Emotional Distress Assessment and Management Initiative

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Diane Corjulo, RN, BSN

Smilow Cancer Hospital at Yale-New Haven

March 6, 2014
Institutional Overview

• Smilow Cancer Hospital (SCH) provides cancer services by Yale Cancer Center faculty in New Haven or one of 9 Care Center community locations.

• Created in 2012 by the acquisition of two community practices, all SCH Care Centers are fully integrated practice sites using a provider-based model and a unified electronic medical record (e.g. EPIC).

• The faculty practice includes 47 oncologists in the New Haven academic campus and 22 oncologists in the Care Center locations.

• The number of analytic cases at SCH reach approximately 5600, including an estimated 1600 patients per year in the Care Center locations.

• In addition, Smilow Cancer Hospital Network oversees and supports cancer services delivered within the Yale-New Haven Health system of Greenwich Hospital.
Problem Statement

• In Spring 2012 QOPI abstraction results, 49% (217/445) of Smilow Cancer Hospital patients had documented assessment of “emotional well-being assessed by the second office visit” identifying a barrier to addressing patient emotional needs.
  – Compliance in 2 of our 10 cancer care centers identified for improvement pilot was below 12%

Note: QOPI data based on physician documentation in paper chart
## Team Members

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Job Function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Sponsor</strong>*</td>
<td>Rogerio Lilenbaum, MD</td>
<td>CMO Smilow Cancer Hospital</td>
</tr>
<tr>
<td></td>
<td>Catherine Lyons, RN, MS</td>
<td>Clinical Program Director/Director of Nursing Smilow Cancer Hospital</td>
</tr>
<tr>
<td><strong>Team Leader</strong>*</td>
<td>Anne Chiang, MD</td>
<td>CMO Smilow Network</td>
</tr>
<tr>
<td><strong>Core Team Member</strong>*</td>
<td>Diane Corjulo, RN</td>
<td>Clinical Program Manager</td>
</tr>
<tr>
<td><strong>Core Team Member</strong>*</td>
<td>Stephanie Amport, MBA</td>
<td>Quality &amp; Safety Coordinator</td>
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<tr>
<td><strong>Facilitator</strong></td>
<td>Stephanie Amport, MBA</td>
<td>Team member who facilitates the team meetings to optimize group processes.</td>
</tr>
<tr>
<td><strong>Other Team Member^</strong></td>
<td>Bruce Lundberg, MD</td>
<td>CCA CLINIC MD &amp; Physician Champion</td>
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<tr>
<td><strong>Other Team Member^</strong></td>
<td>Nancy Hassan, RN</td>
<td>Nurse Coordinator</td>
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<td>June Kelly, RN &amp; Fran Jaworowicz, RN</td>
<td>CCA Clinic Staff Nurses CCB Clinic</td>
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<tr>
<td><strong>Other Team Member^</strong></td>
<td>Nicole Weld, LCSW</td>
<td>CCA &amp; CCB Clinic Social Worker</td>
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<td>Bonnie Indeck, LCSW</td>
<td>Manager Oncology Social Work</td>
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<tr>
<td><strong>Other Team Member</strong></td>
<td>Andrea Silber, MD</td>
<td>CCB Clinic MD &amp; Physician Champion</td>
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<tr>
<td><strong>Advisor</strong></td>
<td>Connie Engelking, RN</td>
<td>Consultant</td>
</tr>
<tr>
<td><strong>Advisor</strong></td>
<td>Ruth McCorkle, RN</td>
<td>Yale School of Nursing Research Expert</td>
</tr>
<tr>
<td><strong>Patient/ Family Member</strong></td>
<td>TBD</td>
<td>Working on determining who is most appropriate</td>
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<tr>
<td><strong>QTP Improvement Coach</strong></td>
<td>Holley Stallings</td>
<td>Provides remote support to the team regarding the science of quality improvement and participation in the QTP.</td>
</tr>
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CCA & CCB CLINICS Emotional Distress Assessment CURRENT STATE Process Map

**Phase 1:**
- Patient arrives
- Check-in and Wrist band

**Phase 2:**
- Calls patient back and draws blood
- Space and staff
- Patient to waiting room

**Phase 3:**
- RN only visit?
- YES
- NO
- Patient to Exam room for vitals, falls & tobacco screen, Med list review
- YES
- NO
- RN confirm treatment plan, review labs and POC, release orders

**Phase 4:**
- Distress identified?
- YES
- NO
- 2 RN confirm treatment plan, review labs and POC, release orders
- YES
- NO
- Interventions:
  - Support group
  - RN counseling & recommendations
  - Focused Reassessment

**Phase 5:**
- Teaching
- Follow-up with RN
- MD on intervention and document full initial assessment or progress notes in EPIC

**Green color denotes where intervention is done**

**Yellow color denotes where emotional assessment is done**

**Non treatment patient types:**
- 6-month follow-up
- Hematology - low-grade CLL or anemia/f/u
- Consult with path report and needing to be staged

**On treatment patient types:**
- Active Chemo
  - Active treatment follow-up
  - Procedure, injection (could get neupogen or anrane)
  - Deferred therapy patient for low counts or toxicity (could get hydration or neupogen)
  - New Patient first dose have path and scans, port placed, consent obtained

**MD Assessment**
- Treatment today?
- YES
- NO
- Distress identified?
- YES
- NO
- 2 RN confirm treatment plan, review labs and POC, release orders

**RN**
- Schedule with patient or seek out identified patients and add-ons same day in infusion or in exam room
- Referral by phone, Indeski, or Huddle

**Intervention**
- Introduce self and role
- Reason for referral
- Obtain patient background
- Address issue/concern
- Schedule follow-up in person or via phone

**Intervention:**
- Support group
- RN counseling & recommendations
- FCP for med assistance
- Home care support
- Chaplain
- Financial assistance, nutrition, palliative care referral

**Social Work**
- Follow-up with RN/MD on intervention and document full initial assessment or progress notes in EPIC

**Intervention:**
- Introduce self and role
- Reason for referral
- Obtain patient background
- Address issue/concern
- Schedule follow-up in person or via phone
Cause & Effect Diagram

**STAFF**
- Bandwidth of RNs and MDs
  - Staff not skilled to assess
    - Lack of training
  - Staff don’t want to ask
    - Fear of change
  - Fear of taking more on with inefficient workflow
  - Staff not comfortable with questions
    - Staff don’t know how to respond
  - Lack of commitment that psychosocial screening is essential

**PROCESS/POLICY**
- Already being done on some patients
  - Physician does not ask
    - No follow-up conversation
  - Too many questions for patients
  - Don’t want to open Pandora’s box & ask
  - No clear delineation of each staff’s role
  - No time to address issues
  - Inadequate documentation
    - MD/RN progress note is not best location
  - Tool used to screen is not adequate
  - MD/RN Communication prior to making referral

**VOLUME/CARE**
- Patient Volume
  - Patient Emergencies
    - Lack of Privacy for Screen
    - Lack of Space

**PATIENT**
- Patient does not feel comfortable saying it
  - Stigma
- Patient does not feel comfortable saying it
  - Stigma
- Too much other data collection by MD
  - Burden of documentation
  - Not enough time with patients
  - Too much other data collection by MD

**RESOURCES**
- Lack of Social Work Resources (Prior to Nicole)
- Lack of Mental Health Resources for poor patients
- Lack of Financial Resources/Counselor
  - Wed busy day in CCB
- Lack of Social Work Resources (Prior to Nicole)
  - Wed busy day in CCB
- Lack of Social Work Resources (Prior to Nicole)
  - Wed busy day in CCB
- Language barriers
  - Cultural barriers
- Lack of Space
- Lack of Social Work Resources (Prior to Nicole)
  - Wed busy day in CCB
- Lack of Social Work Resources (Prior to Nicole)
  - Wed busy day in CCB
- Lack of Social Work Resources (Prior to Nicole)
  - Wed busy day in CCB

**ENVIRONMENT**
- Lack of Privacy for Screen
  - Lack of Space
Diagnostic Data

Compliance with QOPI question
"Patient emotional well-being assessed by the second office visit"
Spring, 2012

- Waterbury (n=12): 86.8%
- North Haven (n=30): 73.3%
- Derby (n=38): 71.7%
- Fellows (n=82): 57.9%
- Greenwich Bendheim (n=48): 30.5%
- Guilford (n=39): 25.0%
- CCB (n=17): 18.0%
- CCA (n=14): 11.8%
- Orange (n=25): 7.1%
- Total: 4.0%
Diagnostic Data

Top 4 Causes/Barriers

- Not enough time w/pts, Volume/Emergencies
- Lack of social work resources
- Lack of privacy & space
- Patient does not feel comfortable saying it
Aim Statement

• By April 2014, increase screening of distress levels to 75% of patients seen in CCA and CCB care center clinics in February and March, 2014.
Materials Developed

Welcome,

The treatment and management of cancer and hematologic disorders requires a team that consists of physicians, nurses, social workers, chaplains, dieticians, and other support staff. Your care team at the Smilow Cancer Hospital at Yale-New Haven wants to make an effort to meet all of your needs – physical, emotional, practical, and spiritual.

To better understand your holistic needs, we ask that you take just a couple of moments to complete this self-assessment about distress.

Based on your feedback, we will provide you with resources that we hope will be helpful to you during this time. Our goal is to ensure that you receive the best care possible.

Please let us know if you have any questions.

Thank you,
Your Care Team
Smilow Cancer Centers

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<tr>
<th>Date</th>
<th>Time</th>
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<th>Notes</th>
<th>Provider</th>
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Process Measure 1

- **PROCESS Measure**: % Patients screened once using distress thermometer/scale by clinical team (provider/nurse)
- **Patient population**: All patients (new & return) seen in CCA and CCB clinics in February & March, 2014.
  - Exclusions: Multi-day treatment patients will not get tool every time
- **Calculation methodology**:
  - Numerator: Number of patients screened with tool once during pilot counted as compliant for each visit
  - Denominator: Number of patient visits (patients counted every visit)
- **Data source**: Paper screening tools
- **Data collection frequency**: Daily & Monthly
- **Data quality (any limitations)**: Ability to look up every patient in EPIC, Staff resources to collect data on busy days, Patient acceptance of new assessment tool
Process Measure 2

- **PROCESS Measure**: % Patients screened for emotional distress by clinical team (provider/nurse)
- **Patient population**: All patients (new & return) seen in CCA and CCB clinics in February & March, 2014.
- **Calculation methodology:**
  - Numerator: Number of patients with distress level documented by RNs in EPIC
  - Denominator: Number of patient visits (patients counted every visit)
- **Data source**: EPIC patient volume reports
- **Data collection frequency**: Monthly
- **Data quality (any limitations)**: Currently EPIC report does not count unique patients
Outcome Measure

- **OUTCOME Measure**: Mean score and % Very Good level of patient satisfaction with “Degree to which staff addressed your emotional needs” from Press-Ganey

- **Patient population**: All that complete survey based on Date of Visit

- **Calculation methodology**: N/A

- **Data source**: Press-Ganey Patient Satisfaction Survey

- **Data collection frequency**: Monthly

- **Data quality (any limitations)**: Delay in obtaining reports, Low N
Baseline Process Data

% Patients with Emotional Distress Level Screened

- CCB (n=17)
  - 11.8%
- CCA (n=14)
  - 7.1%

Spring 2012 QOPI

Process Measure 2

% CCA & CCB Patients with Distress Score in EPIC

(p-chart, 3 sigma)

- Baseline Mean
- Actual Value
- Lower Control Limit
- Upper Control Limit

Month

- Jul, 13
- Aug, 13
- Sep, 13
- Oct, 13
- Nov, 13
- Dec, 13
- Jan, 14

Percent

- 29.1%
- 25.9%
- 30.3%
- 31.9%
- 29.0%
Baseline Outcome Data

CCA Press-Ganey
"Degree to Which Staff Addressed your Emotional Needs"

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec '12</th>
<th>Jan '13</th>
<th>Feb '13</th>
<th>Mar '13</th>
<th>Apr '13</th>
<th>May '13</th>
<th>Jun '13</th>
<th>Jul '13</th>
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<th>Dec '13</th>
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<tbody>
<tr>
<td>Mean Score</td>
<td>83.3</td>
<td>83.3</td>
<td>100</td>
<td>91.2</td>
<td>86.4</td>
<td>95.5</td>
<td>95.8</td>
<td>92.9</td>
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<td>8</td>
<td>12</td>
<td>19</td>
<td>7</td>
<td>4</td>
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<td>% Very Good</td>
<td>33.3%</td>
<td>44.4%</td>
<td>100.0%</td>
<td>64.7%</td>
<td>45.5%</td>
<td>82.1%</td>
<td>83.3%</td>
<td>71.4%</td>
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<td>68.4%</td>
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CCB Press-Ganey
"Degree to Which Staff Addressed your Emotional Needs"

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<th>Dec '12</th>
<th>Jan '13</th>
<th>Feb '13</th>
<th>Mar '13</th>
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<tr>
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<td>90.6</td>
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<tr>
<td>% Very Good</td>
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<td>33.3%</td>
<td>90.0%</td>
<td>0.0%</td>
<td>27.3%</td>
<td>66.7%</td>
<td>100.0%</td>
<td>75.0%</td>
<td>25.0%</td>
<td>100.0%</td>
<td>66.7%</td>
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</table>
Prioritized List of Changes (Priority/Pay-Off Matrix)

Not enough time
Privacy/Space
Patient Comfort

High

Low

Impact

Easy
Difficult

EASE OF IMPLEMENTATION

Patient self screen with paper tool given by RN, RN/MD review during visit and RN document in EPIC

Patient self screen with e-tool on tablet, auto-feed to EPIC and RN/MD review during visit

RN Screen without paper tool and document in EPIC (Initial and Focused Reassessment)

MD screen with paper tool and staff scan into EPIC

Not enough time
Privacy/Space
Patient Comfort

IMPACT

EASE OF IMPLEMENTATION
# PDSA Plan (Tests of Change)

<table>
<thead>
<tr>
<th>Date of PDSA cycle</th>
<th>Description of intervention</th>
<th>Results/Lessons Learned</th>
<th>Action steps</th>
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</table>
| **Start: 1.15.14  
End: 1.23.14** | 1. Finalize tool & implementation plan using cause & effect diagram including patient population  
   a. Invite CCB nurses to meetings 23rd  
2. Define screening workflow including documentation  
   a. Update Patient letter  
   b. Scanning?  
3. Develop data collection plan  
   a. Paper, EPIC, QOPI Dashboard | Tool and workflow finalized.  
Letter updated. Did not address reading level with goal of 6-8th grade or translate. Not scanning.  
Requested EPIC report, developed collection plan for paper tools. | Translate tool into Spanish, Mandarin and Tagalog (Pilipino) |
| **Start: 1.23.14  
End: 1.30.14** | 1. Educate all staff and physicians on screening process  
   a. Summarize process including documentation  
   b. Send via email and one on one education | Intervention plan emailed to RN and MD staff 1.30.14.  
Presented to medical directors in person 1.30.14 | On-going encouragement and support of MDs |
| **Start: 2.3.14  
End: 2.28.14** | 1. Pilot results and review results  
   a. Voice of patient feedback  
   b. Review results 2.20.14 and determine if change in process needed | Some patient feedback obtained.  
Continue with screen into March. Lost one given not translated yet. Snow and staffing impact compliance. | Interview additional patients.  
CCB PCA to hand out tool starting 2.21.14  
Encourage MDs to sign |
PDSA Plan (Voice of Stakeholders)

Voice of Patient

• Long-term pt - no need now but “would have been helpful 12 years ago”
• Mental health worker, 1 year out - useful for others who won’t speak up or do not have resources
• Breast cancer pt in follow up - helpful, very important, easy, would use MyChart.

Voice of Providers

RNs

• Challenges= Distribution of tool upon arrival and sufficient time to review form, especially for patients just seeing MD
• Patients expected to be “10” are often less
• Finding out more about those who are not seen often e.g. monthly shots

MDs

• Tool has “caught” some patients
• Happy about on-site SW, but highlights need for psychiatric services
• Generating RN-MD communication about scores
• Patients have different responses– some more “health-savvy” did not like it, some lower socioeconomic patients seem to like the attention
• Distress level does not correlate with severity of disease, often related to non-cancer life events, e.g. death in family, work or financial issues
Change Data Process Measure – 1 (Paper Tool)

**Weekly % Patients Screened**
February, 2014

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<th></th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
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<tbody>
<tr>
<td>CCA</td>
<td>63%</td>
<td>54%</td>
<td>49%</td>
<td>45%</td>
</tr>
<tr>
<td>CCB</td>
<td>70%</td>
<td>65%</td>
<td>52%</td>
<td>84%</td>
</tr>
<tr>
<td>Total</td>
<td>65%</td>
<td>57%</td>
<td>50%</td>
<td>56%</td>
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CCA
Average Patients per week= 103
Average Paper Tools per week= 27

CCB
Average Patients per week= 45
Average Paper Tools per week= 22
**CCA**
- Average Patients per day = 21
- Average Paper Tools per day = 6
  - more repeaters after the first couple weeks, on-going patients e.g. head & neck with concurrent therapy

**CCB**
- Average Patients per day = 9
- Average Paper Tools per day = 5
  - Less repeaters, more follow-up visits
41% increase in screening in February when started pilot of distress thermometer
Change Outcome Data

- Low N for Dec 13-Feb 14
- Await more returned surveys to evaluate
Conclusions

- We have seen improvements in % screened based on tools collected and RN documentation in EPIC
  - 196 Tools collected
    - CCA=52% (213/410 screened, 107 tools)
      - 13 refused/declined all in CCA
    - CCB=69% (124/180 screened, 89 tools)
      - Increased compliance by 41% in February based on EPIC documentation process measure
- We did not meet our AIM of 75% for the month of February
  - 3 out of 19 total days screening >=75% (CCA 2 days, CCB 7 days)
- Staffing effects compliance:

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<th>CCB</th>
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<tr>
<td>4 RNs</td>
<td>64%</td>
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<tr>
<td>3 RNs</td>
<td>59%</td>
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<tr>
<td>2 RNs</td>
<td>52%</td>
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Lessons Learned

- Distress Level
  - 0-3 = 60% (118/196)
  - 4-7 = 22% (43/196)
  - 8-10 = 10% (19/196)
  - No score = 8% (15/196)
  - 13 Patients Refused/Declined

- Patient reported outcomes can be incorporated into our workflow
- Use of EPIC can be optimized to capture and report on Distress Screening
- Improvements in RN-MD communication and Patient Engagement
Next Steps/Plan for Sustainability

• Additional Tests of Change
  – Incorporate PCA for distribution in CCA
  – Incorporate RN entry into Distress Screen flow sheet in CCB
  – Pilot at next Care Centers
  – Explore utility of MyChart for patient reported outcomes
  – Determine distress score trigger for intervention
  – Use daily huddle to determine who is appropriate for screen

• Data
  – Continue to measure process distress screen rates to evaluate intervention
  – Outcome Press-Ganey measure to be analyzed once more surveys returned
  – Increase measure reliability with EPIC report by Unique patients
  – More detailed analysis of tool by patient, intervention and problems

• Celebrate & Communication
  – Luncheon for staff
  – Share at Hospital, Cancer Hospital and Care Center Quality Committees and staff meetings
  – Use for Magnet submission and Health System annual quality conference and JOP
Emotional Distress Assessment and Management Initiative

**AIM:** By April 2014, increase screening of distress levels to 75% of patients seen in CCA and CCB care center clinics in February and March, 2014.

**TEAM:**
- Smilow Network: Stephanie Buia Amport, MBA, Anne Chiang, MD, Diane Corjulo, RN
- Care Center Staff: Nancy Hassan, RN, Fran Jaworowicz, RN, June Kelly, RN, Bruce Lundberg, MD, Andrea Silber, M
- Social Work: Bonnie Indeck, LCSW & Nicole Weld, LCSW
- Nursing Research: Ruth McCorkle, RN
- Consultant: Connie Engelking, RN

**PROJECT SPONSORS:**
- Rogerio Lilenbaum, MD
- Catherine Lyons, RN, MS

**INTERVENTION:**
- Developed, educated staff on and implemented workflow for:
  - Distribution of NCCN Distress Thermometer paper screening tool to all patients in CCA and CCB clinics for capture of patient reported outcomes (PRO)
  - RN/MD review of results with patient and suggested intervention (i.e. referral to Social Work) and documentation of results
  - Patient tracking in EPIC electronic medical record and collection and analysis of paper tools

**RESULTS:** A statistically significant increase in screening occurred as evidenced by 41% of patients having a distress score documented by RN in EPIC in February, 2014

**CONCLUSIONS:**
- We did not meet our AIM in February, 2014 but saw improvements in % screened based on RN documentation of distress score and on tools collected (see below)
- CCA used tool to screen 52% of patients seen
  - 2 out of 19 days >= 75% screened
- CCB used tool to screen 69% of patients seen
  - 7 out of 16 days >= 75% screened
- Higher RN staffing levels = higher % screened

**NEXT STEPS:**
- Adjust workflow to include Patient Care Associate distribution in CCA, Explore utility of MyChart e-tool for capture of PRO, Determine distress score trigger requiring intervention, pilot at next clinic