ASCO’s Quality Training Program

Project Title: Improving distress in breast cancer patients

Presenter’s Name: Puja Arora

Institution: University of Virginia

Date: 10/18/17
Team Members

- Puja Arora, Heme/Onc Fellow, team leader/owner
- Christiana Brenin, breast oncology attending, Team Sponsor
- Joanne Phillips, breast oncology nurse navigator
- Brenda Griswold, infusion nurse
- Jennifer Kim Penberthy, clinical psychiatrist
- Christina Sheffield, cancer center distress coordinator
- Pooja Mehra, PGY-4, Oncology hospitalist,
- Ms. Schenk, patient
- Mike Keng, QI Mentor
- Amy Guthrie, QI Mentor
Institutional Overview

- Located in Charlottesville, Virginia and serves a mostly rural population across a large geographical area. This includes Northern Virginia, central Virginia, the western part of Virginia as well as eastern portions of West Virginia and Tennessee.
• Academic, NCI-designated cancer center and a tertiary referral center.
• Patient volume of 350-400 patients a week
• Group of 20 oncologists sub-specializing in hematological malignancies, GI, breast, lung, GU, head and neck, and skin cancers
Baseline Measures

• Measure: The screening and documentation of distress
• Patient population: Breast cancer patients who present as a second visit
• Calculation methodology:
  • Numerator: Number of breast cancer patients who are screened by the electronic screening tool and proper documentation by RN is completed
  • Denominator: Total number of breast cancer patient presenting for a second visit

• Data source: Cancer center RN manager provided access to program that allows you to see all second visits by clinic-
  http://hstsbissrst/HSCSDS_SSRS/Pages/ReportViewer.aspx?fTom+-
  +Testing%2fCancer+Center+Second+Visits&rs:Command=Render

• Data collection frequency: once a week
• Data quality(any limitations): Cannot capture those whom survey was offered but lost, those who refused to fill survey
Baseline Data

- 36 second visit breast cancer patients were identified from February 1st-March 31st
- 3 patients had a distress thermometer scanned into epic
- 0 had a documented note
- 0 Required a referral to be placed
- 0 Referral was placed
- 0 Appointments were made after referral placed
- Appointments took place and intervention provided
Lack of Distress Measurement

![Bar chart and table data showing lack of occurrence and cumulative percent for different areas.]

**Problem Data**

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Lack of Occurrence</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation completed</td>
<td>36</td>
<td>52.17%</td>
<td>52.17%</td>
</tr>
<tr>
<td>Survey provided</td>
<td>33</td>
<td>47.83%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Referral appointment made when needed</td>
<td>0</td>
<td>0.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Referral placed when needed</td>
<td>0</td>
<td>0.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Baseline Data

Distress Measurement in Breast Cancer Patients,
February 1st-March 31st 2017
Problem Statement

- From February 1st to March 31st 2017, the UVA Cancer Center assessed distress in just 13% of their breast cancer patients seen on their second visit, leading to a lack of timely communication and intervention with patients in distress along with not meeting of the Commission on Cancer’s accreditation requirements.
Cause & Effect Diagram

**Technology**
- Tedious method to ID patients that need to be screened
- No epic alert to NN or provider that screening needs to occur
- System to generate lists is slow and can only do by day
- Still paper screen, no automatic upload to Epic
- No automatic way to quantify if screening occurred and if documentation complete

**Workflow/Time**
- Slows down rooming of patients
- Nurse navigator has to see patient before MD instead of just after
- Slows down MD
- Some referrals take place in room (using up rooms)
- Takes time to explain screening
- No defined way to document so it easily measurable

**Communication/Staff education**
- MD unaware screening taking place
- Lack of communication between MA and RN
- Lack of new staff being properly trained

**Process related**
- No one following up on results if screening completed when
- Lack of role definition on who is to address distress (NN vs MD)
- Screenings being handed by front desk and backed up registration

Why distress does not get measured or addressed
By October 2017, increase the measurement of distress in breast cancer patients to 90%.
Priority Matrix

- High Impact
  - Dot Phrases for documentation
  - Creating distress committee with leader
- Low Impact
  - Creating CBL for staff

- Easy
  - Electronic survey
  - PFA scheduling
  - Epic Pop-up
  - Increasing core staff
- Difficult
  - Staff training

Ease of Implantation

American Society of Clinical Oncology
## Priority Matrix

<table>
<thead>
<tr>
<th>Impact</th>
<th>Ease of Implantation</th>
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</table>
| High   | • Dot Phrases for documentation  
          • Creating distress committee with leader | • Electronic survey  
          • PFA scheduling  
          • Epic Pop-up  
          • Increasing core staff |
| Low    | • Creating CBL for staff | • Staff training |

*Image credits: [American Society of Clinical Oncology](https://www.asco.org)*
### PDSA Plan

<table>
<thead>
<tr>
<th>Date of PDSA cycle</th>
<th>Description of intervention</th>
<th>Results</th>
<th>Action Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>April–May 2017</td>
<td>• Created a distress committee with point person who was going to look at the data week to week&lt;br&gt;• Create a dot phrase in epic to be used by all nurse coordinators to document distress findings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
112 second visit breast cancer patients were identified from April 18\textsuperscript{th} - June 30\textsuperscript{th}

- 59 had a distress thermometer scanned into epic
- 40 had a documented note
- 13 Required a referral to be placed
- 12 Referral was placed
- 9 Appointments were made after referral placed
- 4 Appointments took place and intervention provided
PDSA Cycle 1-

Cancer Distress Measurement in Breast Cancer Patients

Feb 1- March 31st

April 18th- June 30th

PDSA 1
<table>
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<tr>
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| April-June 2017   | • Created a distress committee with point person who was going to look at the data week to week  
• Create a dot phrase in epic to be used by all nurse coordinators to document distress findings | • Improvement from 13% to 49% of patients screened  
• Improvement in documentation from 0 to 36% | • Will continue with committee and leader  
• Continue dot phrases but will provide further teaching on how to use |
## Priority Matrix

### Ease of Implantation

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| **High** | • Dot Phrases for documentation  
• Creating distress committee with leader | • Electronic survey  
• PFA scheduling  
• Epic Pop-up  
• Increasing core staff |
| **Low** | • Creating CBL for staff | • Staff training |
Priority Matrix

- **High Impact, Easy**: Dot Phrases for documentation, Creating distress committee with leader
- **High Impact, Difficult**: Electronic survey, PFA scheduling, Epic Pop-up, Increasing core staff
- **Low Impact, Easy**: Creating CBL for staff
- **Low Impact, Difficult**: Staff training
# PDSA Plan

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                    • Create a dot phrase in epic to be used by all nurse coordinators to document distress findings | • Improvement from 13% to 49% of patients screened  
                    • Improvement in documentation from 0 to 36% | • Will continue with committee and leader  
                    • Continue dot phrases but will provide further teaching on how to use |
| September - October 2017 | • Implement electronic surveys via ipads which allow for automatic upload to EMR for all to see  
                            • Electronic survey is more comprehensive | | |
Data from PDSA Cycle 2

- 14 second visit breast cancer patients were identified from October 1st- October 13th
- 12 had a distress thermometer scanned into epic
- 10 had a documented note
- 3 Required a referral to be placed
- 3 Referral was placed
- 1 Appointments were made after referral placed
- 0 Appointments took place and intervention provided
PDSA Cycle 2 -

Cancer Distress Measurement in Breast Cancer Patients
April 18th - October 13th

Feb 1 - March 31st
PDSA 1
April 18th - June 30th
PDSA 2
October 1-13th
## PDSA Plan

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| April-June 2017         | • Created a distress committee with a point person who was going to look at the data week to week  
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                          • Improvement in documentation from 0 to 36% | • Will continue with committee and leader  
                          • Continue dot phrases but will provide further teaching on how to use |
| September-October 2017   | • Implement electronic surveys via iPads which allow for automatic upload to EMR for all to see  
                          • Electronic survey is more comprehensive                                                   | • Improvement from 49% to 83% of patients screened  
                          • Improvement in documentation from 36% to 71%                                               | • Continue use of iPads                                                                 |
Conclusions

- Measurement of distress improved with a team leader driving the initiative and making the process more automatic with incorporation of the electronic surveys via ipads
- Continued education on why distress is being measured and how to best incorporate into the work-flow is needed
- Did not meet aim of 90%, but close
Future Measures

**Outcome Measures:**
- Percentage of patients receiving distress screening
- Percentage of patients with distress screening documentation
- Number of referrals placed to address distress

**Process Measures:**
- How often data is being analyzed when collected
- How many cases are monitored weekly
- Wait time for ipads
- How long it takes for second visits to be identified and provided to core staff

**Operational Measures:**
- Length of patient visits
- Length of time to room patients
- Delay in clinic schedules
- Patient satisfaction with survey
Sustainability

- RN manager who has distress screening as one of his/her job descriptors
- Every 3 month check-ins with core staff and nurse navigators
- Incorporating MDs once work flow established
Thank You

Core Team Members:
Christy Sheffield, RN
Christiana Brenin, MD
Joanne Phillips, RN
Brenda Griswold, RN
Jennifer Kim Penberthy, MD

UVA:
Michael Williams, MD, ScM
Mitchell Rosner, MD
Reid Adams, MD
Jody Reyes, RN, MSH
Jeffrey Ware

QI Mentors:
Michael Keng, MD
Amy Guthrie, RN, MSN, CPHQ

And our patients!

ASCO Quality Training Program:
Barbara Corning-Davis, MS, CPHQ
Gene Cunningham, MS
Carole Dalby, RN, MBA, OCN
Timothy Gilligan, MD
Elaine Holton
Joe Jacobson, MD, MSc