

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

#### 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)

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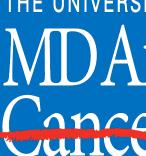
**GOC RRT Consultations are FEASIBLE** & associated with LOW ESCALATION OF CARE in a GOAL-CONCORDANT manner for CRITICALLY ILL patients hospitalized at a Comprehensive Cancer Center



### Discussion

Labor intensive

**Components/members essential to succes** in establishing goal concordant care uncle Impact on survivors' emotional well being and prolonged grief to be determined



Making Cancer History<sup>®</sup>

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

	Solid tumor and non-cancer
Tumor diagnosis	diagnoses
	Acute leukemia, MDS,
	lymphoma, myelofibrosis,
	myeloma, amyloidosis
	Localized, locally advanced and
	non-cancer diagnoses
Disease	Metastatic cancer or leukemia
status	≥1 relapse
	Without evidence of cancer >1
	year
COVID	
status at	Confirmed diagnosis
referral	

		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**

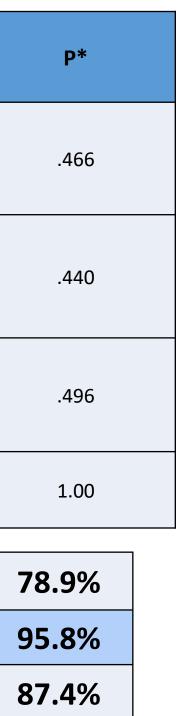
	Measures	Total (N=76)	GOC RRT Number of		
Variables			Incidences		
			1 (N=65)	2-5 (N=11)	
	De-escalation	56 (73.7%)	49 (75.4%)	7 (63.6%)	
Outcome of GOC RRT (Transition	Escalation, No				
Level) per patient, N (%)	escalation, Not	20 (26.3%)	16 (24.6%)	4 (36.4%)	
	applicable				
Change of location, N (%)	APSCU, RNF, Home with Hospice from ICU	16 (21.1%)	15 (23.1%)	1 (9.1%)	
	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%)	
	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%)	
	No, N/A	60 (78.9%)	51 (78.5%)	9 (81.8%)	

Core Health Team **Provider Participation** 

Medical Oncology **Supportive Care Clinical Ethics** Social Work

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N (%) 42 (47.2%) 47 (52.8%) 12 (13.5%) 73 (82.0%) 4 (4.5%) 6 (6.7%)



96.8%