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

perceived the most significant barriers to GOC conversations to be "patients may be too stable to warrant a GOC conversation" (mean Likert scale score 3.2) and "patients may be upset by GOC conversations" (3.0). Participants strongly agreed that training provided skills applicable to clinical practice (4.8) and that they would recommend the training (4.8). In response to an open-ended question about effect on practice, participants most often identified specific communication principles, including "Ask-Tell-Ask" and "I wish" statements.

**Conclusions and Implications.** We successfully recruited medical oncology providers to attend a 90-minute GOC communication training, which was perceived positively and expected to change practice. To assess impact on practice we will review documented GOC discussions before and after training for participants.

### *Improving Advance Care Planning in Residency Through Annual Wellness Visits (QI732)*

Rushil Patel, MD, Memorial Sloan-Kettering Cancer Center, New York City, NY.

*Objectives*

1. Describe the structure and outcomes of a project to increase initiation of advance care planning by Internal Medicine Residents in Medicare Annual Wellness Visits.
2. Evaluate Internal Medicine residents' perspectives on initiating advance care planning during the Medicare Annual Wellness Visit.
3. Assess the feasibility of advance care planning in the Medicare Annual Wellness Visit.

**Background.** The Annual Wellness Visit (AWV) through Medicare offers an opportunity to initiate advance care planning (ACP) in the outpatient setting. In continuity clinics staffed by medical residents, the AMV is also an opportunity for improving trainees' skills for supporting ACP. We piloted an intervention to enhance residents' initiation of ACP during AWV.

**Aim Statement.** Residents will initiate ACP with 1 patient during an AWV.

**Methods.** Among patients for whom they served as the primary care physician, second and third year Internal Medicine residents at a university-affiliated community hospital used a query of the electronic medical record (EMR) to identify patients in Medicare with ≥ 1 high-risk medical condition (specified ICD-10 codes), dependence for ≥ 1 activity of daily living (collected during nursing intake at last visit), and ≥ 1 hospitalization or emergency department visit in the past year. Each resident selected one patient who met all four criteria to address ACP within in an AWV. At the visit, patients first reviewed Prepare For Your Care (https://www.prepareforyourcare.org), an interactive, online resource for ACP with a clinic patient educator. The resident then discussed the patient's preparatory responses and health-related values, and documented them using an EMR template. A post-intervention questionnaire surveyed residents' views of the experience (1-7 scale, 7=most positive) and suggestions for improvement. The primary outcome was the number of residents who initiated ACP with 1 patient.

**Results.** 10 of 12 residents initiated ACP. Most common conditions were CHF requiring hospitalization, ESRD on hemodialysis, diabetes with severe complications, and COPD on home oxygen. The average scores (n=8) for overall experience, impact on patient care, and likelihood of incorporating ACP in future practice were 6.0, 6.1, and 6.6, respectively. Common areas for improvement included delays in scheduling visits and visit duration.

**Conclusions and Implications.** The AWV is an opportunity to initiate ACP with high-risk patients while training physicians in this important area of practice. Future improvements include streamlining clinic workflow.

### *Palliative Medicine Education for Internal Medicine Residents (QI733)*

Gina Piscitello, MD, University of Chicago, Chicago, IL. Shannon Martin, MD MS, University of Chicago, Chicago, IL.

*Objectives*

1. Explain the improvement that a lecture series in palliative medicine can have in resident knowledge and skill in providing palliative care.
2. Describe an educational program in palliative medicine that can be used to train internal medicine providers.

**Background.** Caring for patients with palliative needs is an essential part of internal medicine training, however this care is often not a focus of resident education. Less than half of accredited internal medicine programs have required palliative care lectures in their curriculum. Due to a shortage in palliative care specialists, internal medicine physicians need basic palliative training to help fill this need.

**Aim Statement.** The purpose of this quality improvement project was to create and maintain a curriculum to improve resident knowledge and skill in caring for patients with palliative care needs.

**Methods.** Internal medicine residents at the University of Chicago were surveyed to determine their knowledge, attitudes, and skills regarding palliative care pre and post-curriculum. The curriculum utilized presentations, workshops, and simulation over a one-