safety through documentation of billable work and accurate care goals. Increased work engagement leads to social worker retention. Based on this descriptive study, healthcare systems are encouraged to explore enrollment of social workers in such training to increase palliative care knowledge, attitudes and skills.

It Takes a Village: An Interdisciplinary Effort to Improve the PAL-05 Measure in a Large Academic Medical Center (QI719)

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Objectives

1. Review the Joint Commission PAL-05 measure description and expectations.
2. Discuss some of the barriers to meeting the PAL-05 measure.
3. Describe an interdisciplinary approach using a step-wise method to improve PLA-05 measure compliance.

Background. The National Consensus Project for quality palliative care (2013) guidelines recommend that a patient's or surrogate's goals and treatment preferences are used as the foundation for the plan of care. Despite recognition of the value of these conversations by both physicians and patients, there is often hesitancy to initiate these discussions. According to the PEACE project the use of a Treatment Preferences quality measure will promote discussions regarding treatment preferences and goals between seriously-ill patients and their physicians. The Joint Commission's PAL-05 measure assures that documentation of the patient's treatment preferences and goals accompanies the patient to the next level of care. Joint Commission certified palliative care programs, however, have found it challenging to develop a feasible and effective approach to meet this measure.

Aim Statement. Utilizing an interdisciplinary approach along with a step-wised method is crucial to the successful development and execution of the PAL-05 measure Initiative.

Methods. In order to integrate the important PAL-05 quality measure in our large academic medical center, we developed an interdisciplinary committee encompassing representatives from the palliative care service, nursing leadership, social work, information technology, and quality measure. Several steps were taken, including monthly meetings scheduled over the course of six months, to discuss design, construction, and education of the PAL-05 measure initiative. This initiative encompassed three phases. 1) design and construction; 2) education and training; 3) assessment and impact.

Results. Data regarding compliance of the PAL-05 measure was collected at the one month and three month mark. User feedback regarding the practicality and effectiveness of this initiative was assessed via a survey. Data collected showed marked increased in PAL-05 measure compliance, as well as the impact and feasibility of this initiative.

Conclusions and Implications. Our approach highlights the importance of collaborating with other disciplines, especially when dealing with the complexity of caring for seriously-ill and end-of-life patients.

Opioid Screening & Monitoring in the Palliative Care Clinic: An Attempt at Standardization (QI720)

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Objectives

1. List and recognize components of opioid monitoring.
2. Devise and implement his/her own screening and monitoring plan for the Palliative Care Clinic.

Background. The Centers for Disease Control (CDC) recommend Urine Drug Testing (UDT) for managing non-palliative care patients on chronic opioid therapy (COT)[1]. There are no guidelines for the care of palliative care patients receiving (COT). Studies have shown that in some cohorts roughly half of cancer patients receiving palliative/supportive care have abnormal UDT, suggesting that even palliative care patients misuse/abuse opioids, and that the UDT may serve as an important tool in uncovering this misuse/abuse. Our Palliative Care Clinic (PCC) demonstrated inconsistent use of UDT testing and inaccurate ordering of the appropriate UDT for our patient population. Lack of a formal approved Mercy protocol puts the Palliative Care Clinic at risk of being deemed as subjectively selecting random patients for drug testing. This could be perceived as unfair or unequal treatment of patients from different color, economic backgrounds or gender identity.

Aim Statement.

1. Develop/implement a new policy for standardization of UDT in the PCC.
2. Increase provider compliance ordering the correct UDT.
3. Increase patient/family education and compliance with opioid policy, risk assessment and use of opioid contracts.

Methods. We utilized the IHI Model for Improvement (AIM/Plan-Do-Study-Act).

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.