year period. Chi-squared analysis was used to compare pre and post-curriculum results.

Results. Response rate was 37% pre-curriculum (n=46/123) and 41% post-curriculum (n=51/123). Based on the pre and post-curriculum surveys, 61% self-reported baseline competence in providing symptom management for patients with chronic disease or life limiting illness, improving to 88% post-curriculum (p=0.002). On initial survey, a minority reported competence in providing patients with palliative resources (26%) which improved to 48% post-curriculum (p=0.027). Reported knowledge in the role of palliative care consultants increased from 78% to 90% post-curriculum (p=0.105) and knowledge in the educational training palliative care consultants receive increased from 35% to 57% (p=0.029).

Conclusions and Implications. This study discovered that at baseline, many internal medicine residents report lack of competence in providing palliative care for patients. Following the one year curriculum, improvement in resident knowledge and skill was observed, however residents still report weaknesses in these areas. Based on these results, this curriculum has the potential to improve resident knowledge and skill in caring for patients with palliative needs.

You've Got This! Developing Primary Palliative Care Education Within a Safety-Net Health System (QI734)

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Objectives

1. Identify needs and opportunities to implement primary palliative care education with a focus on vulnerable and underserved patient populations served in safety-net settings.
2. Describe the impact of an interdisciplinary primary palliative care education session for providers caring for seriously ill, vulnerable and underserved patients in safety-net setting.

Background. California recently passed a state bill mandating access to palliative care services for Medi-Cal patients with serious illness. With a limited number of palliative care specialists serving these often vulnerable and underserved patients with complex psychosocial needs, it is crucial to educate non-palliative care trained front-line providers in primary palliative care.

Aim Statement. To increase access to palliative care through the development and implementation of a no-cost primary palliative care curriculum for vulnerable and underserved patients in the San Francisco safety-net system.

Methods. Curriculum development was based on a comprehensive needs assessment, including: interviews with content experts, organizational leaders and key stakeholders; an environmental scan; a literature review; and an online survey. We created a novel half-day training program with content focused on defining palliative care and serious illness, differentiating palliative care from hospice care, and serious illness communication skill training specific to vulnerable patient care. Curricular impact was gauged through pre and post-surveys which assessed for confidence in participants' understanding and ability to provide palliative care (Likert scale from 1-10).

Results. Four half-day education sessions were conducted with a total of 40 participants from the San Francisco Department of Health, including non-clinical case managers, social workers, nurses, nurse practitioners and physicians. Participants reported significantly higher confidence in their ability to describe palliative care to a patient (pre-5.09 to post-8.33), differentiate palliative care vs. hospice care (4.92 to 8.73), define serious illness (6.08 to 8.60), define illness trajectories (4.98 to 7.90), elicit patient's illness understanding, prognostic awareness and goals (5.32 to 8.23) and describe advance care planning (6.03 to 8.23).

Conclusions and Implications. A half-day course introducing basic palliative care concepts and communication skills to non-palliative care trained inter-disciplinary providers can improve confidence in providing palliative care to patients in a safety-net setting.

Coaching Palliative Care Conversations: Evaluating the Impact on Resident Preparedness and Goals of Care Conversations (QI735)

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Objectives

1. Describe a novel coaching intervention to improve palliative care skills of resident physicians.

2. Identify positive outcomes in resident preparedness and goals of care documentation resulting from palliative care coaching sessions.

Background. Lectures alone are likely inadequate to prepare resident physicians for goals of care (GOC) discussions. Drawing on adult learning theories, we developed a real-time, learner-centered coaching intervention to improve palliative care (PC) skills of residents.

Aim Statement. Evaluate whether short interactive PC didactic and coaching sessions increased resident physicians' preparedness in discussing PC topics and completion of GOC discussions with hospitalized patients.

Methods. Prospective quality improvement study involving internal medical residents during their four-week hospitalist rotation at an urban medical center. Two PC physicians led the sessions. Brief didactics trained each three-person resident group in a GOC communication roadmap and appropriate documentation. Informal coaching sessions centered on building skills related to conducting GOC conversations and addressing other PC topics residents raised. Residents completed surveys addressing their level of preparedness on a 5-point scale (from 1 = not well prepared to 5 = very well-prepared) in issues related to discussing GOC pre/post-rotation. We measured GOC documentation in a defined patient population considered "at-risk" by the health system based on age, comorbid conditions, and frequent hospitalizations. We monitored data monthly and made small curricular adjustments during the year.

Results. We trained 39 residents over 12 months in thrice-weekly coaching sessions lasting on average 16 minutes. Residents' level of preparedness increased across several GOC topics. The greatest increases were in eliciting patients' fears for the end of life (pre/post 3.3/4.1, change +0.8) and helping patients talk with their families about the future (pre/post 3.4/4.2, change +0.8). Documented GOC discussions in at-risk patients increased from 17.4% pre-hospitalization to 53.9% by the end of hospitalization. Resident physicians rated coaching sessions as useful (4.5) and relevant (4.3) to their training.

Conclusions and Implications. Brief coaching sessions can integrate PC education into a busy clinical service and improve the likelihood that residents will facilitate GOC discussions with hospitalized patients.

The Implementation of a Comprehensive Advanced Care Planning (ACP) Program (QI736)

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Objectives

1. Explain the importance of advance care planning (ACP) to our nation's healthcare system and specifically how it affects end-of life care.
2. Discuss our advance care planning hospital wide performance improvement project.

Background. A recent national survey found that about 90% of people say that talking with their loved ones about end-of-life care is important but about 27% have actually done so. Much of this care involves extremely aggressive measures to preserve life, resulting in higher costs and decreased patient/family satisfaction

Aim Statement. To create an Advanced Care Planning (ACP) system as an integral part of the health care routine and the community culture by facilitating conversations that help individuals and those close to them come to a clear and fuller understanding of their values, goals and treatment preferences.

Methods. Over a two year period, we conducted three hospital wide trainings on having ACP discussions, developed educational materials including an informational video, improved workflow in the electronic medical record (EMR) to track discussions, education and documentation, and stressed use of billable codes for discussion to generate revenue.

Results. Initial preliminary data showed 24.76% of outpatients and 36.95% of inpatients had an advance directive in the EMR. This increased to 92% into the second year for outpatients. The improved EMR workflow to track discussion and education revealed that, at start of second year, 69% of inpatients had been asked about advance directives ("discussion"), 52% were provided information packet/shown educational video ("education"), and 15% of inpatients had an advance directive on file. Increased discussions are further revealed by steadily increasing revenue from billable discussions (CPT codes 99497 & 99498) with $4,693 at end of first year to $9,998 three months into second year.

Conclusions and Implications. Training providers, distribution of educational materials to patients and improving workflows in the EMR resulted in increased ACP billable discussions. Examination of inpatient data suggests that increased discussions do not readily translate into documentation on file, suggesting cultural factors might affect actual completion of documents.