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Objectives

1. Discuss the evaluation of insomnia in the palliative care clinic of a large academic medical center.
2. Discuss the use of trazodone in the palliative care population and discuss the concerns regarding the use of trazodone.

Background. Insomnia is a common symptom in the Palliative Care patient population with some estimates showing up to 70% of patients having symptoms of Insomnia. However, patients continue to depend on pharmaceutical agents owing in part due to lack of access to Cognitive Behavioral Therapy and longtime use of medications to treat insomnia. Although trazodone has limited efficacy for insomnia, it is used roughly by 1% of the U.S. adult population. We sought to better define within our clinic population the likelihood patients were using trazodone and also the likelihood of recognition of its use for insomnia.

Aim Statement. evaluate the use and documentation of Insomnia and trazodone use in the outpatient clinic in the palliative care clinic of a large academic medical center.

Methods. This is a retrospective chart review assessing patients seen in the Palliative Care Clinic at a large academic center from June 2017 to November 2017. Data includes demographics, presence of trazodone in their medication list, and documentation of ESAS (date documented, and drowsiness score). Charts were manually reviewed for any documented discussion of insomnia either in the problem list, discussion, or history. Descriptive statistics were used during analysis.

Results. Fifteen (9.2%) of 163 patients had trazodone in their medication list during the review period; 6(40%) were female with mean age of 63.5. Discussion of insomnia was documented for only 4(26.6%) patients. The mean ESAS drowsiness score was 5.03. The most common prescribed dose of trazodone was 50 mg (47%). We were unable to identify thorough assessment or alternative non-pharmacologic strategies within any of these charts.

Conclusions and Implications. Discussion with patients regarding the effectiveness of interventions to help treat insomnia are rare in palliative care patients receiving trazodone. Future interventions will focus on implementing better screening methods, patient education, and documentation regarding insomnia and its management.

Driving Organizational Change in Serious Illness Communication: Successes and Challenges of Implementing the Serious Illness Care Program (QI729)

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Objectives

1. Describe different approaches to the use of clinical tools, clinician training, and systems-changes to improve serious illness communication throughout a system.
2. Examine aggregate implementation data across three health systems on structures and processes of implementing a primary palliative care program focused on communication.
3. Explore strategies to maximize clinician behavior change and factors that may influence uptake of serious illness communication on the frontlines.

Background. Clinicians commonly miss opportunities to engage seriously ill patients in conversations about values and goals, or do so late in the illness course. Achieving more, earlier, and better serious illness communication requires system-level change.

Aim Statement. Examine early learnings about successes and challenges of implementing a communication quality-improvement initiative in three health systems.

Methods. Three U.S. systems have adapted and implemented the Serious Illness Care Program (SICP), which includes tools, training, and systems-changes, in partnership with Ariadne Labs (AL) using a system-level implementation model. We combined and analyzed structure and process data from the three systems and routinely collected coaching notes to understand early successes and challenges.

Results. From 2016-present, AL trained and coached 24 champions (including 20 palliative care specialists) at the 3 systems. Champions launched SICP in cardiology, oncology, geriatrics, surgery, and primary care; Champions have trained 330 clinicians. EMRs have been modified to include an accessible template; 1,852 patients have a documented conversation thus far. Preliminary analysis of coaching notes revealed: 1) Structures and capabilities (e.g. clinician training, EHR template) can be replicated, yet clinician uptake of serious illness conversations varies and may depend on factors not captured in the model, e.g. attitudes toward palliative or end-of-life care; 2) Uncertainties about the role of inter-professionals (e.g. nurses) and specialists vs. generalists in serious illness

communication may contribute to workflow challenges; 3) Supportive coaching, leadership/peer engagement, and/or data-reporting are likely to enhance practice change but require time and resources.

Conclusions and Implications. Successful adaptation and adoption of SICP structures and processes in three health systems suggests the promise of a systems-level implementation model to improve serious illness communication. More effective workflows that activate the care team and a better understanding of the mechanisms and contextual factors that support practice change are likely to enhance efforts.

Rapid Access Service for Symptom Management: An Out-Patient Palliative Medicine Clinic Initiative in a Cancer Institute (QI730)

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Objectives

1. Discuss the operation of a mobile out-patient consult team.
2. Discuss the challenges for the mobile out-patient service.

Background. The benefits of early introduction of palliative care in patients with advanced cancer are increasingly recognized and integration of palliative care in standard oncology care is recommended. Since oncology care is mostly in the out-patient setting, access to out-patient palliative care service is important.

Aim Statement. To share our experience with our mobile out-patient palliative medicine consult team.

Methods. In May 2017, the section of Palliative Medicine under the Department of Supportive Oncology at Levine Cancer Institute piloted a Rapid Access (RA) service for symptom management. This is a mobile out-patient service to complement the out-patient palliative medicine clinic. The goals of the service are: 1) provide immediate assistance to patients with poorly controlled symptoms related to their cancer and/or treatments; 2) prevent unnecessary emergency room (ER) visits; and 3) facilitate early palliative medicine integration in cancer care. The RA service is staffed by a nurse and a palliative medicine physician. The team sees urgent referrals for uncontrolled symptoms.

Results. 183 patients were referred over 12 months. 75% of the patients have solid tumor malignancies, 15% have gynecologic cancers, and 9% have hematologic malignancies. Majority of patients referred were seen on the same day or next day. The most common reasons for referral are uncontrolled pain (83%) and GI symptoms (6%). Of the patients seen by the RA team, only 4% needed to be sent to the ER. Longitudinal follow-up was arranged in the out-patient palliative medicine clinic.

Conclusions and Implications. The RA access service increased out-patient palliative referrals of patients with advanced cancer.

Evaluation of Goals of Care Communication Training for Medical Oncologists (QI731)

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Objectives

1. Develop succinct goals of care communication skills training for oncologists.
2. Design an evaluation tool for the above training sessions.
3. Recognize that such succinct training sessions can be perceived as effective, relevant, and practice-changing.

Background. Medical oncologists commonly have goals of care (GOC) conversations with their patients, but many report insufficient formal communication training. The lengthy nature of many training curricula may limit participation.

Aim Statement. Evaluate the effect of a 90-minute GOC communication training for medical oncology providers on perceived barriers to GOC conversations.

Methods. This training evaluation was conducted at the University of North Carolina at Chapel Hill. Recruitment targeted medical oncology providers specializing in lung, breast, and genitourinary cancers. Medical oncology leadership participated in study planning and assisted with recruitment. Training consisted of a 90-minute interactive primary palliative care skills session, offered four times to accommodate clinicians' schedules. Training consisted of elements from the Ariadne Labs Serious Illness Conversation Guide, VitalTalk, and a case-based exercise. Participants learned to document advanced care planning (ACP) notes in the EMR. Participants evaluated the training on semi-structured surveys using a 5-point Likert scale (1 = not at all, 5 = very much) and open-ended questions assessing perceived communication barriers, quality and relevance of training, and expected effect on practice.

Results. Seventeen of twenty eligible medical oncologists (85%) and five of nine NPs (56%) attended the training and completed the evaluation. They