

**Results.** Cycle 1 investigated baseline clinical practice as we had no existing policy for UDT in the PCC. Our institution has 4 different UDT's and we frequently ordered the wrong test. Cycle 2 we developed and presented a policy that was accepted by hospital administration. We provided a staff educational session for policy compliance, correct test codes, opioid contract compliance, and physician follow-up of UDT results. Cycle 3 we provided patient/family education and tracked 100% compliance with opioid contract use, correct UDT, policy compliance and physician follow-up of UDT results. Cycle 4 is in process with initiation of opioid risk assessments and continued maintenance of previous interventions.

**Conclusions and Implications.** Physician monitoring of opioid therapy is essential from legal, regulatory and professional mandates in the palliative care setting.

### ***The Implementation of a Palliative Care Intervention During Induction Chemotherapy for Patients with Acute Myeloid Leukemia (AML) at a Community Cancer Institute (QI721)***



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#### *Objectives*

1. Recognize the benefits of upstream palliative care in patients with hematologic malignancies.
2. Describe multifaceted intervention to increase palliative care utilization in patients with AML undergoing induction chemotherapy.
3. Discuss future directions to assess uptake of palliative care utilization in patients with AML.

**Background.** Patients with hematologic malignancies are referred to palliative care less than patients with solid tumor malignancies. Clinical trials are underway at academic centers exploring early inpatient palliative care for patients newly diagnosed with AML receiving induction chemotherapy. Feasibility of such interventions have not been studied in a community setting.

**Aim Statement.** We structured a multi-faceted intervention for our community hematology and palliative team on the benefits of early palliative care in

hematologic malignancies with the aim to increase utilization.

**Methods.** In 2017, 24% of patients with AML admitted to Lancaster General Hospital for induction chemotherapy received an inpatient palliative care consultation. Needs assessment performed on the hematology and palliative teams demonstrated a need for integration of palliative care into clinical pathways, automatic triggers for consultation, a need for increased education on AML, and creation of standard elements in inpatient consultations.

**Results.** In the spring of 2018, we integrated palliative care into institutional AML clinical pathways such that all patients receive inpatient palliative consultation within 72 hours of admission. A consultation trigger was placed within the admission order set and is currently being incorporated into the chemotherapy treatment protocol. An educational program on AML was created and presented by the hematology team to the inpatient palliative team. This intervention included creation of minimum standards for inpatient palliative consultation including provider assessment within 72 hours of referral, two visits per week by a provider, and a minimum of one visit by the interdisciplinary team during admission with a focus on symptom management, psychosocial assessments, and advanced care planning.

**Conclusions and Implications.** We have demonstrated feasibility of creating standards for early palliative care intervention in AML patients with collaboration from the hematology and palliative teams. Next steps will include assessing whether these interventions increase uptake of palliative care utilization and specific patient outcomes.

### ***Increasing Outpatient Palliative Care Referrals in a Veteran's Affairs Hospital Oncology Clinic: A Quality Improvement Project (QI722)***



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#### *Objectives*

1. Describe a quality improvement project regarding increasing outpatient palliative care utilization among advanced cancer patients.
2. Describe different PDSA cycles that can affect outpatient palliative care referrals.

**Background.** The American Society of Clinical Oncology recently published guidelines recommending palliative care (PC) to patients with advanced stage cancer. PC referral and involvement may provide improved goals of care discussions and planning for transitions to end of life care.

**Aim Statement.** To increase referrals from oncology clinic to palliative care to 60% for patients with advanced solid tumor malignancies.

**Methods.** A PC screening tool was used to identify patients with advanced solid tumor malignancies with other poor prognostic factors seen in oncology clinic from October 1 to November 17, 2017. Patients were followed over 6-months. Oncology clinicians, nurse coordinators, and social workers were educated in the use of the screening tool. Additional PDSA cycles included individual provider feedback on PC referral rates and integration of PC referrals to clinician pay-for-performance in 2018 fiscal year.

**Results.** Among 559 unique patient encounters, 174 patients met PC screening criteria. 33% of these patients had been referred previously to PC, primarily by oncology, other providers (ie GI, ENT, Radiation Oncology), and inpatient medicine. At 6-month follow up, 51% of patients had a PC referral, with new consults placed primarily by inpatient medicine, then oncology providers. 25% of patients had died and 26% were on hospice at 6 months. 42% of patients who died were on home hospice and 84% were seen by palliative care prior to death. Palliative care consultation was associated with hospice referral prior to death ( $p < 0.01$ ).

**Conclusions and Implications.** Oncology patients with advanced solid tumor malignancies are not currently referred to palliative care in congruence with current guidelines. Outcomes data on the results of a screening tool to increase these referrals showed minimal improvement by oncology providers over 6-month period. Further long-term analysis is necessary to evaluate the effect of pay-for-performance on PC referrals for advanced cancer patients.

### *Supportive Cardiology Quality Improvement Project: Identifying Symptomatic, Advanced Heart Failure Patients for Palliative Care Consultation (QI723)*



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#### *Objectives*

1. Reflect on one possible barrier faced by health-care providers in documenting goals of care discussions for in-patients with heart failure.
2. Describe the benefits and drawbacks of using the numerical rating scale (NRS) for dyspnea as a screening tool for symptomatic patients with heart failure.

**Background.** Heart failure is a life-limiting illness and the leading cause of hospitalization in Canada.

The Toronto Western Hospital Palliative Care Consultation Service identified an opportunity for improvement when it noted only 9 in-patient cardiology referrals for palliative consultation were received from January to September 2017 despite 472 cardiology in-patient admissions.

**Aim Statement.** The aim of this quality improvement project was to increase the number of palliative consultations completed for cardiology in-patients with symptomatic, advanced heart failure by 50% compared to the previous year, starting in February 2018. The project also aimed to document a numerical rating scale (NRS) score for dyspnea for 100% of patients at the time of initial consultation and last palliative care visit and document goals of care discussions for 100% of referred patients by time of discharge.

**Methods.** A process map identified an opportunity for screening cardiology in-patients and screening criteria were developed: nurses identified patients with a NRS for dyspnea of  $> 3/10$ ; a palliative care physician then attended cardiology interdisciplinary team rounds once weekly to identify symptomatic patients with advanced heart failure and approached the cardiology physicians for referral.

**Results.** Results from February to June showed an increase in total cardiology referrals for palliative consultation from 3 (2017) to 19 (2018), with 16 referrals received at team rounds. Though all referrals received were appropriate for palliative consultation, only 6 of 19 referrals screened positive using screening criteria. Only ten out of 19 patients were able to report dyspnea using a NRS. Five of nineteen patients referred had documentation of goals of care discussions prior to consultation, compared to 18 out of 19 patients post-consultation.

**Conclusions and Implications.** Refinement of screening criteria and criteria used to identify symptomatic patients is ongoing. This project may expand to other in-patient services and provided evidence to support teaching serious illness communication skills to cardiology fellows.

### *Evidence-Based Triggers: Incorporating Patient-Reported Outcomes (PROs) into Palliative Care Referrals (QI724)*



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#### *Objectives*

1. Describe how to develop, scalable, transferable and sustainable symptom management systems to monitor and address common cancer