spirituality that make them more alike than different. These shared Latino characteristics can influence Latinos' understanding and acceptance of palliative care. In addition, it can affect the delivery of culturally-sensitive services by healthcare providers who may not be familiar with Latino cultural constructs. Presenters will introduce Latino cultural values and describe how they can impact seeking behaviors, delivery of palliative care, and patient-clinician relationships. The audience will be engaged to share their own experiences and challenges while taking care of these patients. Participants will be able to integrate attained knowledge into clinical practice; increasing cross-cultural knowledge on the complex beauty of Latino cultural values and attaining culturally sensitive communication skills could lead to a reduction in healthcare disparities.

Emergency Department Admission Triggers Sustainably Generate High-Value Palliative Care Consultations (TH310A)

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Objectives

- Describe how admission triggers can be implemented in the ED to effectively facilitate earlier palliative care consultation during the inpatient course.
- Demonstrate that specificity in trigger design can capture high value consultations while maintaining sustainable workflows.

Background. Capturing admitted patients for palliative care (PC) consultation earlier in their hospital course helps achieve better alignment with the quadruple aim. Emergency department (ED) admission triggers have been proposed to facilitate earlier engagement, however their impact is not adequately studied.

Aim Statement. Demonstrate that specific admission triggers can generate early palliative care consultations directly from the ED while maintaining sustainable workflows.

Methods. ED admission triggers were derived from literature review and prior quality improvement initiatives. Only three criteria were implemented to ensure actionability and sustainability: presence of serious illness, chair/bedbound >50% of time, and unsurprised if the patient dies this hospitalization. Eligible patients met all three criteria. Any ED interdisciplinary staff could identify eligibility. After verifying, the emergency physician coupled the admission with a "heads-up" PC consult. PC evaluated the patient within 24 hours; they were not expected to call back or come to the ED. High specificity enabled the mature PC consult team to prioritize their fully-stretched resources. Institutional alignment acquired from all stakeholders (ED, ICU, hospitalists, administration) designated this workflow as "standard of care." Data from 03/2018-06/2018 were tracked through the Palliative Care Quality Network registry.

Results. ED-initiated consults during this four-month pilot increased 180% year over year (50 vs.18, p=0.000). Compared to usual PC consults, ED-initiated consults were comparable in age, gender, and palliative performance scale; however, they had significantly shorter median length of stay prior to consultation (0 days vs. 4 days, p=0.000). Among live discharges, more ED-initiated consults received hospice services (51% vs. 38%, p=0.148). Eight planned admissions were avoided. Overall PC consult volume remained proportionately steady, although 21% now originated from the ED. ED-initiated consults were evenly distributed across weeks. Stakeholders valued this new workflow and approved continuing as "standard of care."

Conclusions and Implications. Emergency department admission triggers can effectively and sustainably drive earlier palliative care consultation to achieve the quadruple aim.

Opioid Risk Stratification in an Outpatient Palliative Care Clinic (TH310B)

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Objectives

- List common barriers of implementing a process for opioid risk stratification in an outpatient palliative care clinic.
- Explain why opioid risk stratification is important within the outpatient palliative care population.
- Interpret the results of a statistical process control (SPC) chart and understand when to consider using a SPC chart for a QI project.

Background. Approximately a quarter of patients in academic cancer centers are at high risk for opioid abuse.[1,2] At Dana-Farber Cancer Institute, we sought to create a high-reliability process within our palliative care clinic that risk stratifies our patients for opioid abuse using the Opioid Risk Tool (ORT).

Aim Statement. Our aim was to increase ORT completion rate from 0% to 70% for eligible new consults.

Methods. Our primary outcome measure was the percentage of ORT completed among eligible consults. Eligible consults were defined as new consults seen in the outpatient palliative care clinic who were prescribed opioids by their oncologist or palliative care provider. Charts were audited retrospectively to determine if the ORT was completed. We used a statistical process control (SPC) chart to track percentage of completed ORT over time and to differentiate between special cause and common cause variation. We implemented multiple Plan-Do-Study-Act (PDSA) cycles that included clinician education about ORT