clinicians to focus on taking care of their patients without distractions. In turn, this improved the work environment for all team members, even non-clinicians.

Conclusions and Implications. Though this data does not take into account the fluctuating FTE of the providers on the team, there is a trend to improvement in both quantitative parameters after initiation of the Nurse Triage role. Qualitative data was resoundingly positive in terms of improved wellbeing and pride in the quality of the work done by the team. Nurse Triage is an effective possibly replicable model to improve delivery of care in Palliative Care inpatient consult teams.

Open-Ended Responses to Bereaved Surveys: Best Practices from the Veterans Health Administration and Kaiser Permanente (QI710)

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Objectives

1. Recognize opportunities to collect and/or use existing qualitative self-reported data in their practice settings for quality improvement.
2. Discuss how self-reported data can be used to educate administrators and non-palliative care clinicians about end-of-life care.

Background. The U.S. Veterans Health Administration's (VA) Bereaved Family Survey (BFS) is administered to the next-of-kin of Veterans who die in VA hospitals; Kaiser Permanente (KP) recently piloted an abridged version of the BFS, adapted items for its members across inpatient and outpatient settings. Narrative responses to 2 BFS open-ended questions informed identification of best end-of-life practices.

Aim Statement. We compared VA and KP BFS narrative responses to identify best care practices across 2 large integrated delivery systems.

Methods. Content analysis of: *Is there anything else that you would like to share about either:*

1. *The patient's care during his/her last month of life?*
2. *How the care could have been improved for the patient?*

Results. A sample of responses to VA's and 1,463 responses to KP's open-ended questions were reviewed to identify best practices. Responses confirmed the quantitative BFS structured content (i.e., multiple-choice items) and generally supported its domains. However, unique processes of care emerged. For example, using music therapy to calm and sooth Veterans was identified in the VA sample. Data suggests opportunities and specific approaches for improving quality of life at the end of life. Other processes of care to emerge from both data sets included frequent and timely updates to family and loved ones on patients' clinical status as death nears. Among KP responses, it was noted that families appreciate more frequent and timely interaction with clinicians with respect to early information sharing and dialogue about end-of-life process, what to expect, and how they can help their loved one.

Conclusions and Implications. Analysis of qualitative data affirmed the domain structure and comprehensive nature of the BFS. It also provided unique insights into best end of life care practices.

Department of Veteran Affairs Gold Status Practice—Advance Care Planning Using Group Visits (QI711)

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Objectives

- Describe key components of advance care planning group visits, including social worker and team-based facilitation, clinic-based needs, and staffing resources.
- Obtain person-centered tools and communication skills to successfully facilitate advance care planning group visits.

Background. Advance care planning (ACP) is a health behavior that requires person-centered education, support by trained professionals and motivational strategies to promote goal-setting and actions. Group visits in the healthcare setting can effectively increase an individual's knowledge, motivation and self-efficacy.

Aim Statement. This session presents a best practice and lessons learned from implementation of group visits focused on ACP.

Methods. To improve care delivery for our nation's Veterans, the Department of Veterans Affairs (VA) developed the Diffusion of Excellence Initiative to identify and spread practices developed through quality improvement methods. One such practice is Advance Care Planning via Group Visits (ACP-GV), which uses an interactive and patient-centered group session to engage Veterans in thinking about and planning for future medical decisions. In these sessions, social workers, or other health professionals, facilitate discussions for Veterans and their trusted others. Facilitators emphasize that while completing an advance directive is voluntary, it increases the chance that their care aligns with their wishes and values and relieves trusted others of having to make these difficult decisions. In addition, ACP-GV increases the effectiveness of advance care planning through allowing Veterans to discuss and process these complex topics with other Veterans in a group session.

Results. To date, 34 VA Medical Centers (VAMCs) have adopted the ACP-GV practice and more than 10,250 Veterans have attended ACP-GV sessions. Of those participants, approximately 18-20% developed a new advance care directive within one month of the session, and 86% set a smart goal to take additional steps toward advance care planning. Continued rollout of this innovative practice to VAMCs across the nation is ongoing.

Conclusions and Implications. At the conclusion of the session, attendees will have practical guidance, techniques and tools for implementation of ACP discussions using group visits in integrated (VA) or fee-for-service (Medicare) outpatient settings.

It's Everyone's Business: Capturing the Conversation (QI712)

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Objectives

1. Describe an innovative way to increase goals of care communication between providers.
2. State the required components of goals of care discussions.

Background. Results of research studies show that clinicians typically avoid discussing goals of care (GoC) and prognoses with patients. However, in order for patients facing serious illness to receive the care they want that is consistent with their values and wishes, health care providers must be skilled at challenging conversations. Currently, the GoC documentation is variable between generalist providers leaving the Palliative Care clinicians unclear as to if the discussions took place or what was understood regarding quality of life goals. Because of this, a standardized GoC form was implemented in the EHR to help facilitate communication between clinicians that would be accessible for subsequent admissions and sudden changes in the patient's condition.

Aim Statement. The purpose of this quality improvement project is to improve communication, collaboration and decision making about GoC between clinicians, patients and family members.

Methods. The current standard of care is for clinicians to review GoC with patients upon admission and to document them in the GoC section of the EHR utilizing specific criteria. After an education session to all clinicians regarding the essential information to be included, GoC discussions were reviewed for all palliative care consults and rated as good, intermediate, or poor. Monthly standardized e-mail messages are sent to providers acknowledging good documentation as well as to offer assistance to improve discussion and documentation.

Results. Good GoC discussions increased by over 25% and patients with no GoC discussion decreased by over 20% during the initial study intervention. A secondary analysis of individual provider results is in progress.

Conclusions and Implications. Providing feedback to clinicians helped to improve GoC discussions and documentation in the EHR. Additional recognition as a GoC ambassador was sent to the managers of those clinicians who consistently performed at a high level. By educating providers regarding how to have difficult discussions surrounding GoC documentation increased leading to care that aligns with the patient's wishes.

Capturing Wishes: A Novel Approach to Goals of Care Documentation for Inpatient Palliative Care Consults (QI713)

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Objectives

1. Identify the need for improved goals of care documentation in the inpatient electronic medical record among patients seen by an inpatient palliative care service.
2. Articulate a strategy for improving goals of care documentation among patients seen by an inpatient palliative care service.