Background. Patients with life-threatening illness face critical decisions regarding goals of care (GOC) and treatment preferences (TP). Palliative Care (PC) consultants play a pivotal role in clarifying and documenting patients' wishes to ensure they receive goals-aligned care. However, inconsistencies in documentation of GOC/TP in the electronic medical record (EMR) can result in patients receiving interventions incongruent with their preferences. Among a baseline sample of patients seen by the University of California San Francisco (UCSF) PC service for GOC discussions in April and May 2017, only 63.3% had any goals documented in the EMR, and only 54.5% had both overall GOC (e.g., curative) and at least one specific TP specified in addition to code status (e.g., artificial nutrition, dialysis, etc). This quality improvement study examined the impact of an easily accessible, highly reproducible EMR note template on the consistency of GOC/TP documentation for patients seen by the UCSF PC service.

Aim Statement. This study aimed to increase documentation of GOC/TP among patients seen for GOC by the UCSF PC service from 54% to 80% with the use of a note template designed to integrate into the Advance Care Planning (ACP) problem in Epic.

Methods. Study authors designed an Epic note template to facilitate consistent documentation of GOC/TP. The PC service encouraged routine use of the dot phrase by all consulting PC physicians. Analysts assessed compliance at monthly intervals.

Results. Among 640 patients seen by the UCSF PC service between September 2017 and May 2018, 466 (72.8%) were seen for GOC. Of these, 461 patients (98.9%) had documentation of both overall GOC and at least one TP in their ACP problem in Epic.

Conclusions and Implications. Implementation of an EMR note template increased consistency and clarity of GOC/TP documentation for patients seen by the PC consult service.

Reducing Medication Errors in Home Hospice to Improve Patient Safety (QI714)

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Objectives

1. Reduce medication errors in the home hospice setting by focusing on performance improvement efforts in nurse practice and patient/caregiver practice.
2. Develop patient- and family-centered educational tools for safe medication practices in a home hospice setting.

Background. Gilchrist Hospice Care's average daily census is 433 in the home care setting, representing 49% of the total served. In FY15, our medication error rate was 0.61, with 55% in home care. A Medication Safety Team uncovered root causes and focused efforts on nurse centered medication reconciliation practices and patient/caregiver education.

Aim Statement. To reduce medication errors in home hospice service by 20% by FY18.

Methods. The Medication Safety Team includes our home care Medical Director, Clinical Nurse Specialist, and nurses from home care, triage, admissions, and after-hours teams. Using the IHI model, the team developed new educational tools for medication safety: Syringe Tool, Medication Record, PRN Medication Tracker. Feedback about the ease of use during a crisis to prevent medication errors was collected from patients, family caregivers, and clinicians. The Patient and Family Advisory Council consulted on the visual representation of the tools. A double check process was initiated in the new First Dose Protocol, providing families 24/7 access to our nurse help line. Our Medical Director trained nurses in polypharmacy, to improve crucial conversations about reducing the number of medications taken.

Results. The nurses and family members surveyed reported over 90% satisfaction with use of new education tools. The FY18 medication error rate is 0.34, representing a 44% decline over a three-year period. The errors in home care decreased 9% during the same period.

Conclusions and Implications. The new tools are integrated into the hospice Caregiver Handbook and provide cues about when to administer medications, how to safely check dosing, and provide clinicians a clear picture of medication usage between visits. The double check process in triage has led to countless 'great catches'. These simple improvements to nurse practice and patient education have made a lasting impact at the frontline of care to improve patient safety and overall caregiver confidence.

Nursing Telephonic Intervention to Reduce No-Show Rates for Outpatient Oncologic Palliative Care (QI715)

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Objectives

1. Illustrate the potential value of a nursing telephonic intervention to reduce no-show rates to an outpatient palliative care practice.
2. Identify care coordination needs of patients with serious illness that may be addressed through

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.