Results. Overall, use of mortality risk prediction scores was acceptable and feasible. There was some disagreement related to the use of SOFA scores as an effective way for determining patient mortality risk. Providers with limited ICU experience were eager and accepting of the scores while those with vast experience found the scores to be an adjunct to their own intuition. All providers acknowledged the benefit of looking at daily scores or 'trends' and the most substantial theme was the need to consider SOFA scores in relation to patient context.

Conclusion. Use of SOFA scores for potentially increasing EOL goals-of-care conversations appears to be most beneficial for providers with limited ICU experience. A case example will be provided for attendees.

Implications for Research, Policy, or Practice. Deficiencies in EOL care communication can compromise quality of EOL care and increase resource utilization. Although large-scale studies are needed to determine the effect on patient EOL outcomes, routine consideration of mortality prediction scores may provide an avenue for more accurate and timelier EOL goals-of-care communication.

For Change You Need a Roadmap: An Implementation Model to Improve Serious Illness Communication Across Health Systems (S860)

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Objectives
1. Describe the three phases of a novel implementation model designed to achieve system-level improvement in serious illness communication.
2. Apply incremental milestones derived from implementation science and organizational change to primary palliative care programs.

Original Research Background. Programs that aim to improve clinician-patient communication about values and goals ('serious illness communication') often focus on skills-training while neglecting the system in which communication takes place. Driving measurable improvements in communication requires organization-level change.

Research Objectives. Develop a novel implementation model for improving serious illness communication across a health system with practical steps for palliative care leaders.

Methods. Researchers and implementers with the Serious Illness Care Program (SICP) at Ariadne Labs (AL) conducted a four-stage process: 1) Assembled an expert panel (n=10) to draft a theory of change. 2) Reviewed the implementation science and organizational change literature. 3) Synthesized learnings into key implementation features and engaged a designer to create a "roadmap." 4) Refined the roadmap with feedback from its application in three systems.

Results. The 'Implementation Roadmap' has three phases: Prepare; Train/Coach; Sustain. Phase one creates a supportive environment for implementation. Actions include engaging leaders and colleagues to gain buy-in, assembling and training a team of champions (trainers + implementation team) with dedicated resources, selecting levers to support practice change, choosing pilot sites, and customizing the program (clinician training/coaching; workflow; EHR template; metrics for monitoring/evaluation). Phase two launches the program in pilot sites with rapid-cycle-improvement. The team trains early-adopter clinicians in serious illness communication who initiate the workflow, resulting in documented conversations with patients. The team uses metrics to track conversations, get feedback, and provide support to frontline clinicians. Phase three expands the program to new sites and plans for evaluation and sustainability, e.g. dashboards, automated triggers.

Conclusion. An Implementation Roadmap provides incremental milestones and practical steps to support palliative care leaders interested in organization-level, measurable improvements in serious illness communication across populations and settings.

Implications for Research, Policy, or Practice. Improving communication for a population requires education plus systems-change; following a roadmap may increase the likelihood of reaching the destination: every patient, every time.

Measuring the Quality of Palliative Care for Patients with End Stage Liver Disease (S861)

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