consults seen, with secondary outcomes including re-consultation during the same hospitalization, duration of consult follow-up, and hospice discharges. Analyses were done at the patient level. We used *T* tests for continuous data and chi-square tests for proportions.

Results. During the pre-SOR (January-June 2016) and post-SOR (January-June 2017) periods, the PC team completed 955 and 975 unique patient consults, respectively. There were no sociodemographic differences between the two cohorts. The team signed off a greater proportion of consults in the post-SOR period (28.7% vs 21.4%, $p<0.001$). The mean follow-up duration was significantly reduced post-SOR (6.4 vs 10.1 days, $p<0.001$). While there was a trend towards more re-consultation rates, it was not statistically significant (13.9% vs 16.7%, $p=0.41$) Hospice discharges increased after implementation of SORs (15.0% vs 6.9%, $p=0.002$).

Conclusions and Implications. Sign Off Rounds is a scalable, innovative workflow intervention that may allow a busy inpatient PC team to sign off follow-up consults earlier and see more new patients, without causing harm. Future work should evaluate additional PC quality metrics and the impact on PC clinicians' job satisfaction and burnout.

The Integrated Care Service: Impact of a Multidisciplinary Supportive Care Service on Hospice Discharge Rates for Medical Oncology Patients in a NCI-Designated Cancer Center (SA511B)

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Objectives

- Comprehend various models of inpatient palliative care.
- Analyze why the integrated care service did not demonstrate decreases in length of stay and readmission rate as seen by other co-rounding oncology and palliative care teams.

Background. Palliative care (PC) has shown benefits to inpatient length of stay (LOS), symptom burden reduction, decreased utilization, and time on hospice. It has shown less impact on the rate of hospice referrals.

Aim Statement. We assessed the impact of an integrated care model on quality end of life metrics.

Methods. From January to July 2018, the Department of Supportive Care Medicine collaborated with medical oncology, nursing and administration to create the integrated care service (ICS). The ICS was designed to have geographic colocation, morning PC and medical oncology rounds, multidisciplinary rounds, and postacute management. Multidisciplinary rounds include medical oncology, PC, social work, spiritual care, psychiatry, psychology, hospice liaison, nursing, case management, nutrition, and physical and occupational therapy. Admission criteria include: 1) later-stage disease, 2) noncurative intent therapy, 3) high-distress burden, and 4) poor prognosis. The ICS was compared with other medical oncology patients (non-ICS) and Mantel-Haenszel Chi-Square statistical significance ($p<0.05$) was calculated using Epi Info StatCalc.

Results. In 6 months, 190 medical oncology patients (pts) were admitted to ICS vs 537 non-ICS pts. Compared with non-ICS, the ICS pts had a higher Case Mix Index (1.81 vs 1.56) and metastatic disease incidence (95% vs 78%, $p=0.008$). Discharge to hospice was higher from the ICS service vs non-ICS (23% vs 7%, $p=<0.001$), and average hospice LOS increased from 9 to 15 days. No ICS patient received chemotherapy in the last two weeks of life (0 vs 6 non-ICS pts). Length of stay (LOS) was higher on ICS as compared to non-ICS (8.45 vs 5.26 days) and readmission rates were similar (12% vs 13%).

Conclusions and Implications. For medical oncology inpatients, the ICS significantly improved discharge rates to and LOS on hospice, avoided patients receiving chemotherapy, and maintained similar readmission rates. Based on this pilot, the ICS is planning for expansion to include hematology and surgical services.

Dancing the WOLST: A Quality Improvement Project on Withdrawal of Life Sustaining Therapies (WOLST) (SA511C)

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Objectives

- Design a systematic approach to the WOLST process.
- Integrate the systematic approach to WOLST into the EMR.

- Maximize interdisciplinary team communication during a WOLST procedure.

Background. Literature demonstrates many patients with life threatening complex chronic conditions die in the intensive care unit (ICU), with nearly half of these patients dying after withdrawal or withholding of life sustaining therapies.[1-7] There is considerable variation in how WOLST occurs and whether formal training is provided.[2] No prior research has established the best practices for this procedure.[1-7]

Aim Statement. In patients undergoing WOLST, we will use a best practice guideline and electronic medical record (EMR) templated note to increase provider confidence and quality of death by 10% in 12 months.

Methods. We created a best practice WOLST guideline through literature review and expert consensus. This guideline included a pre-WOLST huddle template and a templated EMR note. Care team members involved in a WOLST received a survey to assess their confidence with the process and evaluate their perception of quality of death in their patient. Participants included clinicians involved in a patient's WOLST. The setting included all ICUs at a quaternary children's hospital.

Results. Baseline data was collected following 35 WOLST procedures, 250 surveys were sent with 116 responses, resulting in a survey response rate of 46%. Physicians and nurses reported a mean score of 84 and 82 out of 100 respectively for confidence in preparing families for the dying process. Data revealed marked variability when evaluating clinicians perception of death, with scores ranging 0-100; mean=81. Thematic analysis identified key processes on which to focus PDSA cycles including: anticipatory guidance to team and family, provider role clarity, and earlier involvement of interdisciplinary team members.

Conclusions and Implications. Little has been published regarding a specific methodology for teaching the process of WOLST to care teams, thus development of a systematic approach is critical to providing the best care at the end of life. Identifying key drivers to WOLST procedures has enabled creation of a practice guideline and EMR template for continued PDSA cycles.

Training Nonpalliative Care Clinicians in Serious Illness Communication: Results of a Train-the-Trainer Model in Three Health Systems (SA511D)

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Objectives

- List the steps of a structured approach to training clinicians in serious illness communication using the Serious Illness Conversation Guide.
- Evaluate clinician-reported outcomes of serious illness communication training, including self-assessment of change in skills.
- Categorize and reflect on clinician takeaways from training that they will apply in practice as well as trainer perceptions of common barriers.

Background. Failure to initiate discussions about values and goals in serious illness ('serious illness communication') remains a common problem. Insufficient training leaves clinicians unsure of what to say or how/when to approach these conversations. Given the shortage of palliative care clinicians, evidence is needed to guide the development and implementation of consistent high-quality communication training for all clinicians.

Aim Statement. Evaluate the impact of clinician training as part of an organization-wide initiative and train-the-trainer program in three health systems.

Methods. In partnership with the Serious Illness Care Program at Ariadne Labs (AL), 3 health systems identified champions to complete a novel train-the-trainer program. Subsequently, these trainers delivered skills-based trainings on the Serious Illness Conversation Guide (SICG) to nonpalliative-care clinicians in their own systems. After each training, clinician participants completed a survey, including self-assessment of change in skills and self-reported learnings.

Results. From 2016-2018, AL trained 22 trainers (18/22 were palliative care MDs) in three systems, who then trained 331 clinicians (48% MD; 32% APP; 20% RN, SW) in 53 sessions spanning subspecialties (67%); primary care (25%); other (8%). Upon completion, participants reported improvement in each of the communication tasks (e.g. assessing illness understanding, sharing prognosis, exploring goals/values); improvements between self-rating scores pre- and posttraining were all significant ($p<0.0001$). Participants rated the quality of the training highly (98% mostly/extremely effective) and shared a diverse array of personalized takeaways to apply in practice, including core skills learned (e.g. reflective listening) and the usefulness of a structure.

Conclusions and Implications. Serious Illness Conversation Guide training, delivered through a train-the-trainer model and system-level program, was highly acceptable and resulted in significant