Aim Statement. To increase referrals from oncology clinic to palliative care to 60% for patients with advanced solid tumor malignancies.

Methods. A PC screening tool was used to identify patients with advanced solid tumor malignancies with other poor prognostic factors seen in oncology clinic from October 1 to November 17, 2017. Patients were followed over 6-months. Oncology clinicians, nurse coordinators, and social workers were educated in the use of the screening tool. Additional PDSA cycles included individual provider feedback on PC referral rates and integration of PC referrals to clinician pay-for-performance in 2018 fiscal year.

Results. Among 559 unique patient encounters, 174 patients met PC screening criteria. 33% of these patients had been referred previously to PC, primarily by oncology, other providers (ie GI, ENT, Radiation Oncology), and inpatient medicine. At 6-month follow up, 51% of patients had a PC referral, with new consults placed primarily by inpatient medicine, then oncology providers. 25% of patients had died and 26% were on hospice at 6 months. 42% of patients who died were on home hospice and 84% were seen by palliative care prior to death. Palliative care consultation was associated with hospice referral prior to death ($p<0.01$).

Conclusions and Implications. Oncology patients with advanced solid tumor malignancies are not currently referred to palliative care in congruence with current guidelines. Outcomes data on the results of a screening tool to increase these referrals showed minimal improvement by oncology providers over 6-month period. Further long-term analysis is necessary to evaluate the effect of pay-for-performance on PC referrals for advanced cancer patients.

Supportive Cardiology Quality Improvement Project: Identifying Symptomatic, Advanced Heart Failure Patients for Palliative Care Consultation (QI723)

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Objectives

1. Reflect on one possible barrier faced by healthcare providers in documenting goals of care discussions for in-patients with heart failure.
2. Describe the benefits and drawbacks of using the numerical rating scale (NRS) for dyspnea as a screening tool for symptomatic patients with heart failure.

Background. Heart failure is a life-limiting illness and the leading cause of hospitalization in Canada. The Toronto Western Hospital Palliative Care Consultation Service identified an opportunity for improvement when it noted only 9 in-patient cardiology referrals for palliative consultation were received from January to September 2017 despite 472 cardiology in-patient admissions.

Aim Statement. The aim of this quality improvement project was to increase the number of palliative consultations completed for cardiology in-patients with symptomatic, advanced heart failure by 50% compared to the previous year, starting in February 2018. The project also aimed to document a numerical rating scale (NRS) score for dyspnea for 100% of patients at the time of initial consultation and last palliative care visit and document goals of care discussions for 100% of referred patients by time of discharge.

Methods. A process map identified an opportunity for screening cardiology in-patients and screening criteria were developed: nurses identified patients with a NRS for dyspnea of $> 3/10$; a palliative care physician then attended cardiology interdisciplinary team rounds once weekly to identify symptomatic patients with advanced heart failure and approached the cardiology physicians for referral.

Results. Results from February to June showed an increase in total cardiology referrals for palliative consultation from 3 (2017) to 19 (2018), with 16 referrals received at team rounds. Though all referrals received were appropriate for palliative consultation, only 6 of 19 referrals screened positive using screening criteria. Only ten out of 19 patients were able to report dyspnea using a NRS. Five of nineteen patients referred had documentation of goals of care discussions prior to consultation, compared to 18 out of 19 patients post-consultation.

Conclusions and Implications. Refinement of screening criteria and criteria used to identify symptomatic patients is ongoing. This project may expand to other in-patient services and provided evidence to support teaching serious illness communication skills to cardiology fellows.

Evidence-Based Triggers: Incorporating Patient-Reported Outcomes (PROs) into Palliative Care Referrals (QI724)

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Objectives

1. Describe how to develop, scalable, transferable and sustainable symptom management systems to monitor and address common cancer

symptoms and trigger referral to palliative care with PROs.
2. Describe how to test prototypes of an integrated PROs clinical assessment pathway and understand who are the stakeholders and how to beta test PRO measures.

Background. Specialty palliative care (SPC) has been shown to improve quality of life, reduce unnecessary healthcare utilization, and decrease mortality in patients with advanced cancer. Despite calls for universal palliative-oncologic co-management for people with metastatic disease, only a small proportion of such patients are appropriately and promptly referred.

Aim Statement. Test hypothesis that improving documentation, availability, tracking, and transparency of PROs in oncology visits will increase SPC referrals.

Methods. 74 English-speaking patients seen at least once by oncology in a breast cancer clinic were invited and agreed to participate in the study. Patients completed the electronic, validated PROMIS and PRO-CTCAE PRO questionnaires in the waiting room. Results were presented to the oncologist during the encounter if PRO-CTCAE score exceeded 3 ("severe") in at least one domain. Data was also gathered via chart review and patient/provider interviews.

Results. At baseline, 9 (12.2%) patients reported severe anxiety; 17 (23.0%) severe pain; and 27 (32.1%) severe fatigue. At study entry, 25 (33.8%) already had been referred to SPC; 19 were seen (76% of those referred; 25.7% of all participants). 63 (85.1%) had complete data. Among these, 13 (20.6%) reported at least “severe” in ≥ 2 or more components of the CTCAE domains, 6 (46.2%) of whom had been previously referred to SPC. The 7 remaining patients with severe symptoms never received a referral to SPC. Oncologists reported that referrals were limited by concern of negative impact to doctor-patient relationship and challenge of having this conversation during a time-constrained oncology encounter.

Conclusions and Implications. While oncologist referral has been a traditional mechanism through which patients can access SPC services, the decision to refer is complex and subjective. Referrals trigged by PRO have the potential benefit of accessing the proven survival benefits of PROs and rationalizing patient identification for SPC.

An Innovative Tuck-In Program to Improve Service Delivery in Hospice Patients (QI725)

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Objectives

1. Demonstrate an innovative delivery of hospice services to anticipate care needs in a rural environment.
2. Manage resource delivery to anticipate patient status, current and future needs, to avoid service failures and improve continuity of care.

Background. Hospices face unique challenges, including broad service areas, and, in Maine, extreme weather conditions. Patients may express frustration and anxiety if supply and medication needs are not well anticipated, requiring urgent visits to provide them. Deploying weekend/overnight staff for visits unassociated with acute symptom management misdirects resources.

Aim Statement. The quality initiative will result in anticipation and resolution of supplies, medications, and visit planning to improve continuity of care delivery to hospice home care patients, and to decrease off-shift requests.

Methods. Historical weekend/night triage data analysis showed 45% of calls requested urgent medications, supplies, or visit planning. A volunteer led program uses a scripted Tuck-In questionnaire to call patients several days before each weekend and anticipated weather event. Urgencies are prioritized and forwarded to an RN for resolution. All calls are reviewed each service day for quality assurance.

Results. Immature data demonstrates an 18% decline in medication, supply, and visit planning requests. Acute symptom management data remain consistent with pre-initiative data. Unanticipated benefits include capture of additional clinical data useful in early intervention, and longitudinal data trending nurse performance in anticipating patient needs.

Conclusions and Implications. Tuck-In programs for hospices provide an additional evaluation point, review of service satisfaction, and early identification of patient needs. Staff travel burden is reduced, and additional nursing performance measures can be monitored.

Integrating COMFORT^{TMSM} at a Comprehensive Cancer Center (QI726)

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Objectives

1. Describe use of COMFORT Communication Curriculum to promote primary palliative care among oncology nurses.