative care team by instituting a standard weekly huddle.
2. Support the oncology team to better introduce and educate the cancer patient about SPC services.
3. Improve access for SPC consults by utilizing direct bookable appointments.
4. Reduce unnecessary triage of referrals.
5. Improve patient education and reference material for SPC services.

Measures

Measure	Data Source	Target
Outcome		
% of patients who received a SPC consult	Manual chart abstraction	57%
Quality of death experienced by patients during the project	Manual chart abstraction	75%
Process		
% of patients referred to palliative care	e-consult report Tableau Manual chart abstraction	TBD
% of held huddles with oncology and palliative care	Manual data collection	98%
Balancing		
% of patients who declined SPC referrals	Supportive care services regional report Tableau Manual data collection	TBD

Team

Palliative Care MD Co lead	Dr. E.L.
Oncology MD Co lead	Dr. H.L.
Oncology Clinic RN Manager	C.N.
Oncology RN Case Manager	R.R.
Specialty Palliative Care RN	H.T.
Specialty Palliative Care RN	C.D.
Specialty Palliative Care Medical Assistant	F.G.
Specialty Palliative Care MSW	S.P.
Specialty Palliative Care MSW	M.W.
Specialty Palliative Care Chaplain	R.K.

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Appendix F. Dartmouth Worksheet

Specialty Care Practice Profile

A. Purpose:
Why does your practice exist?

Site Name: Palliative Care	Site Contact: Diana Stevenson	Date: 09/15/2020
Practice Manager: Carrie Bibb	MD Lead: Dr. Sudha Gattupalli	Nurse Lead: Barbara Morrissey/Huai-En Tsai

B. Know Your Patients: Take a close look into your practice, create a "high-level" picture of the PATIENT POPULATION that you serve. Who are they? What resources do they use? How do the patients view the care they receive?

Est. Age Distribution of Patients:	%
Birth-10 years	0
11-18 years	0
19-45 years	10
46-64 years	20
65-79 years	40
80 + years	30
% Females	

Health Outcomes
Care is consistent with patient wishes

List Your Top 5 Diagnoses	List Your Top 5 consults
1. Cancer	1. Initial consults
2. Heart Failure	2. followup consults
3. Renal Failure	3. Joint visits
4. Dementia	4. Warm handoffs
5. lung failure	5. Home visits

List Your Top 5 Referrers

Referrer	What are they referring?
Oncology	Terminal illness
Inpatient PC	Ongoing support post DC
Adv Heart failure	Terminal illness
Nephrology	Declined dialysis

Patient Satisfaction Scores	% Excellent
Experience via phone	
Length of time to get your appointment	<7 days
Saw who patient wanted to see	UNK
Satisfaction with personal manner	UNK
Time spent with person today	UNK

Pt Population Census: Do these numbers change by season? **(Y/N)**	#	Y/N
Patients seen in a day	3	
Patients seen in last week	13	
New patients in last month		
Encounters per provider per year	Out/IN	

***Complete "Through the Eyes of Your Patient", pg 9**

C. Know Your Professionals: Create a comprehensive picture of your practice. Who does what and when? Is the right person doing the right activity? Are roles being optimized? Are all roles who contribute to the patient experience listed? What hours are you open for business? How many and what is the duration of your appointment types? How many exam rooms do you currently have? What is the morale of your staff?

Current Staff	FTEs	Days/Hours					
MD Total	1.3	M	T	W	TH	F	S
		1	2	1	1	1	
NP/PAs Total	N/A	0	0	0	0	0	0
RNs Total	2	2	2	2	2	2	0
LPNs Total	N/A	0	0	0	0	0	0
LNA/MAs Total	1	1	1	1	1	1	0
Others Total							
Patient coordinator	.5	.5	.5	.5	.5	.5	0
Secretaries Total							

3rd Next Available		Cycle Time Range
New	F/U	
Same day Or Next day for urgent referrals Routine referrals are 7-14 days	Same day Or Next day for urgent referrals Routine followup is at the discretion of the clinician and patient. Usually less than 3 mos.	

Do you offer any of the following? Check all that apply.
X Group Visit
X E-mail
☐ Web site
X RN Clinics
X Phone Care Management
X Registries
☐ Protocols/Guidelines

 # Exam Rooms 1
 # Minor Rooms ________

Supporting diagnostic Depts. (e.g. respiratory, lab, cardio.)
Yes depending on the illness
For prognostication

Appt. Type	Duration	Comment
NewPt	90 min	
Follow-up	30-60 min	
Minor		

Staff Satisfaction Scores: see Appendix B		%
Daily rounds are productive and efficient	% Not Satisfied	100%
I feel comfortable expressing perspectives that differ from the rest of the team's?	% Strongly Agree	86%

Do you use Float Pool? ____ Yes _x_ No
Do you use On-Call? x___ Yes ____ No

***Each staff member should complete the Personal Skills Assessment and "The Activity Survey", pgs 11-13**

D. Know Your Processes: How do things get done in the microsystem? Who does what? What are the step-by-step processes? How long does the care process take? Where are the delays? What are the "between" microsystems hand-offs?

1. **Track cycle time for patients from the time they check in until they leave the office using the Patient Cycle Time Tool. List ranges of time per provider on this table, pg 14/15**
2. **Complete the Core and Supporting Process Assessment Tool, pg 16**

E. Know Your Patterns: What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss patient care? Are patients and families involved? What are your results and outcomes?

- Does every member of the practice meet regularly as a team? yes
- How frequently? Daily
- Do the members of the practice regularly review and discuss safety and reliability issues? Yes
- What have you successfully changed? econsult
- What are you most proud of? Care of PC pt
- What is your financial picture? At budget
- What is the most significant pattern of variation?

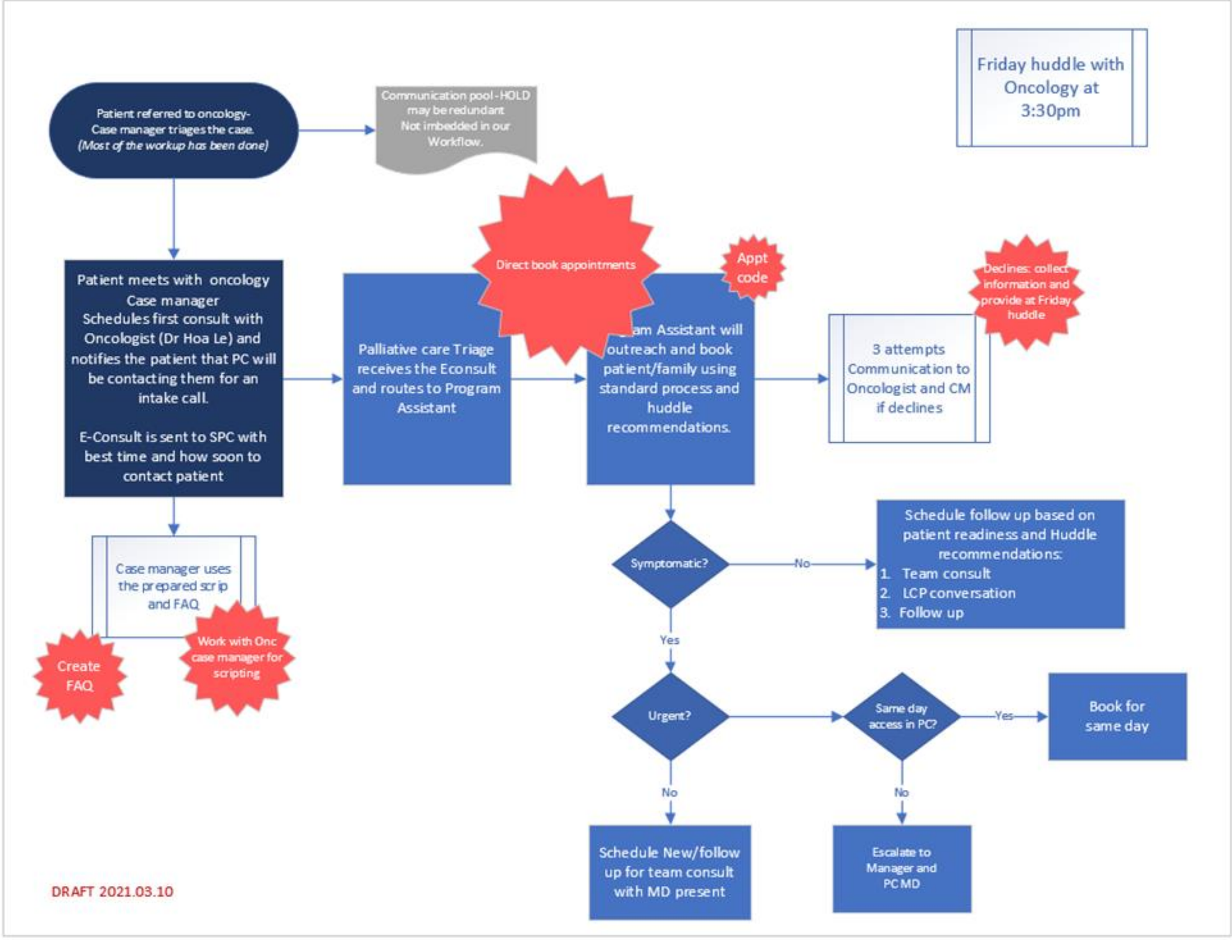
***Complete "Metrics that Matter", pg 22**

Dartmouth-Hitchcock Medical Center. (n.d.). *Microsystem assessment tool*. http://www.ihi.org/resources/Pages/Tools/ClinicalMicrosystemAssessmentTool.aspx

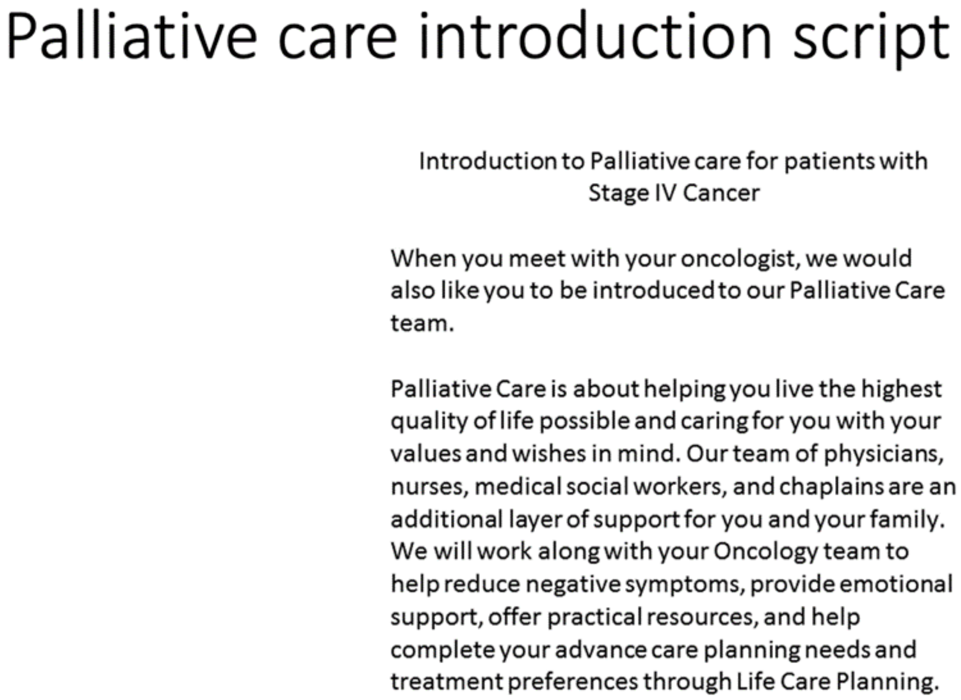
Appendix G. Spreadsheet Columns

MRN	Patient Name	Age	Diagnosis	Currently on PC service ?	DATE of referral to PC	LCP Registry?	PC registry?	plan	PC team	Code Status	POLST	LCP	ADV Dir.	# of hosp. admissions in last 6 mos.	Date Initial consult	Hospice enrollment	QOD

Appendix H. Oncology/Palliative Care Workflow



Appendix I. Introduction for Palliative Care Script



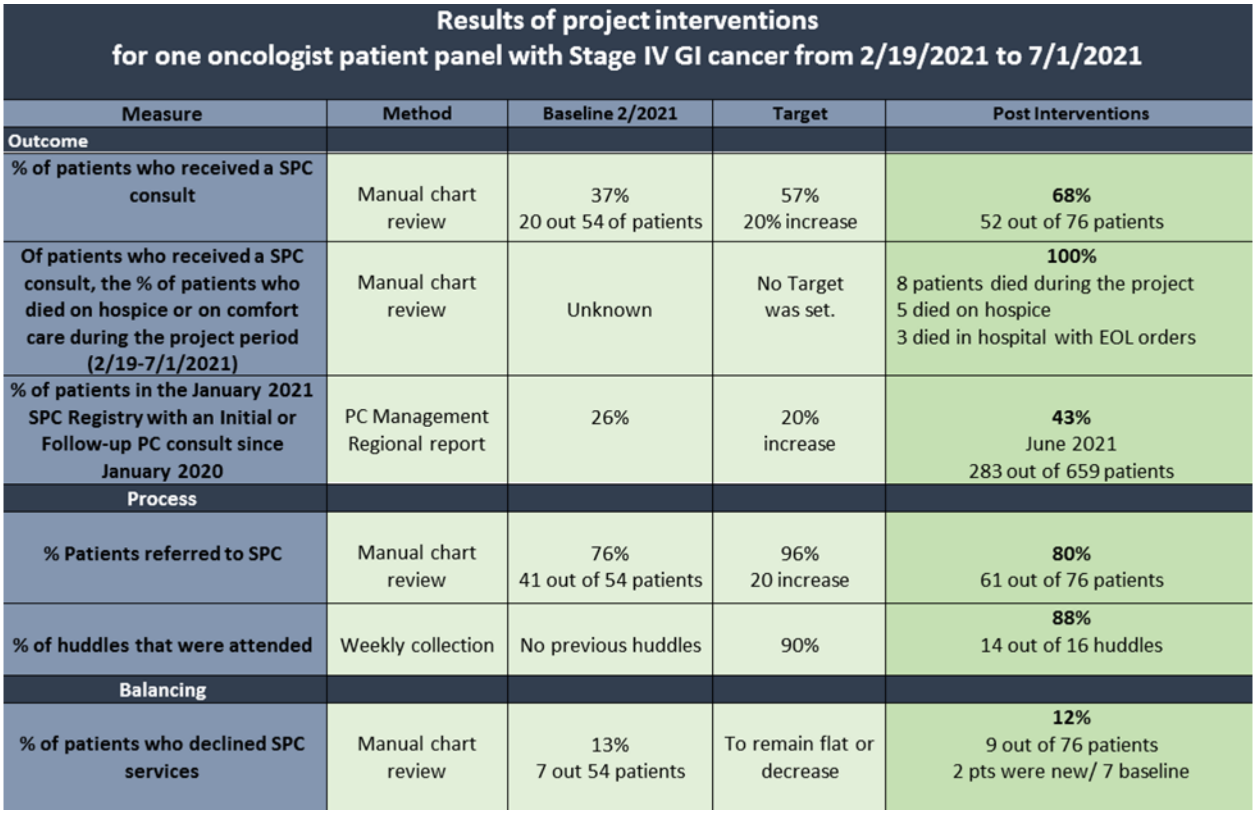
Palliative care introduction script

Introduction to Palliative care for patients with Stage IV Cancer

When you meet with your oncologist, we would also like you to be introduced to our Palliative Care team.

Palliative Care is about helping you live the highest quality of life possible and caring for you with your values and wishes in mind. Our team of physicians, nurses, medical social workers, and chaplains are an additional layer of support for you and your family. We will work along with your Oncology team to help reduce negative symptoms, provide emotional support, offer practical resources, and help complete your advance care planning needs and treatment preferences through Life Care Planning.

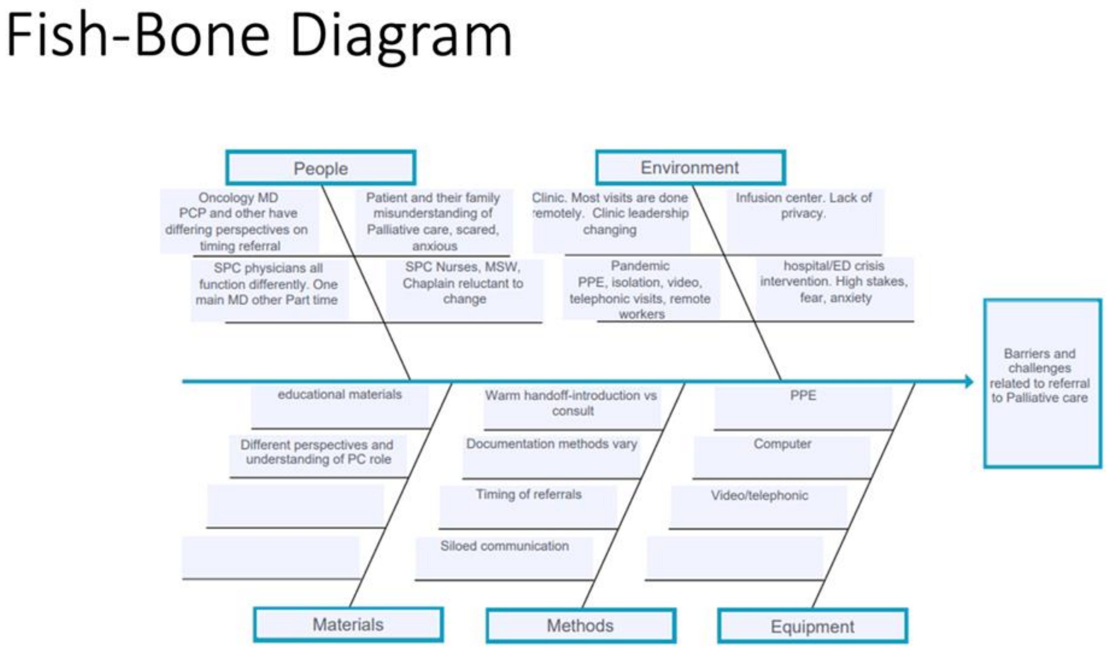
Appendix J. Project Intervention Results



Results of project interventions
for one oncologist patient panel with Stage IV GI cancer from 2/19/2021 to 7/1/2021

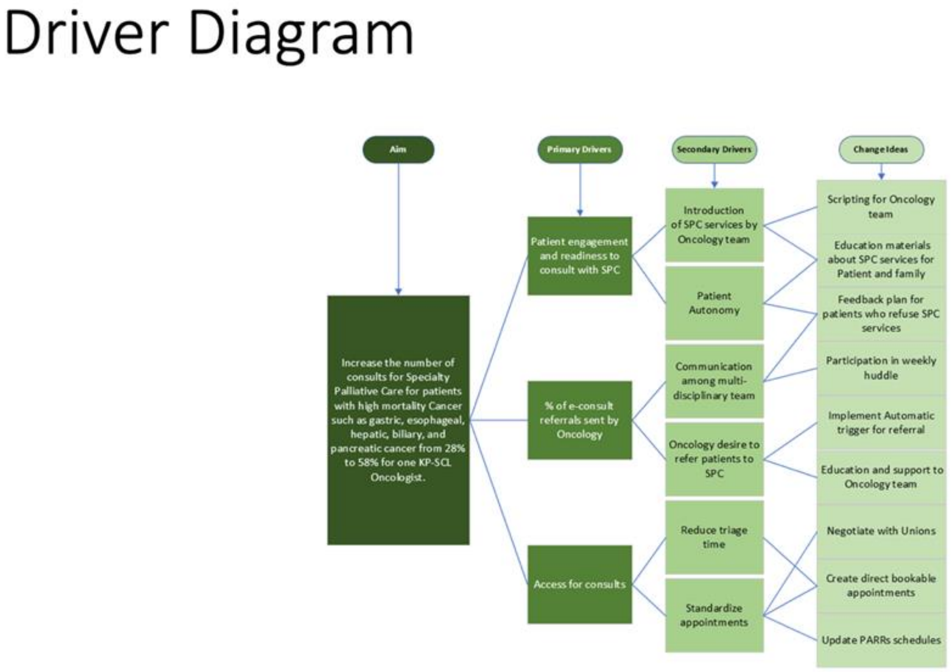
Measure	Method	Baseline 2/2021	Target	Post Interventions
Outcome				
% of patients who received a SPC consult	Manual chart review	37% 20 out 54 of patients	57% 20% increase	**68%** 52 out of 76 patients
Of patients who received a SPC consult, the % of patients who died on hospice or on comfort care during the project period (2/19-7/1/2021)	Manual chart review	Unknown	No Target was set.	**100%** 8 patients died during the project 5 died on hospice 3 died in hospital with EOL orders
% of patients in the January 2021 SPC Registry with an Initial or Follow-up PC consult since January 2020	PC Management Regional report	26%	20% increase	**43%** June 2021 283 out of 659 patients
Process				
% Patients referred to SPC	Manual chart review	76% 41 out of 54 patients	96% 20 increase	**80%** 61 out of 76 patients
% of huddles that were attended	Weekly collection	No previous huddles	90%	**88%** 14 out of 16 huddles
Balancing				
% of patients who declined SPC services	Manual chart review	13% 7 out 54 patients	To remain flat or decrease	**12%** 9 out of 76 patients 2 pts were new/ 7 baseline

Appendix K. Fishbone Diagram



Fish-Bone Diagram

Appendix L. Driver Diagram



Driver Diagram

Aim

Increase the number of consults for Specialty Palliative Care for patients with high mortality Cancer such as gastric, esophageal, hepatic, biliary, and pancreatic cancer from 28% to 58% for one KP-SCL Oncologist.

Primary Drivers

Patient engagement and readiness to consult with SPC

% of e-consult referrals sent by Oncology

Access for consults

Secondary Drivers

Introduction of SPC services by Oncology team

Patient Autonomy

Communication among multi-disciplinary team

Oncology desire to refer patients to SPC

Reduce triage time

Standardize appointments

Change Ideas

Scripting for Oncology team

Education materials about SPC services for Patient and family

Feedback plan for patients who refuse SPC services

Participation in weekly huddle

Implement Automatic trigger for referral

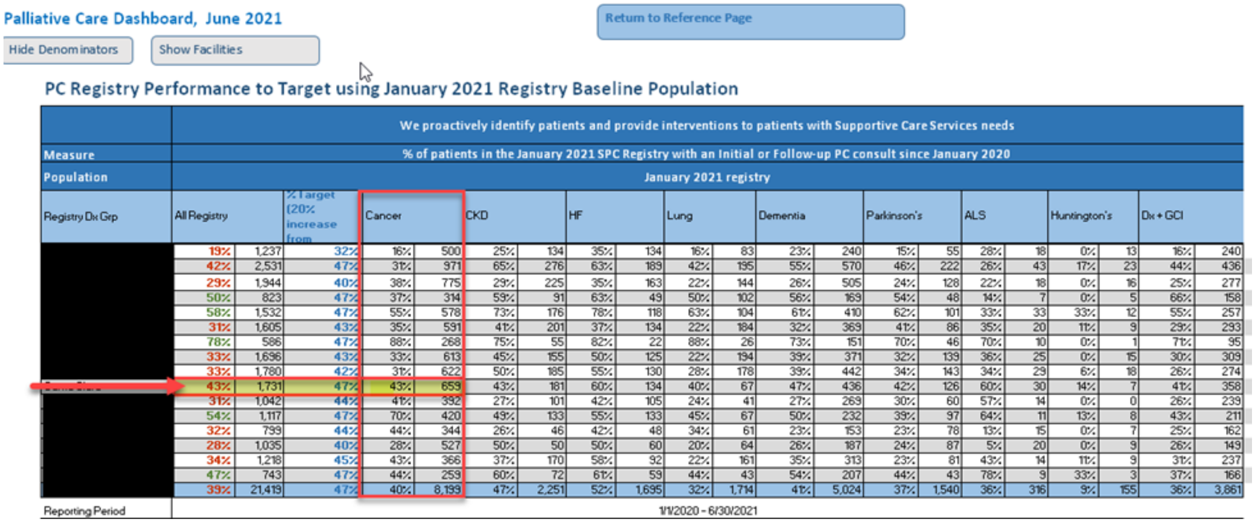
Education and support to Oncology team

Negotiate with Unions

Create direct bookable appointments

Update PARRs schedules

Appendix M. June Regional Data



Palliative Care Dashboard, June 2021

PC Registry Performance to Target using January 2021 Registry Baseline Population

We proactively identify patients and provide interventions to patients with Supportive Care Services needs

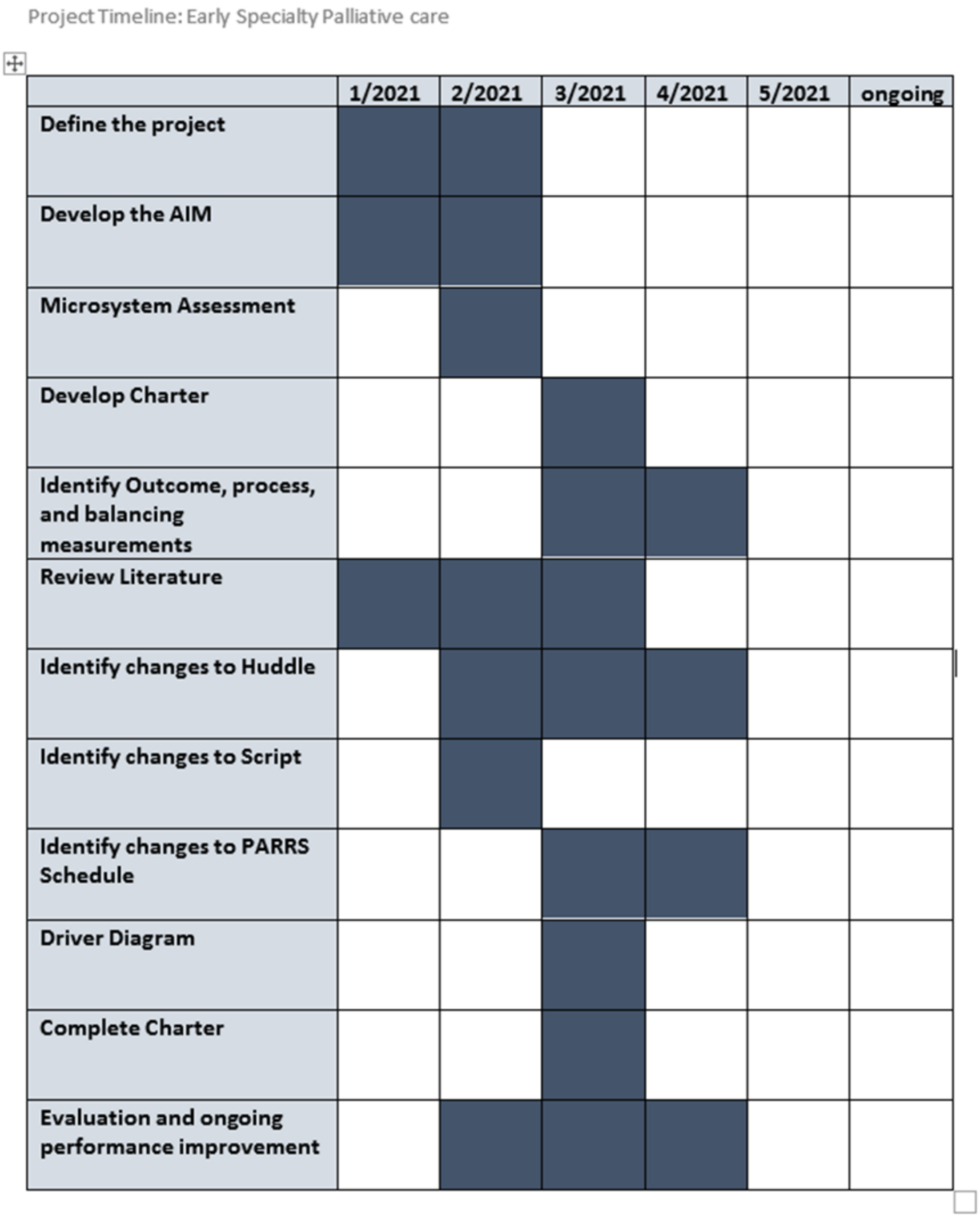
Measure: % of patients in the January 2021 SPC Registry with an Initial or Follow-up PC consult since January 2020

Population: January 2021 registry

Registry Dx Grp	All Registry		%Target (20% increase from	Cancer		CKD		HF		Lung		Dementia		Parkinson's		ALS		Huntington's		Dx + GCI	
[redacted]	19%	1,237	32%	16%	500	25%	134	35%	134	16%	83	23%	240	15%	55	28%	18	0%	13	16%	240
[redacted]	42%	2,531	47%	31%	971	65%	276	63%	189	42%	195	55%	570	46%	222	26%	43	17%	23	44%	436
[redacted]	29%	1,944	40%	38%	775	29%	225	35%	163	22%	144	26%	505	24%	128	22%	18	0%	16	25%	277
[redacted]	50%	823	47%	37%	314	59%	91	63%	49	50%	102	56%	169	54%	48	14%	7	0%	5	66%	158
[redacted]	58%	1,532	47%	55%	578	73%	176	78%	118	63%	104	61%	410	62%	101	33%	33	33%	12	55%	257
[redacted]	31%	1,605	43%	35%	591	41%	201	37%	134	22%	184	32%	369	41%	86	35%	20	11%	9	29%	293
[redacted]	78%	586	47%	88%	268	75%	55	82%	22	88%	26	73%	151	70%	46	70%	10	0%	1	71%	95
[redacted]	33%	1,696	43%	33%	613	45%	155	50%	125	22%	194	39%	371	32%	139	36%	25	0%	15	30%	309
[redacted]	33%	1,780	42%	31%	622	50%	185	55%	130	28%	178	39%	442	34%	143	34%	29	6%	18	26%	274
[redacted]	43%	1,731	47%	43%	659	43%	181	60%	134	40%	67	47%	436	42%	126	60%	30	14%	7	41%	358
[redacted]	31%	1,042	44%	41%	392	27%	101	42%	105	24%	41	27%	269	30%	60	57%	14	0%	0	26%	239
[redacted]	54%	1,117	47%	70%	420	49%	133	55%	133	45%	67	50%	232	39%	97	64%	11	13%	8	43%	211
[redacted]	32%	799	44%	44%	344	26%	46	42%	48	34%	61	23%	153	23%	78	13%	15	0%	7	25%	162
[redacted]	28%	1,035	40%	28%	527	50%	50	50%	60	20%	64	26%	187	24%	87	5%	20	0%	9	26%	149
[redacted]	34%	1,218	45%	43%	366	37%	170	58%	92	22%	161	35%	313	23%	81	43%	14	11%	9	31%	237
[redacted]	47%	743	47%	44%	259	60%	72	61%	59	44%	43	54%	207	44%	43	78%	9	33%	3	37%	166
[redacted]	39%	21,419	47%	40%	8,199	47%	2,251	52%	1,695	32%	1,714	41%	5,024	37%	1,540	36%	316	9%	155	36%	3,861

Reporting Period: 1/1/2020 - 6/30/2021

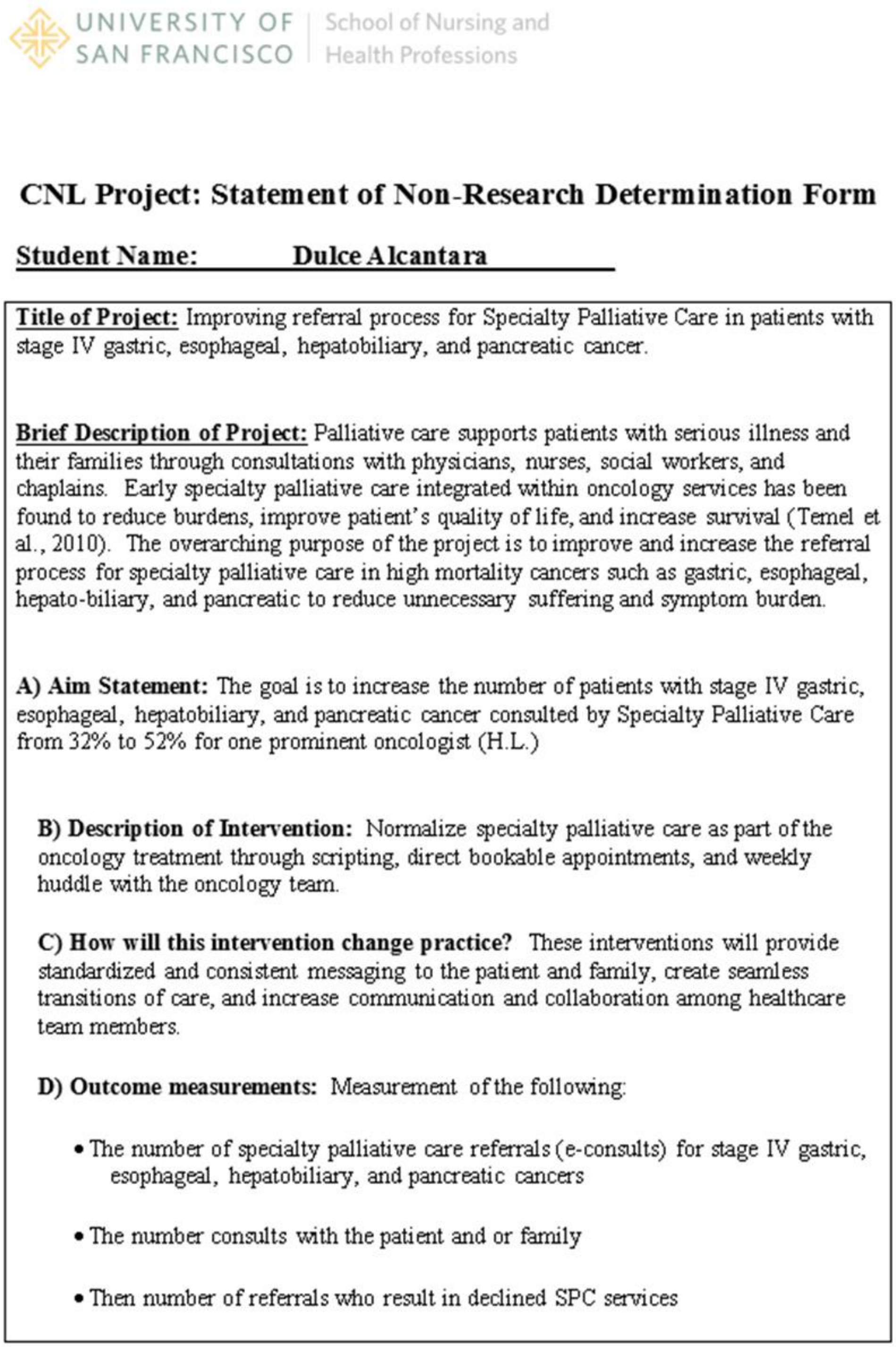
Appendix N. Project Timeline



Project Timeline: Early Specialty Palliative care

	1/2021	2/2021	3/2021	4/2021	5/2021	ongoing
Define the project	■	■				
Develop the AIM	■	■				
Microsystem Assessment		■				
Develop Charter			■			
Identify Outcome, process, and balancing measurements			■	■		
Review Literature	■	■	■			
Identify changes to Huddle		■	■	■		
Identify changes to Script		■				
Identify changes to PARRS Schedule			■	■		
Driver Diagram			■			
Complete Charter			■			
Evaluation and ongoing performance improvement		■	■	■		

Appendix O. Statement of Non-Research Determination



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CNL Project: Statement of Non-Research Determination Form

Student Name: **Dulce Alcantara**

Title of Project: Improving referral process for Specialty Palliative Care in patients with stage IV gastric, esophageal, hepatobiliary, and pancreatic cancer.

Brief Description of Project: Palliative care supports patients with serious illness and their families through consultations with physicians, nurses, social workers, and chaplains. Early specialty palliative care integrated within oncology services has been found to reduce burdens, improve patient's quality of life, and increase survival (Temel et al., 2010). The overarching purpose of the project is to improve and increase the referral process for specialty palliative care in high mortality cancers such as gastric, esophageal, hepato-biliary, and pancreatic to reduce unnecessary suffering and symptom burden.

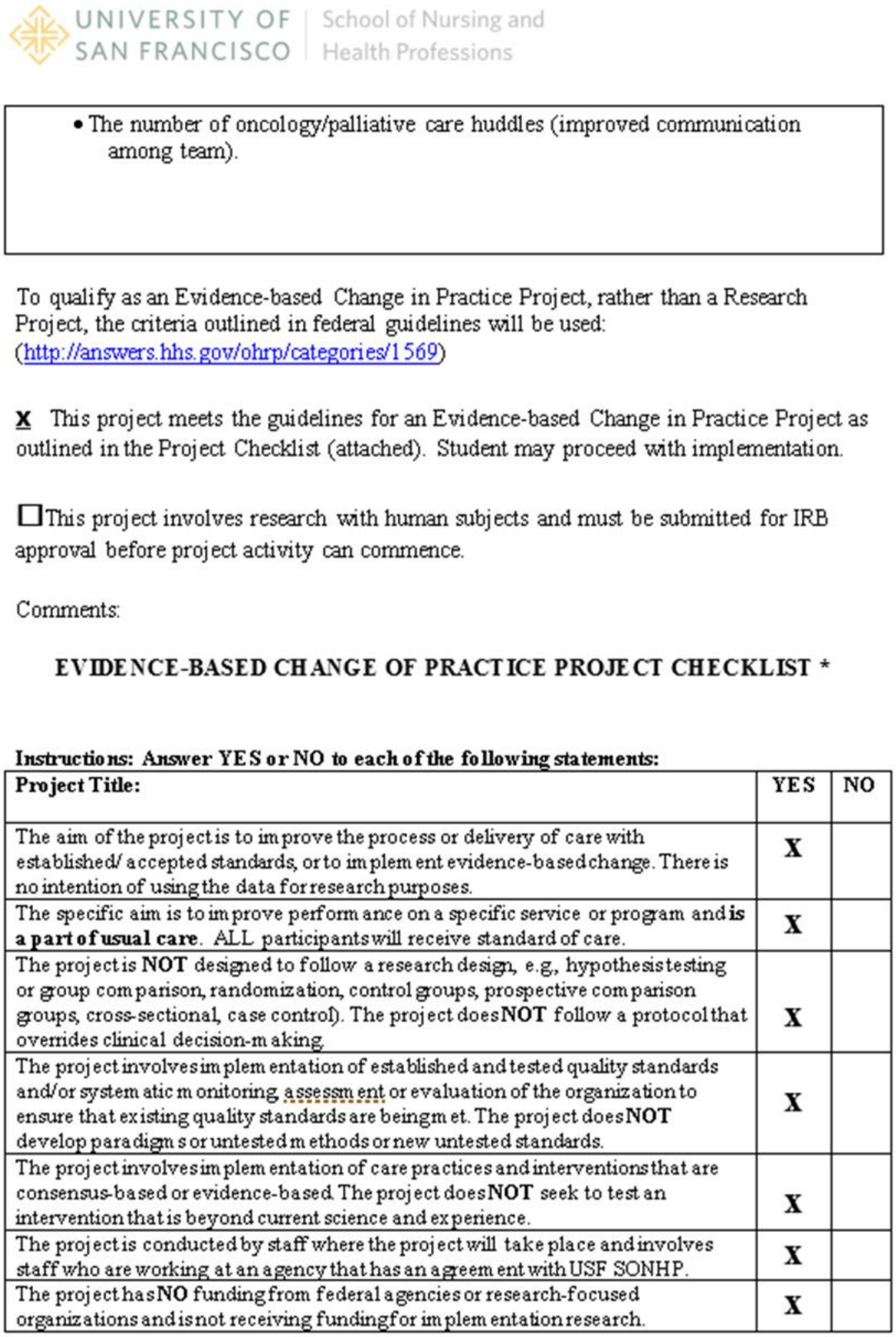
A) Aim Statement: The goal is to increase the number of patients with stage IV gastric, esophageal, hepatobiliary, and pancreatic cancer consulted by Specialty Palliative Care from 32% to 52% for one prominent oncologist (H.L.)

B) Description of Intervention: Normalize specialty palliative care as part of the oncology treatment through scripting, direct bookable appointments, and weekly huddle with the oncology team.

C) How will this intervention change practice? These interventions will provide standardized and consistent messaging to the patient and family, create seamless transitions of care, and increase communication and collaboration among healthcare team members.

D) Outcome measurements: Measurement of the following:

- The number of specialty palliative care referrals (e-consults) for stage IV gastric, esophageal, hepatobiliary, and pancreatic cancers
- The number consults with the patient and or family
- Then number of referrals who result in declined SPC services



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- The number of oncology/palliative care huddles (improved communication among team).

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

X This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

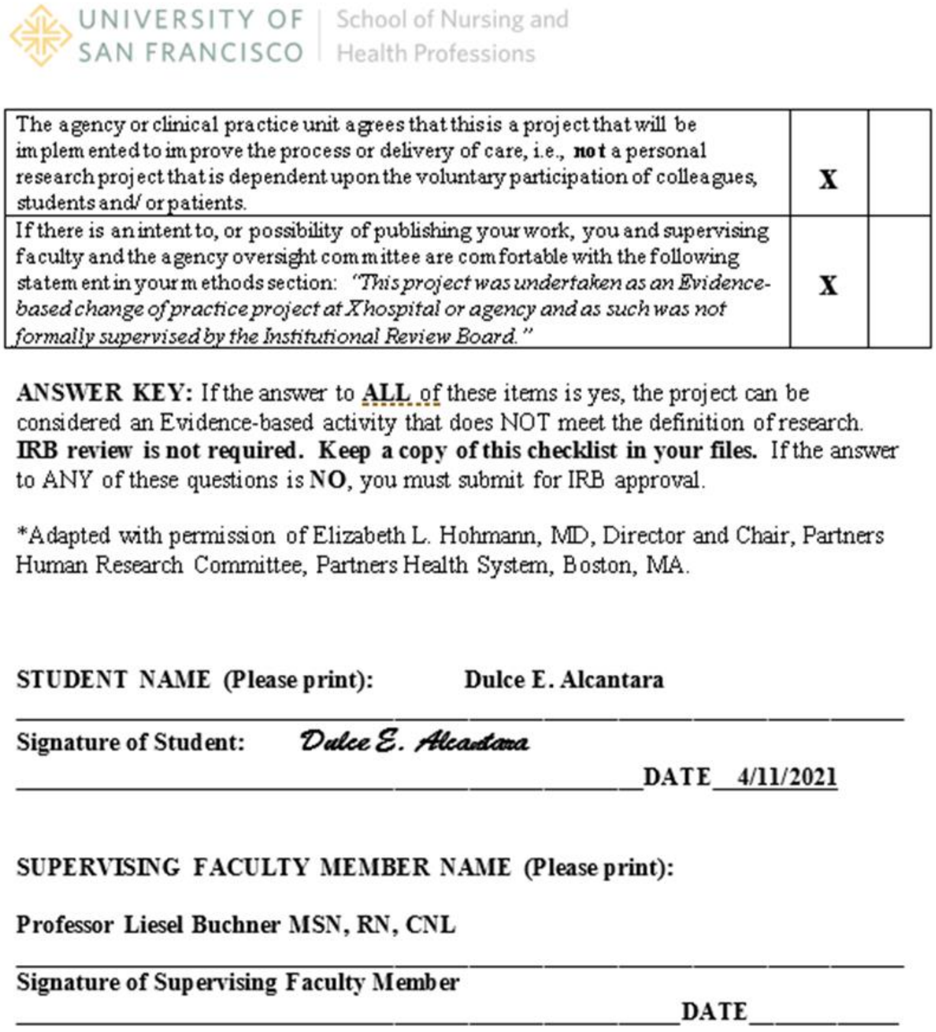
☐This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**X**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**X**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**X**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**X**	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**X**	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	**X**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**X**	



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The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	X	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	X	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): **Dulce E. Alcantara**

Signature of Student: Dulce E. Alcantara

DATE 4/11/2021

SUPERVISING FACULTY MEMBER NAME (Please print):

Professor Liesel Buchner MSN, RN, CNL

Signature of Supervising Faculty Member

DATE__________

Appendix P. Specialty Care Practice Profile

Specialty Care Practice Profile

A. *Purpose:*
Why does your practice exist?

Site Name: Palliative Care	Site Contact: Diana Stevenson	Date: 09/15/2020
Practice Manager: Carrie Bibb	MD Lead: Dr. Sudha Gattupalli	Nurse Lead: Barbara Morrissey/Huai-En Tsai

B. *Know Your Patients:* Take a close look into your practice, create a "high-level" picture of the PATIENT POPULATION that you serve. Who are they? What resources do they use? How do the patients view the care they receive?

Est. Age Distribution of Patients:	**%**
Birth-10 years	0
11-18 years	0
19-45 years	10
46-64 years	20
65-79 years	40
80 + years	30
% Females	
Health Outcomes	
Care is consistent with patient wishes	

List Your Top 5 Diagnoses	**List Your Top 5 consults**
1. Cancer	1. Initial consults
2. Heart Failure	2. followup consults
3. Renal Failure	3. Joint visits
4. Dementia	4. Warm handoffs
5. lung failure	5. Home visits

List Your Top 5 Referrers

Referrer	**What are they referring?**
Oncology	Terminal illness
Inpatient PC	Ongoing support post DC
Adv Heart failure	Terminal illness
Nephrology	Declined dialysis

Patient Satisfaction Scores	% Excellent
Experience via phone	
Length of time to get your appointment	<7 days
Saw who patient wanted to see	UNK
Satisfaction with personal manner	UNK
Time spent with person today	UNK

Pt Population Census: Do these numbers change by season? **(Y/N)**	**#**	**Y/N**
Patients seen in a day	3	
Patients seen in last week	13	
New patients in last month		
Encounters per provider per year	**Out/IN**	

****Complete "Through the Eyes of Your Patient", pg 9***

C. *Know Your Professionals:* Create a comprehensive picture of your practice. Who does what and when? Is the right person doing the right activity? Are roles being optimized? Are all roles who contribute to the patient experience listed? What hours are you open for business? How many and what is the duration of your appointment types? How many exam rooms do you currently have? What is the morale of your staff?

Current Staff	**FTEs**	**Days/Hours**						**3rd Next Available**		**Cycle Time Range**
								New	F/U	
MD Total	1.3	M	T	W	TH	F	S			
		1	2	1	1	1		Same day Or Next day for urgent referrals Routine referrals are 7-14 days	Same day Or Next day for urgent referrals Routine followup is at the discretion of the clinician and patient. Usually less than 3 mos.	
NP/PAs Total	N/A	0	0	0	0	0	0			
RNs Total	2	2	2	2	2	2	0			
LPNs Total	N/A	0	0	0	0	0	0			
LNA/MAs Total	1	1	1	1	1	1	0			
Others Total										
Patient coordinator	.5	.5	.5	.5	.5	.5	0			
Secretaries Total										

Do you offer any of the following? Check all that apply.
- ☒ Group Visit
- ☒ E-mail
- ☐ Web site
- ☒ RN Clinics
- ☒ Phone Care Management
- ☒ Registries
- ☐ Protocols/Guidelines

 # Exam Rooms 1
 # Minor Rooms ______

Supporting diagnostic Depts. (e.g. respiratory, lab, cardio.)
Yes depending on the illness
For prognostication

Appt. Type	**Duration**	Comment
NewPt	90 min	
Follow-up	30-60 min	
Minor		

Do you use Float Pool? ____ Yes _x_ No
Do you use On-Call? x___ Yes ____ No

Staff Satisfaction Scores: see Appendix B		**%**
Daily rounds are productive and efficient	% Not Satisfied	100%
I feel comfortable expressing perspectives that differ from the rest of the team's?	% Strongly Agree	86%

***Each staff member should complete the Personal Skills Assessment and "The Activity Survey", pgs 11-13**

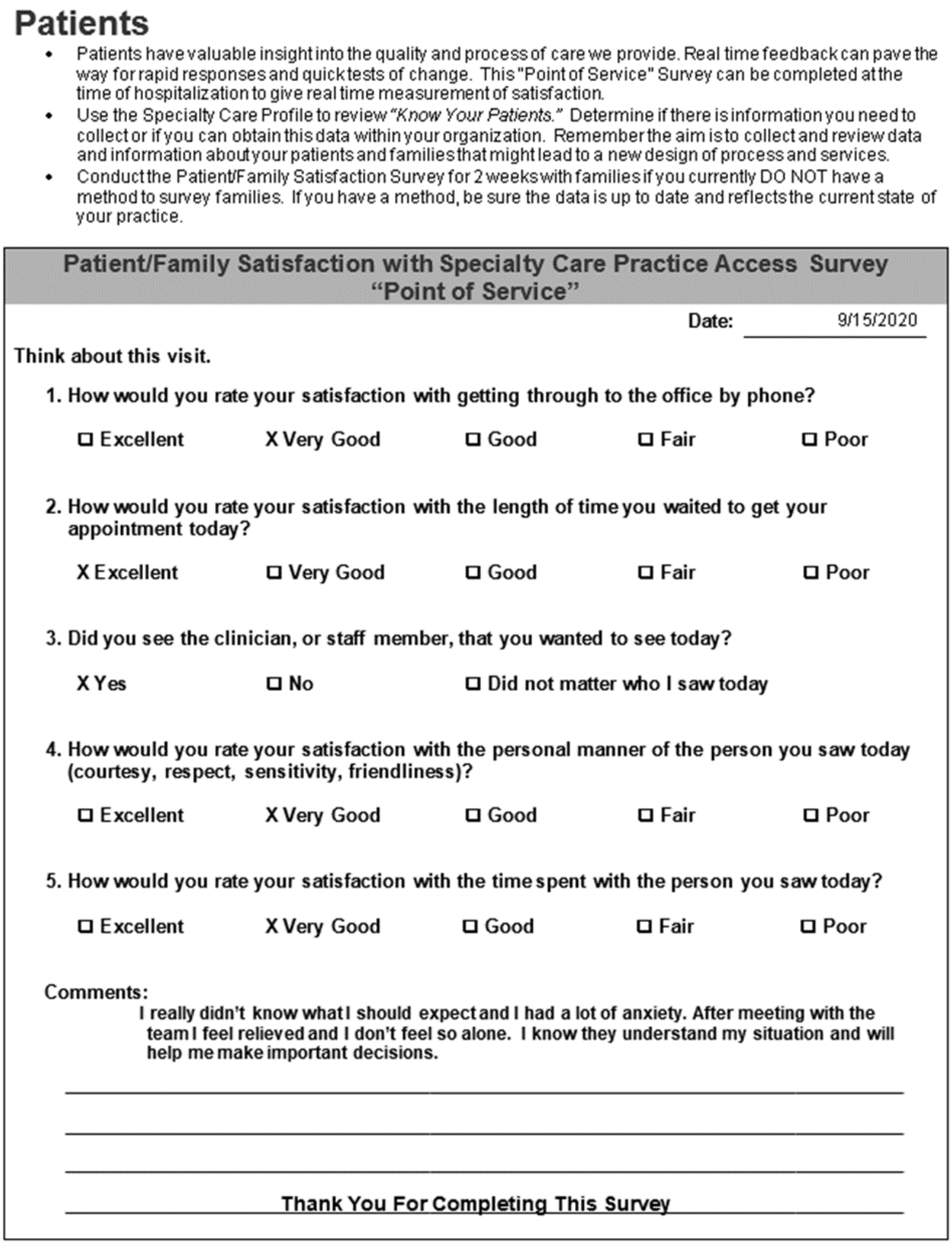
D. *Know Your Processes:* How do things get done in the microsystem? Who does what? What are the step-by-step processes? How long does the care process take? Where are the delays? What are the "between" microsystems hand-offs?

1. **Track cycle time for patients from the time they check in until they leave the office using the Patient Cycle Time Tool. List ranges of time per provider on this table, pg 14/15**
2. **Complete the Core and Supporting Process Assessment Tool, pg 16**

E. *Know Your Patterns:* What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss patient care? Are patients and families involved? What are your results and outcomes?

- Does every member of the practice meet regularly as a team? yes
- How frequently? Daily
- Do the members of the practice regularly review and discuss safety and reliability issues? Yes
- What have you successfully changed? econsult
- What are you most proud of? Care of PC pt
- What is your financial picture? At budget
- What is the most significant pattern of variation?

***Complete "Metrics that Matter", pg 22**



Patients

- Patients have valuable insight into the quality and process of care we provide. Real time feedback can pave the way for rapid responses and quick tests of change. This "Point of Service" Survey can be completed at the time of hospitalization to give real time measurement of satisfaction.
- Use the Specialty Care Profile to review *"Know Your Patients."* Determine if there is information you need to collect or if you can obtain this data within your organization. Remember the aim is to collect and review data and information about your patients and families that might lead to a new design of process and services.
- Conduct the Patient/Family Satisfaction Survey for 2 weeks with families if you currently DO NOT have a method to survey families. If you have a method, be sure the data is up to date and reflects the current state of your practice.

Patient/Family Satisfaction with Specialty Care Practice Access Survey
"Point of Service"

Date: 9/15/2020

Think about this visit.

1. How would you rate your satisfaction with getting through to the office by phone?

☐ Excellent X Very Good ☐ Good ☐ Fair ☐ Poor

2. How would you rate your satisfaction with the length of time you waited to get your appointment today?

X Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. Did you see the clinician, or staff member, that you wanted to see today?

X Yes ☐ No ☐ Did not matter who I saw today

4. How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)?

☐ Excellent X Very Good ☐ Good ☐ Fair ☐ Poor

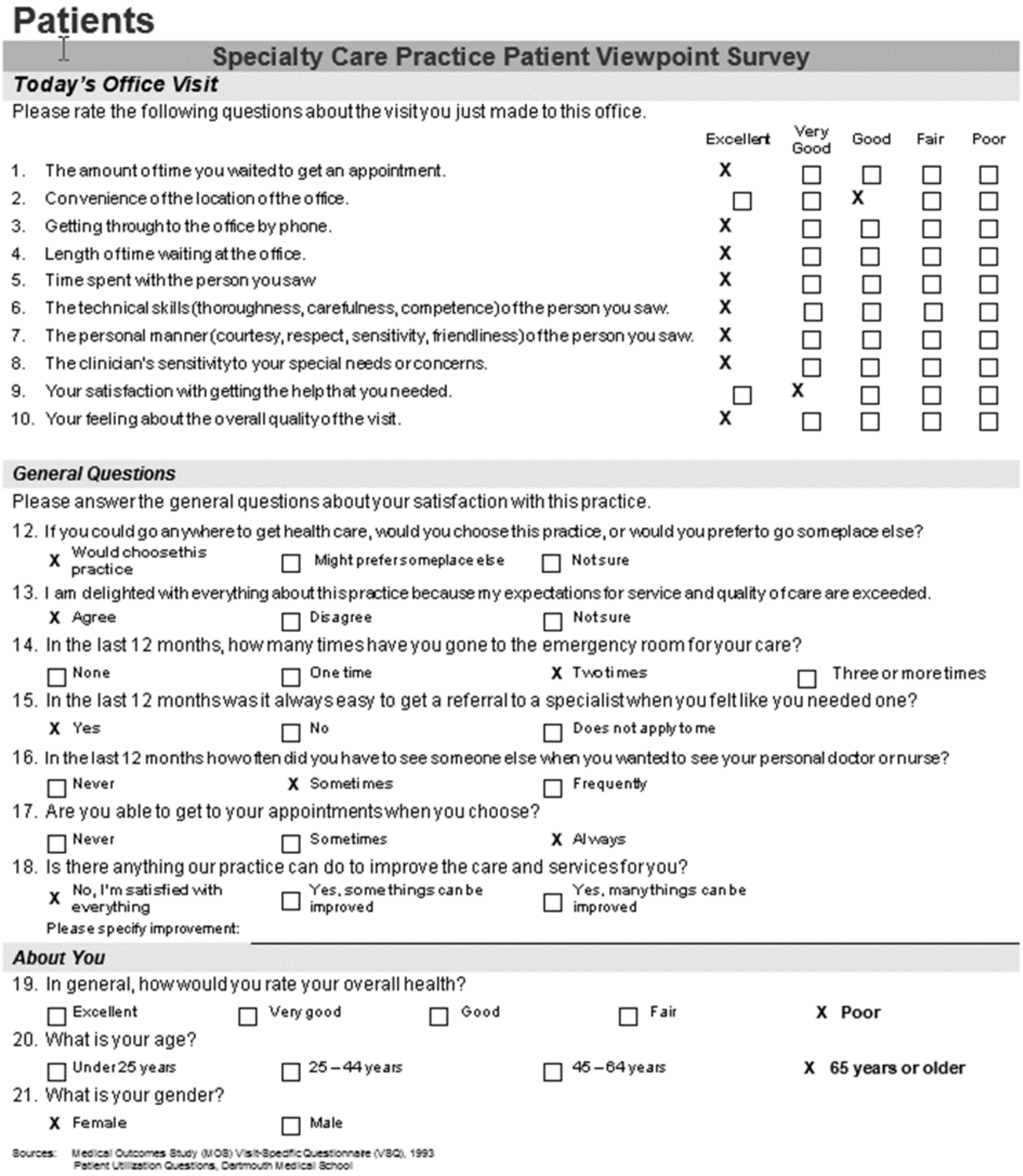
5. How would you rate your satisfaction with the time spent with the person you saw today?

☐ Excellent X Very Good ☐ Good ☐ Fair ☐ Poor

Comments:

I really didn't know what I should expect and I had a lot of anxiety. After meeting with the team I feel relieved and I don't feel so alone. I know they understand my situation and will help me make important decisions.

Thank You For Completing This Survey



Patients

Specialty Care Practice Patient Viewpoint Survey

Today's Office Visit

Please rate the following questions about the visit you just made to this office.

	Excellent	Very Good	Good	Fair	Poor
1. The amount of time you waited to get an appointment.	☒	☐	☐	☐	☐
2. Convenience of the location of the office.	☐	☐	☒	☐	☐
3. Getting through to the office by phone.	☒	☐	☐	☐	☐
4. Length of time waiting at the office.	☒	☐	☐	☐	☐
5. Time spent with the person you saw	☒	☐	☐	☐	☐
6. The technical skills (thoroughness, carefulness, competence) of the person you saw.	☒	☐	☐	☐	☐
7. The personal manner (courtesy, respect, sensitivity, friendliness) of the person you saw.	☒	☐	☐	☐	☐
8. The clinician's sensitivity to your special needs or concerns.	☒	☐	☐	☐	☐
9. Your satisfaction with getting the help that you needed.	☐	☒	☐	☐	☐
10. Your feeling about the overall quality of the visit.	☒	☐	☐	☐	☐

General Questions

Please answer the general questions about your satisfaction with this practice.

12. If you could go anywhere to get health care, would you choose this practice, or would you prefer to go someplace else?

☒ Would choose this practice ☐ Might prefer someplace else ☐ Not sure

13. I am delighted with everything about this practice because my expectations for service and quality of care are exceeded.

☒ Agree ☐ Disagree ☐ Not sure

14. In the last 12 months, how many times have you gone to the emergency room for your care?

☐ None ☐ One time ☒ Two times ☐ Three or more times

15. In the last 12 months was it always easy to get a referral to a specialist when you felt like you needed one?

☒ Yes ☐ No ☐ Does not apply to me

16. In the last 12 months how often did you have to see someone else when you wanted to see your personal doctor or nurse?

☐ Never ☒ Sometimes ☐ Frequently

17. Are you able to get to your appointments when you choose?

☐ Never ☐ Sometimes ☒ Always

18. Is there anything our practice can do to improve the care and services for you?

☒ No, I'm satisfied with everything ☐ Yes, some things can be improved ☐ Yes, many things can be improved

Please specify improvement: ______________________________

About You

19. In general, how would you rate your overall health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☒ **Poor**

20. What is your age?

☐ Under 25 years ☐ 25 – 44 years ☐ 45 – 64 years ☒ **65 years or older**

21. What is your gender?

☒ Female ☐ Male

Sources: Medical Outcomes Study (MOS) Visit-Specific Questionnaire (VSQ), 1993
Patient Utilization Questions, Dartmouth Medical School