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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.

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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 work flows 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, hand-offs 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.

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EFFORTS TO MANAGE AND REDUCE DISCHARGE PHARMACY CRISES 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.

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ASSESSMENT AND REVISION OF PATIENT SCHEDULING FOR HSCT RELATED APHERESIS 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 staffing, resource scheduling process, communication, and distribution of work process across time periods were identified. An analysis of historical volume of