ADVANCED CARE PLANNING (ACP) BEFORE STEM CELL TRANSPLANTATION (SCT) TREATMENT BEGINS
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SCT is a high risk/reward proposition. Many experienced SCT practitioners perceive that SCT patients are not consistently prepared for the possibility of life threatening complications and poor outcomes. The SCT department was selected to pilot a patient-centered intervention to improve ACP discussions in our institution. ACP is an extraordinarily complex process, and many patient, provider, and system factors influence whether discussions occur.

Aim: Increase SCT patients’ awareness of the possibility of life threatening complications and poor outcomes by examining the number of advance directives (AD) and/or documentation of ACP conversations by at least 10%.

Interventions: A patient-centered educational initiative was developed. An existing admission class was enhanced by distributing a previously created ACP document. Salient points were discussed and patients were encouraged to talk to their providers prior to admission if they had any additional questions or concerns.

Results: A chart audit for documentation of ACP discussions and AD documents before (N = 32) and after (N = 35) the intervention was used. A patient survey was used to assess the patients’ response to ACP information presented in the class. Twelve (37%) AD documents were found before the intervention and 14 (40%) after. Documentation of the conversations between patients and providers (MD, PA, SW) occurred with 23 (72%) patients before the intervention and 31 (89%) after the intervention. Patient evaluations indicated the majority agreed or strongly agreed that this information was understandable, useful and prompted them to think about decisions and discussions they may need to have with family and care providers.

Conclusions: Because of the brief duration, we were unable to identify cost savings. However, based on improved understanding of ACP and patient-provider shared determinations of best patient-centered practice, further investigation is warranted which will include review of length of stay and changes in ICU usage and related cost savings. We have continued the intervention and are collecting additional data. Interventions will be modified as indicated, and we will continue to work on developing other metrics. Further, we plan to examine more specifically the meaning of a substantive conversation, leading to the development of trigger points for discussions. We ultimately expect to develop guidelines and training for providers, and continue to promote the importance of ACP.

INTEGRATING HSCT EVALUATION-PHASE ACTIVITIES TO REDUCE COST AND STREAMLINE WORKFLOW
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The evaluation process required for insurance approval for HSCT occurs alongside the clinical work-up process which is in part governed by eligibility assessment standards set by FACT, the FDA, and other regulatory bodies. In a large academic cancer center, the functional differentiation among clinical staff, financial registrars and counselors, and transplant coordinators supporting patient case management during the evaluation phase for HSCT tends to generate separate standard workflows for each function, leading to inefficiency among staff and overuse of clinical testing. A workflow and decision tree analysis demonstrated an opportunity to create a single process engaging all coordination and clinical evaluation functions to reduce time to insurance approval, reduce overall effort for staff, reduce excess testing, and produce greater clarity and comfort for patients. Benefit review and documentation, testing requirements, handoffs for appropriate peer to peer discussion and negotiation were all addressed as distinct processes that required optimized and integrated process improvement. The new workflow involves time point requirements and decision trees to ensure consistency and compliance. A focus on reducing non-critical or repeat testing generated a greater use of existing testing results and the education of payer case managers in FACT and cancer center eligibility standards effectively reduced requirements for early or up front testing that would need to be repeated prior to admission. Implementation revealed further opportunities for streamlining which were incorporated into the process. Outcomes show marked reduction/elimination of non-clinically valuable or duplicate testing, faster insurance authorization, and greater throughput relative to staffing levels.

EFFORTS TO MANAGE AND REDUCE DISCHARGE PHARMACY CRISIS AMONG HIGH RISK HSCT PATIENTS
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The HSCT program at Dana-Farber/Brigham and Women’s Cancer Center was experiencing increasing instances of unexpected pharmacy benefit crises and associated delayed discharge, provision of emergency medications at time of discharge at the expense of the hospital, and last minute crisis management by many staff members. After review and analysis of the root causes for these problems, an infrastructure was established to focus on early intervention during the HSCT work-up process to identify and address a set of risks associated with a significant subset of HSCT patients, including psychosocial support needs, lack of outpatient caregiver, financial shortfalls, complex pharmacy benefit plans and insurance restrictions that contribute to medication access crises. New positions were proposed and filled – an Ambulatory Care Coordination Nurse (ACCRN) and a Pharmacy Resource Specialist (PRS). These key resources work together with other members of patients’ transplant team from social work, ambulatory and inpatient care coordination, the clinical team, the transplant coordination team, and financial counseling staff. The ACCRN researches the patient’s high risk issues, incorporating patient information provided by other team members to plan a safe and organized discharge. Pharmacy benefits and calculation of the expected pharmacy costs are presented to the patient in advance of the transplant admission. The PRS researches drug assistance programs as needed. The ACCRN and the PRS discuss drug coverage options with the patient and assist with completion of necessary paperwork. After 18 months of service, this effort has yielded significantly fewer discharge medication issues, has reduced emergency medication dispensing at the time of discharge, generated a smoother discharge path for the inpatient care coordination and clinical team, generated greater patient satisfaction and understanding of post transplant care and costs, and reduced instances of extended days in hospital due to delayed discharge.

ASSESSMENT AND REVISION OF PATIENT SCHEDULING FOR HSCT RELATED APERHESIS AND CELL PROCESSING TO REDUCE OVER-ALLOCATION AND UNDERUTILIZATION OF RESOURCES
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With the initiation of the use of plerixafor and its impact on apheresis flow and utilization relative to HSCT in a large academic cancer center, resulting disruptive shifts in utilization prompted an evaluation of the scheduling processes supporting the clinical and product pathway from apheresis through processing and issuing of products for infusion. Several opportunities for improvement in scheduling, communication, and distribution of work process across time periods were identified. An analysis of historical volume of
procedures, incidences of underutilization and over-allocation from a scheduling perspective, along with review of overtime employment of staff, generated further root cause assessment of several concerning patterns of poor utilization along with poorly managed spikes in volume which can generate patient safety risk and employee burn-out. Based on the analysis, a centralized scheduling process for apheresis was developed and implemented using the existing GE/IDX platform. New guidelines for apheresis scheduling based on clinical criteria as well as new rules for scheduling were activated. Restructuring of cell processing technical staff work schedules and procedure scheduling were implemented based on a new assessment of demand and greater management of procedure scheduling during each processing day. Outcomes include significantly greater actual throughput, improved efficiency of the scheduling process itself, nearly eliminated overtime, higher staff satisfaction among cell processing technicians, and reduction of risk-generating volume spikes.

577 OUTPATIENT PHARMACY ESTIMATE OF CHARGE FINANCIAL COUNSELING
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Planning for the stem cell transplant (SCT) patient’s discharge is complex requiring a multidisciplinary team (MDT) approach. Challenges identified by the MDT include costly prescription co-pays and limited pharmacy coverage which is overwhelming and frustrating to patient and MDT.

This challenge led to the creation of a MDT task force. Based on several meeting discussions and MDT feedback, an outpatient pharmacy estimate of charge (EOC) process was developed and an EOC form was designed to address pharmacy co-pays/deductible, high-dollar prescriptions, annual lifetime maximum and potential discharge medication list, with a goal to counsel all patients prior to SCT admission.

In October 2009, the Related Coordinator started the new process by scheduling the patient’s pharmacy EOC counseling at the time of pre-admission work-up. The Patient Access Specialist (PAS) verifies prescription benefits from the health insurance and reviews coverage with the patient, who signs the EOC form after counseling. The Patient Access Coordinator addresses questions related to the medications. The PAS faxes the signed EOC to the case manager who reviews the EOC with the patient when planning for discharge. Patients are counseled at the bedside when appointment is missed. Texas residents who are unable to financially meet the co-pays/deductible or have limited benefits are provided with a Supplemental Financial Assistance application. The Pharmacy Reimbursement Specialist counsels all Medicare, Indigent and Self-pay patients for Pharmacy Assistance Program.

As a result, patient’s verbalized marked decrease in their anxiety and increased knowledge on their benefits empowering them to make informed decisions regarding their discharge prescriptions. Identification of limited pharmacy coverage prior to SCT admission enables the MDT timely intervention to address the patient’s dilemma. Pharmacy counseling coupled with the EOC form as a tool enhanced the quality of patient care, increased patient satisfaction and MDT greater job fulfillment.

578 A RANDOMIZED PILOT STUDY COMPARING INFECTION RATES IN MYELOABLATIVE ALLOGENEIC STEM CELL TRANSPLANT PATIENTS RECEIVING A NON-NEUTROPENIC DIET OR A NEUTROPENIC DIET
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Purpose: The primary objective of this study is to compare the incidence of grade 3 or 4 bacteremia as defined by the NCI Common Terminology Criteria for Adverse Events (CTCAE) v4.0 in patients undergoing myeloablative allogeneic stem cell transplant when receiving a neutropenic diet or a non-neutropenic diet. Secondary objective is to assess the nutritional status of patients undergoing myeloablative allogeneic stem cell transplant in those receiving a neutropenic diet as compared to those receiving a non-neutropenic diet using the Scored Patient-Generated Subjective Global Assessment (PG-SGA).

Materials and Methods: To date, a convenience sample of 18 myeloablative allogeneic hematopoietic stem cell transplant patients have been randomized to receive either a neutropenic or non-neutropenic diet during their period of neutropenia. Several nutritional standard indicators, CBC, and PG-SGA were assessed weekly. Blood cultures were obtained per unit standard.

Results: When comparing maximum change in prealbumin, transferrin, and days of TPN, only borderline statistical difference is detected. Wilcoxon Rank-sums p = 0.056. The median number of TPN days for the controls is 18 and for the experimental group it’s 13, Wilcoxon Rank-sums p = 0.5; therefore, it is not statistically different. 25% of the controls have a grade 3 blood stream infection compared to 40% of the experimental, the chi-square test for comparing these proportions is 0.50; therefore, these proportions are not statistically significantly different. No grade 4 blood stream infections were noted during neutropenia.

Conclusions: This small sample set does not show any significant difference in grade 3 or 4 infections between the arms of the study.

Days of TPN and overall nutritional status does not appear to be significant as well.

Limitations: Small sample size, inconsistent patient recording of food diaries.

Future directions: Continue enrollment in this study to increase statistical power of results.

579 PALONOSETRON VERSUS ONDANSETRON IN CHEMOTHERAPY INDUCED NAUSEA AND VOMITING
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Introduction: Palonosetron is a longer acting 5-hydroxytryptamine-3 (5-HT3) antagonist, used in preventing chemotherapy induced nausea and vomiting (CINV). It is licensed initially for the oncology patient group. It is given as an injection and acts over a five days period.

Method: In our haematology setting we have conducted a small comparison study to compare the efficiency of Palonosetron and Ondansetron for haematology patients for preventing CINV. Stage 1 data was collected prospectively for Palonosetron over a year period. Second stage data was collected for efficiency of Ondansetron retrospectively, simply because Ondansetron is the main anti-sickness drug used in our centre. Patients who were in the Ondansetron group were selected randomly without any information given to ward nurses. The information was collected day 1- day 11 from the day chemotherapy started. There were 24 patients in each group.

The data was compared in three different categories: complaints of nausea (severity), vomiting (how many episodes over 24 hour) and the requirement of additional anti-sickness.

The patients in both groups received similar chemotherapy regimens. Patient demographic data and chemotherapy regimen are shown Table I.

Result: Due to limited word count of this abstract, the outcome is evaluated on two sections instead of three: severity of nausea and frequency of vomiting.

According to our study, patients who received Palonosetron suffered less from mild nausea. In this group a maximum of seven patients reported mild nausea where as 12 patients were reported similar episodes in the Ondansetron group.

However, in the evaluation of vomiting, there was a trend in the Palonosetron group. Those patients receiving Palonosetron had their sickness/vomiting peak on day 4. Palonosetron was given day 5, where the vomiting subsidised again. However 46% of patients