

DUKE CENTER FOR BRAIN AND SPINE METASTASIS (DCBSM) SUCCESS STORY

Success Story | May 2021

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BACKGROUND:

The Duke Center for Brain and Spine Metastasis (DCBSM) is the most comprehensive destination program in the country for people with any cancer type that has spread to the brain or spine. A referral to the center often marks a crossroad in the patient's care in which a discussion with the patient and family about goals and what matters most are vital to ensuring care is consistent with their wishes.

A team convened in October of 2020 to focus on creating a new process with the goal of increasing both the quality and frequency of goal of care (GOC) discussions with new patient referrals to the center. Palliative Care PA Betsy Fricklas, who is embedded in the DCBSM, served as a key liaison to identify opportunities to increase discussions and maximize the skills of all team members. The team designed a process that utilizes the center's multi-disciplinary approach to normalize goals conversations with new patients from the beginning, facilitates communication among the team and targets documenting patient's goals within the first three clinic visits. The new process kicked off in January 2021



HIGHLIGHTS:

The project team was comprised of stakeholders from the clinical area, including Medical Oncology, Neurosurgery, Radiation Oncology, Palliative Care, Nursing Navigators, and Administration. The new process has three key components:

1. New patient referrals receive a patient letter about GOC conversations in the new patient information packet. The letter is intended to normalize the conversation for patients and prepare them to discuss this key information early in their experience with the clinic.
2. The nursing navigators, who have received communication training for GOC discussions, begin introducing these conversations with patients during their initial assessments. Contact between the navigators and patient is made prior to new patient visits.
3. The navigators identify patients who could benefit from further GOC discussions with their care team and then discuss these patients during a pre-clinic team huddle.

The team utilized the new note documentation templates developed by the Palliative Care Department for this project to document all GOC discussions. The note template for the navigators is the Universal GOC template, which include foundational aspects (most important goals, worries, surrogate decision maker, and discussion of advance directives) of a GOC conversation. The note template the medical oncology team will utilize is the Critical Decisions template, which was developed for patients approaching a decision point requiring clarification of priorities in order to develop a plan of care.

OUTCOMES AND IMPACT:

The team has seen a significant increase in the volume of documented GOC notes since the new process kicked off. Key lessons learned from this work include:

- Simple interventions can increase the frequency of goals of care conversations in diverse populations
- The entire clinical team can contribute to goals of care conversations (e.g. Nursing Navigators, New Patient Coordinator, Chaplain, Social Worker, Providers/Trainees)

- Multi-Disciplinary approach enhances communication among team and allows for earlier conversations with patient and family
- It is beneficial to normalize goals conversations on initial contact with patient through use of patient facing handout.
- Regular (weekly or bi-weekly) reporting is essential.