

Aim Statement. Using two projects as case studies, we will delineate one academic healthcare system's step-wise approach to developing and conducting quality improvement (QI) related to primary PC across an entire healthcare system, offering challenges, lessons learned, and solutions.

Methods. We solicited proposals from PC clinical faculty regarding interventions to fulfill an overarching mission to expand the provision of primary PC. Second, we translated proposals into logic models to delineate inputs, outputs, and anticipated outcomes. Third, we worked closely with data engineers to design semi-automated data reports. A steering team met monthly, adopting a "plan, do, study, act" framework to evaluate data, troubleshoot barriers, and brainstorm strategies to mitigate weaknesses and improve on successes.

Results. In FY2018, we implemented 7 interventions, ranging from a thrice-weekly coaching intervention to improve residents' competency in GOC discussions, to the implementation of a nursing checklist to identify unmet palliative needs and trigger GOC consultations, in settings ranging from the CCU to outpatient general medicine clinics. Projects began meeting milestones within 6 months of deployment, overcoming impediments such as determining comparator and denominator populations, and extracting data. In the coaching intervention (n=35), rates of documented GOC among high-risk patients increased from 17% to 54% pre/post-hospitalization. In the CCU intervention, a PC physician provided on-going education sessions about family meetings to residents resulting in an increase in documented GOC for CCU patients from a monthly average of 35.6% to 53.5%.

Conclusions and Implications. While challenging, simultaneously rolling out multiple primary palliative care QI initiatives was made possible through standardization tools such logic model templates as well as the use of common data elements whenever possible.

8:15–10 am

Plenary Session

Getting the Results that Matter: Addressing Quality in Hospice and Palliative Care (101)

Shantanu Agrawal, MD MPhil, National Quality Forum, Washington, DC.

Objectives

- Recognize the role of quality measurement in the overall healthcare landscape and how quality improvement can impact behavior and outcomes.
- Explain how and why quality will continue to be essential to the drive toward value and the

important role of the hospice and palliative care community.

- Identify how the National Quality Forum (NQF) is evolving to focus on quality improvement initiatives that add value to the healthcare system and make care safer, more effective, and more affordable for patients and their families.

This session will provide an overview of how quality measurement is evolving to address the shift to value, tools and resources available to providers to focus on quality care at the bedside, and opportunities to provide quality hospice and palliative care. The session will also discuss how to involve patients and families more fully in quality improvement activities. Panelists Martha Twaddle, MD HMDC FACP FAAHPM, and Betty Ferrell, MA CHPN FAAN FPCN, and will join moderator Amy Melnick, MPA, executive director of the National Coalition for Hospice and Palliative Care in a discussion with Dr. Agrawal on the intersections of quality with palliative care and hospice.

10:45–11:45 am

Concurrent Sessions

Nurses as Sources in Health News: Developing Media Competencies (TH311)



Barbara Glickstein, MPH MS RN, HealthCetera Media Lab, New York, New York.

Objectives

- Discuss the importance of media for leadership in nursing and health policy.
- Describe key media competencies nurses must have for strategic engagement of news media.
- Identify how to successfully craft three strong, clear media messages to prepare for future media opportunities.

Nurses continue to be left out of dominant media narratives. A recent study, *The Woodhull Study Revisited: Nurses Representation in Health News Stories*, which replicated the original research published in 1998, reported on nurses' representation in health news. The study found that, although nurses are the largest group of health professionals, they are cited as sources in only 2% of articles published by newspapers, news weeklies and trade publications. A companion study of health journalists provided some explanations, including newsrooms' biases about women and nurses, a lack of understanding of what nurses do, and difficulty in finding nurses with specific expertise. Nurses are diverse, dynamic, front-line experts who know the latest real-world effects of healthcare and health policy. There are solutions that could help bring nurses to the forefront as media sources. Learn

how to engage with the media and become a source on all media platforms to change the health narrative on palliative care and hospice. Get your voices in health news to help the public understand and normalize end-of-life care.

What's the Deal with Blood Cancers? Navigating a New Frontier in Palliative Cancer Care (TH313)



Thomas LeBlanc, MD MA MHS FAAHPM, Duke University School of Medicine, Durham, NC. Areej El-Jawahri, MD, Harvard Medical School, Boston, MA. Eric Roeland, MD FAAHPM, Massachusetts General Hospital, Boston, MA. Jason Webb, MD, Duke University and Health System, Durham, NC.

Objectives

- Recognize evidence about areas of unmet palliative care needs in the blood cancer population.
- Understand oncologists' unique perspectives about blood cancers, and identify barriers to palliative care integration.
- Develop strategies to align the palliative care and oncology teams to improve integration and promote early palliative care in the blood cancer setting.

Blood cancers account for over 55,000 annual U.S. cancer deaths, a number higher than the 40,000 expected from breast cancer, yet they receive comparatively little attention in discussions about palliative cancer care. While concurrent palliative care is heralded as a standard for patients with advanced solid tumors, those with blood cancers are less likely to use palliative care services, and are more likely to receive aggressive care at end of life, chemotherapy in their last 14 days, and to die in the hospital. These shortcomings highlight unmet needs that warrant further attention and education in the palliative care community. When we talk with blood cancer specialists, they often complain that palliative care clinicians do not understand blood cancers, and that this reduces their willingness to call a consult. Our session proposal will help remedy this knowledge gap.

Contrary to popular belief, these diseases are seen and treated in academic centers and community-based settings alike, often in outpatient settings. Yet blood cancers pose several unique challenges for palliative care clinicians, including highly-variable prognoses, greater responsiveness to treatment, rapidly-evolving treatments, and often a chance of cure. Our presentation highlights the unique challenges posed by this population, with attention to strategies that have paid dividends in our own practices caring for them. A multi-institutional, multi-disciplinary team of presenters with training in oncology and palliative medicine will utilize a case-based approach to discuss these issues,

including perspectives from a clinician who built a palliative care program within a stem cell transplant unit, two who have done trials of early palliative care in hematologic malignancies, and one who is seeing these patients regularly in palliative care practice and as part of clinical trials. We have presented on this topic at national oncology venues, and wish to bring this important perspective to the palliative care community.

Interdisciplinary Team Training at the Art Museum: Breaking Down Hierarchy and Building Resilience (TH314)



Ali John Zarrabi, MD, Emory University School of Medicine, Atlanta, GA. Gordon Wood, MD MSCI FAAHPM, Northwestern University, Chicago, IL. Paul DeSandre, DO, Grady Hospital and Emory University School of Medicine, Atlanta, GA. Barbara Reville, DNP ACHPN NP, Dana-Farber Cancer Institute, Boston, MA. Jane deLima Thomas, MD FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Laura Morrison, MD FAAHPM, Yale School of Medicine, New Haven, CT. Marsha Joselow, MSW LCSW, Boston Children's Hospital/DFCI, Boston, MA. Bryan Brooks, BA, The High Museum of Art—Atlanta, Atlanta, GA.

Objectives

- Describe the evidence supporting the use of museum-based education (MBE) to develop core clinician competencies of perception, empathy, reflective practice, and resilience.
- Recognize how MBE can improve interprofessional practice by decreasing perceived hierarchy and promoting team building.
- Experience an MBE session.

Burnout among palliative care practitioners can lead to poor performance and attrition. Museum-based education (MBE) is an innovative strategy that aims to reduce burnout by enhancing perception and empathy, flattening perceived hierarchy, and strengthening interprofessional teams. The goal of this session is to provide palliative care educators with evidence and approaches to use art as a strategy to promote team building and enhance clinically relevant observation and reflective competencies.

MBE employs specific pedagogical strategies to train participants to intentionally, thoughtfully, and reflectively perceive patients and their unique situations. It is also a strategy to lessen a sense of hierarchy among teams by connecting participants to others' personal perceptions and histories, irrespective of professional role. MBE participants have improved perception, comfort with ambiguity, and empathy, making this an important tool for palliative care teams and training programs as they seek to foster effective interprofessional teams and professional resilience.