telephonic follow-ups to potentially decrease ED utilization and hospitalizations.

Background. Missed appointments for palliative care clinics are reportedly as high as 50-70% and may be prevalent in cancer patients due to care coordination confusion, late referrals, and time burden. In our urban academic cancer center, the no-show rate in 2017 was 38% despite automated appointment reminder alerts. This results in inefficient utilization of limited palliative care resources.

Aim Statement.
- Decrease no-show rates in our oncologic palliative care clinic through implementation of a nursing telephonic intervention.
- Provide follow up telephone calls to identify symptom management and care coordination needs.

Methods. Patients were called the day before their scheduled appointment to introduce the service for new referrals, identify needs, and coordinate scheduling changes. Follow-up calls were provided one week after the patient encounter to monitor interventions and triage for needs at home. No-show patients were called to identify potential barriers to the visit.

Results. A total of 408 patients, 202 new and 206 follow-ups, were scheduled for palliative care appointments over the course of 3 months. The most commonly represented oncologic disease groups included GI and thoracic malignancies. 329 patient calls were attempted, and 252 patients were reached. 40% (n=133) of the patients reached reported needs that were addressed during these calls, ranging from prescription problems, symptom management, and patient education. No-show rates during our intervention period decreased to 19%. The most common reasons for no-shows included last minute patient cancellation and illness/hospitalizations.

Conclusions and Implications. Our telephonic nursing intervention reduced no-show rates by 50% as compared to automated appointment reminder alerts. 40% of patients reached reported needs at home that were addressed, possibly reducing ED visits and hospitalizations for pain and symptoms. This preliminary intervention can have implications for improving quality of care and more efficient utilization of limited outpatient palliative care resources.

Got WiFi? Exploring the Feasibility of Televisits Among Vulnerable Patients (QI716)

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Objectives
1. Appraise existing literature regarding the implementation of telehealth palliative care, with attention to the patient populations studied.
2. Review the methods, findings, and experiences of a pilot telehealth initiative at an urban, safety net palliative care clinic.
3. Reflect on lessons learned and formulate approaches to overcoming barriers to completing tele-visits, for vulnerable patients.

Background. No-show rates for palliative care clinic visits can be high (21-36% in our setting), frequently due to severe illness, limited transportation, or fatigue from multiple appointments. Telehealth visits may expand access to community-based palliative care for these complex patients.

Aim Statement. To explore the feasibility of telehealth visits with vulnerable patients in an urban, safety net palliative care clinic.

Methods. We developed a brief technology access survey to assess patients' access to email and necessary technology, and experience with videoconferencing. The survey was professionally translated into Spanish and Chinese. All patients who completed in-person clinic visits between November 2017 and May 2018 were eligible to participate. Patients who reported access to the necessary technology were offered training to complete televisits.

Results. During the study period, 109 patients completed in-person visits. Patients were 26% Latino, 24% Asian/Pacific Islander, 21% African American, and 20% Caucasian; 34% had Limited English Proficiency, and 10% were either marginally housed or homeless. 89 patients (82%) completed the survey. 60 patients (67%) reported access to a smartphone, tablet, or computer and were screened for eligibility. 18 (20%) were deemed ineligible due to significant sensory impairment, cognitive impairment, or limited technology experience. Of the 42 patients eligible for televisits, only 11 (26%) accepted training for televisits. The most common reasons patients declined were preference for in-person visits and lack of WiFi access. 5 patients were scheduled for televisits, and 4 completed visits (4%). The no-show rate for televisits was lower than the general clinic during the same time period (20% vs. 26%).

Conclusions and Implications. In our setting, likely 10-20% of patients have the access, capability, and interest to attempt televisits. More study is needed to determine whether these patients no-show at lower rates for televisits compared to in-person clinic visits.