Goals Of Care Rapid Response Team at a Comprehensive Cancer Center: Feasibility and Preliminary Outcomes

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center
Making Cancer History®

Introduction

- COVID-19 has prioritized issues of resource utilization. Our institution developed a Goals of Care Rapid Response Team (GOC RRT) to support goal concordant care for critically ill inpatients.
  - Patient, Medical Power of Attorney/surrogate decision maker Primary Oncologist, Inpatient Oncologist, Supportive Care, Social Work, Clinical Ethics
  - Within 24 hours, usually within 4 hours

Objectives

- Evaluate *feasibility* of GOC RRT consultations: *Do they happen?*
- Describe *adherence* to GOC RRT consultation processes
  - Core team member participation (Clinical Ethics, Medical Oncology, Supportive Care and Social Work)
- Explore *preliminary efficacy* in limiting care escalation
  - Change to DNR status, lower-level care intensity and/or withdrawal of life sustaining therapy

Methods

- Retrospective chart review (3/23/2020-9/30/2020)
- Descriptive analysis

Results

- Feasible: 76/89 (85%) ≥1 consult
- Target critically ill population
  - 68.5% in-hospital mortality
  - *No significant difference* in demographic or clinical characteristics among patients by consult completion status (none vs 1 vs >1)
- Adherence to processes good, varied by discipline
  - All core team members present in 64%
- Care de-escalation occurred in 73.7%

Discussion

More research needed to:

- Establish outcomes compared to patients without GOC RRT
- Essential components
- Impact on patients' survivors (emotional well-being, prolonged grief)

GOC RRT Consultations are FEASIBLE & associated with LOW ESCALATION OF CARE in a GOAL-CONCORDANT manner for CRITICALLY ILL patients hospitalized at a Comprehensive Cancer Center

Discussion

- Labor intensive
- Components/members essential to success in establishing goal concordant care unclear
- Impact on survivors' emotional well being and prolonged grief to be determined

Demographics and Clinical Characteristics

Age, years	Median (Range)	61 (27, 86)
		N (%)
Sex	Female	41 (46.1%)
Marital status	Married, Significant Other	65 (73.0%)
Religion	Catholic	19 (21.3%)
	Christian (not Catholic)	40 (44.9)
	None	7 (7.9%)
	Other	23 (25.8%)
Ethnicity	Hispanic or Latino	17 (19.1%)
Race	Asian	11 (12.4%)
	Black or African American	16 (18.0%)
	White or Caucasian	43 (48.3%)
	Other	19 (21.3%)

		N (%)
Tumor diagnosis	Solid tumor and non-cancer diagnoses	42 (47.2%)
	Acute leukemia, MDS, lymphoma, myelofibrosis, myeloma, amyloidosis	47 (52.8%)
Disease status	Localized, locally advanced and non-cancer diagnoses	12 (13.5%)
	Metastatic cancer or leukemia in ≥1 relapse	73 (82.0%)
	Without evidence of cancer ≥1 year	4 (4.5%)
COVID status at referral	Confirmed diagnosis	6 (6.7%)

		N (%)
Discharge disposition	Expired	61 (68.5%)
	Home without hospice	15 (16.9%)
	Home with hospice	8 (9.0%)
	Other	5 (5.6%)
Hospital discharge service	Supportive Care	18 (20.2%)
	Other services	71 (79.8%)

GOC RRT Consult De-escalation Outcomes

Variables	**Measures**	**Total (N=76)**	**GOC RRT Number of Incidences**		**P***
			1 (N=65)	2-5 (N=11)	
Outcome of GOC RRT (Transition Level) per patient, N (%)	De-escalation	56 (73.7%)	49 (75.4%)	7 (63.6%)	.466
	Escalation, No escalation, Not applicable	20 (26.3%)	16 (24.6%)	4 (36.4%)	
Change of location, N (%)	APSCU, RNF, Home with Hospice from ICU	16 (21.1%)	15 (23.1%)	1 (9.1%)	.440
	All Other	60 (78.9%)	50 (76.9%)	10 (90.9%)	
Change in resuscitation status from FULL CODE to Do Not Resuscitate (DNR), N (%)	Yes	50 (65.8%)	44 (67.7%)	6 (54.5%)	.496
	No, N/A	26 (34.2%)	21 (32.3%)	5 (45.5%)	
Did patient have any withdrawal of an LST? N (%)	Yes	16 (21.1%)	14 (21.5%)	2 (18.2%)	1.00
	No, N/A	60 (78.9%)	51 (78.5%)	9 (81.8%)	

Core Health Team Provider Participation

Medical Oncology	**78.9%**
Supportive Care	**95.8%**
Clinical Ethics	**87.4%**
Social Work	**96.8%**

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