autonomy and beneficence, which were not included in PM notes.

Conclusions and Implications. We noted that many of the services provided by clinical ethics are similar to those offered by PM including assistance with goals of care conversations and advice regarding surrogacy. However, use of language such as "ethically permissible" or "legally permissible," accompanied by moral reasoning, may be delivering additional reassurance to medical teams not currently provided by PM. PM clinicians may be able to further assist primary teams by using ethical reasoning in their assessments and recommendations.

Development and Implementation of a Patient-Centered Tool for the Assessment of an In-Patient Palliative Care Team (QI739)

Ana Marija Sola, BA BS, University of California, San Francisco School of Medicine, San Francisco, CA. Alejandro Perez, BS, University of California, San Francisco, San Francisco, CA. Sirisha Narayana, MD, University of California, San Francisco, San Francisco, CA. Teri Rose, BA, Braddock Family Foundation, Walnut Creek, CA. David O'Riordan, PhD MPH, University of California, San Francisco, San Francisco, CA. Giovanni Elia, MD FAAHPM, University of California, San Francisco, San Francisco, CA.

Objectives

1. Identify primary issues for patients' satisfaction with an inpatient Palliative Care team.
2. Describe areas for improvement for the palliative care team's operation and composition as identified by patients receiving care.
3. Recognize the use of Lean A3 process to improve the administration and refine the content of a survey tool.

Background. Patient feedback is an important part of evidence-based, high value care. We wanted to develop a tool for more rigorous assessment of Palliative Care Services (PCS) at our institution.

Aim Statement. Design and implement a protocol, using a standard Lean A3 problem-solving approach, for collecting inpatient feedback on Palliative Care (PC) team performance.

Methods. Eligible inpatients receiving PCS at our institution were approached in person over a 9-month period, to complete a semi-structured interview regarding their experience of care. The survey tool included Likert scale-based and open-ended questions. We examined characteristics of all patients meeting eligibility criteria and thematically reviewed responses from patient interviews. Lean A3 methods were applied to plan and improve the process.

Results. Of the 74 eligible patients, 21 completed the interview. Major themes included: Felt understood (excellent/good: 95%); communicating plans (excellent/good: 80%), effectively respond to spiritual and religious needs (excellent/good: 75%), team availability (always: 65%), controlling/alleviating symptoms (excellent/good: 80%), sharing information about illness (excellent/good: 70%), likelihood to recommend PCS (very likely: 90%). The open-ended questions identified satisfaction with time spent with and clarification of issues by the PC team. Other common themes included the desire for increased cultural sensitivity and diversity of the PC team. We observed mixed responses about patients' previous or current understanding of PC and the PCS offered.

Conclusions and Implications. Patient's perception of team effort, active listening and strength of relationship with providers has a beneficial impact on the patient's experience of care. Areas for improvement were identified as team availability and sharing of information between providers and patients. Feedback regarding team diversity and previous misunderstandings of PC highlighted the need for continuing public education and re-assessment of the composition of the PC team at our institution. Lean A3 methods were helpful in planning and improving the survey process.

Caution! Unstable Patients Will Collapse Without Warning: Improving Advance Directive Completion for Patients with Chronic Obstructive Pulmonary Disease in an Urban, Safety-Net Hospital (QI740)

Amanda Stephens, MD, National Jewish Health, Denver, CO. Kathleen Bickel, MD MPhil MS, University of Colorado School of Medicine, Aurora, CO. Daniel Handel, MD, University of Colorado School of Medicine, Aurora, CO. Stefani Madison, MD, Stephenson Cancer Center, Oklahoma City, OK.

Objectives

1. Recognize the unique challenges to advance care planning discussions in patients with severe pulmonary disease.
2. Identify markers of poor prognosis in pulmonary disease through a novel advance care planning trigger.
3. Evaluate an intervention to increase advance care planning in the outpatient setting with severe pulmonary disease.

Background. Despite recommendations, advanced care planning (ACP) occurs infrequently in patients with COPD. A few studies describe rates of 11-15%, with scant information regarding methods to increase ACP in this population.

Aim Statement. Over six months, to increase advance directive (AD) completion by 10% in patients with COPD requiring outpatient subspecialty care.

Methods. Stakeholders (physicians and nurses) at an urban, safety-net pulmonary subspecialty clinic convened, reporting three primary challenges in ACP: discomfort discussing ACP in clinic, inability to locate AD documents and identifying patients appropriate for ACP. Consequently, a two-step intervention was implemented over 8 months: 1) education addressing ACP discomfort and 2) a novel reminder nudge with COPD-specific ACP criteria plus re-structuring the clinic's AD process. As pulmonary providers were encouraged to complete patient ADs themselves or refer to an outpatient palliative care specialist, AD completion of patients with COPD seen in either clinic was tracked, using statistical process control p-charts.

Results. Before the intervention (June 2016-September 2017), the monthly AD completion rate among COPD patients seen in pulmonary and palliative subspecialty clinics was unstable by statistical process control, with a mean of 25.4% (range 13%-39%). The average monthly number of patients with COPD seen in both clinics was 106. With the education cycle (end October 2017), followed by the reminder nudge and AD paperwork optimization (March 2018), the new average AD completion rate was 28.8% (range 6-42%). Special cause signals indicating significant process change were a shift (December 2017-June 2018) and a point outside the 3-sigma upper control limit (June 2018).

Conclusions and Implications. Although the project aim was not met, the combined intervention was associated with special cause improvement in AD completion. The process was not under statistical control prior to intervention, and continued measurement is necessary to ensure sustained results. However, this study implies that with combined education, a nudge and re-organization, AD completion in this population can improve, thus improving outcomes for patients and families.

Compassionate Technology: Palliative Care Telemedicine in the Rural Hospital Setting (QI741)

Matt Stinson, PA, Calaway Young Cancer Center, Glenwood Springs, CO. Elizabeth Belanger-Shugart, APRN, Valley View Hospital, Glenwood Springs, CO. Katherine Morrison, MD FAAHPM, University of Colorado, Aurora, CO. Maurice Scott, MD, The University of Colorado School of Medicine, Denver, CO.

Objectives

1. Recognize the challenges of providing palliative care in rural hospitals.
2. Describe the use of telemedicine to improve access to palliative care in our organization.
3. Reflect on how a similar approach may be used in other rural medical organizations.

Background. Early hospital-based palliative care is associated with significant improvement in patient quality of life and lower hospital costs. Although there is a robust presence of palliative care services in urban centers, there is a substantial disparity of care for seriously ill patients in rural areas. The medical literature demonstrates that telemedicine has been successful in the hospital setting for treatment of disease and in the home setting for palliative care. There is currently no available literature describing the use of telemedicine to address inpatient palliative care at rural hospitals.

Aim Statement. The purpose of the program is to determine the feasibility of utilizing telemedicine with palliative care services for adult inpatients at a rural community hospital.

Methods. An interdisciplinary team was formed at Valley View Hospital consisting of local providers, social workers, chaplains, and physicians from the University of Colorado Anschutz Medical Campus via teleconferencing. Palliative care consultations were performed with adult inpatients with a focus on advance care planning, symptom management, communication and prognostication. At subsequent visits, the patients were asked about the perceived value of the service and acceptability of the teleconferencing component.

Results. The program launched in January 2018, and 19 patients were seen in the initial 4 months of the service. 95% of patients tolerated teleconferencing well and reported satisfaction with the service. There was a 26% increase in completion and documentation of advance care plans following the visit. 30 patients were identified as needing palliative care services but could not be seen due to limited staff and time.

Conclusions and Implications. Telemedicine may be an option for rural healthcare facilities needing inpatient specialized palliative care services. Key components to program success include concurrent education for involved providers, adequate staffing, and sufficient technological support for telemedicine equipment and software.

Characterizing Life-Sustaining Treatment Decisions of Seriously Ill Veterans During Pilot Testing of the Veterans Health Administration's Life-Sustaining Treatment Decisions Initiative (QI742)

Anne Walling, MD, University of California, Los Angeles, Los Angeles, CA. Karleen Giannitrapani, PhD, VA Health Services Research and Development Service/Stanford, Palo Alto, CA. Mary Beth Foglia, PhD MA RN, Veterans Health Administration, Washington D.C. Jill Lowery, PsyD, Veterans Health