perceived the most significant barriers to GOC conversations to be "patients may be too stable to warrant a GOC conversation" (mean Likert scale score 3.2) and "patients may be upset by GOC conversations" (3.0). Participants strongly agreed that training provided skills applicable to clinical practice (4.8) and that they would recommend the training (4.8). In response to an open-ended question about effect on practice, participants most often identified specific communication principles, including "Ask-Tell-Ask" and "I wish" statements.

Conclusions and Implications. We successfully recruited medical oncology providers to attend a 90-minute GOC communication training, which was perceived positively and expected to change practice. To assess impact on practice we will review documented GOC discussions before and after training for participants.

Improving Advance Care Planning in Residency Through Annual Wellness Visits (QI732)

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Objectives

1. Describe the structure and outcomes of a project to increase initiation of advance care planning by Internal Medicine Residents in Medicare Annual Wellness Visits.
2. Evaluate Internal Medicine residents' perspectives on initiating advance care planning during the Medicare Annual Wellness Visit.
3. Assess the feasibility of advance care planning in the Medicare Annual Wellness Visit.

Background. The Annual Wellness Visit (AWV) through Medicare offers an opportunity to initiate advance care planning (ACP) in the outpatient setting. In continuity clinics staffed by medical residents, the AMV is also an opportunity for improving trainees' skills for supporting ACP. We piloted an intervention to enhance residents' initiation of ACP during AWV.

Aim Statement. Residents will initiate ACP with 1 patient during an AWV.

Methods. Among patients for whom they served as the primary care physician, second and third year Internal Medicine residents at a university-affiliated community hospital used a query of the electronic medical record (EMR) to identify patients in Medicare with ≥ 1 high-risk medical condition (specified ICD-10 codes), dependence for ≥ 1 activity of daily living (collected during nursing intake at last visit), and ≥ 1 hospitalization or emergency department visit in the past year. Each resident selected one patient who met all four criteria to address ACP within in an AWV. At the visit, patients first reviewed Prepare For Your Care (https://www.prepareforyourcare.org), an interactive, online resource for ACP with a clinic patient educator. The resident then discussed the patient's preparatory responses and health-related values, and documented them using an EMR template. A post-intervention questionnaire surveyed residents' views of the experience (1-7 scale, 7=most positive) and suggestions for improvement. The primary outcome was the number of residents who initiated ACP with 1 patient.

Results. 10 of 12 residents initiated ACP. Most common conditions were CHF requiring hospitalization, ESRD on hemodialysis, diabetes with severe complications, and COPD on home oxygen. The average scores (n=8) for overall experience, impact on patient care, and likelihood of incorporating ACP in future practice were 6.0, 6.1, and 6.6, respectively. Common areas for improvement included delays in scheduling visits and visit duration.

Conclusions and Implications. The AWV is an opportunity to initiate ACP with high-risk patients while training physicians in this important area of practice. Future improvements include streamlining clinic workflow.

Palliative Medicine Education for Internal Medicine Residents (QI733)

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Objectives

1. Explain the improvement that a lecture series in palliative medicine can have in resident knowledge and skill in providing palliative care.
2. Describe an educational program in palliative medicine that can be used to train internal medicine providers.

Background. Caring for patients with palliative needs is an essential part of internal medicine training, however this care is often not a focus of resident education. Less than half of accredited internal medicine programs have required palliative care lectures in their curriculum. Due to a shortage in palliative care specialists, internal medicine physicians need basic palliative training to help fill this need.

Aim Statement. The purpose of this quality improvement project was to create and maintain a curriculum to improve resident knowledge and skill in caring for patients with palliative care needs.

Methods. Internal medicine residents at the University of Chicago were surveyed to determine their knowledge, attitudes, and skills regarding palliative care pre and post-curriculum. The curriculum utilized presentations, workshops, and simulation over a one-

year period. Chi-squared analysis was used to compare pre and post-curriculum results.

Results. Response rate was 37% pre-curriculum (n=46/123) and 41% post-curriculum (n=51/123). Based on the pre and post-curriculum surveys, 61% self-reported baseline competence in providing symptom management for patients with chronic disease or life limiting illness, improving to 88% post-curriculum (p=0.002). On initial survey, a minority reported competence in providing patients with palliative resources (26%) which improved to 48% post-curriculum (p=0.027). Reported knowledge in the role of palliative care consultants increased from 78% to 90% post-curriculum (p=0.105) and knowledge in the educational training palliative care consultants receive increased from 35% to 57% (p=0.029).

Conclusions and Implications. This study discovered that at baseline, many internal medicine residents report lack of competence in providing palliative care for patients. Following the one year curriculum, improvement in resident knowledge and skill was observed, however residents still report weaknesses in these areas. Based on these results, this curriculum has the potential to improve resident knowledge and skill in caring for patients with palliative needs.

You've Got This! Developing Primary Palliative Care Education Within a Safety-Net Health System (QI734)

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Objectives

1. Identify needs and opportunities to implement primary palliative care education with a focus on vulnerable and underserved patient populations served in safety-net settings.
2. Describe the impact of an interdisciplinary primary palliative care education session for providers caring for seriously ill, vulnerable and underserved patients in safety-net setting.

Background. California recently passed a state bill mandating access to palliative care services for Medi-Cal patients with serious illness. With a limited number of palliative care specialists serving these often vulnerable and underserved patients with complex psychosocial needs, it is crucial to educate non-palliative care trained front-line providers in primary palliative care.

Aim Statement. To increase access to palliative care through the development and implementation of a no-cost primary palliative care curriculum for vulnerable and underserved patients in the San Francisco safety-net system.

Methods. Curriculum development was based on a comprehensive needs assessment, including: interviews with content experts, organizational leaders and key stakeholders; an environmental scan; a literature review; and an online survey. We created a novel half-day training program with content focused on defining palliative care and serious illness, differentiating palliative care from hospice care, and serious illness communication skill training specific to vulnerable patient care. Curricular impact was gauged through pre and post-surveys which assessed for confidence in participants' understanding and ability to provide palliative care (Likert scale from 1-10).

Results. Four half-day education sessions were conducted with a total of 40 participants from the San Francisco Department of Health, including non-clinical case managers, social workers, nurses, nurse practitioners and physicians. Participants reported significantly higher confidence in their ability to describe palliative care to a patient (pre-5.09 to post-8.33), differentiate palliative care vs. hospice care (4.92 to 8.73), define serious illness (6.08 to 8.60), define illness trajectories (4.98 to 7.90), elicit patient's illness understanding, prognostic awareness and goals (5.32 to 8.23) and describe advance care planning (6.03 to 8.23).

Conclusions and Implications. A half-day course introducing basic palliative care concepts and communication skills to non-palliative care trained inter-disciplinary providers can improve confidence in providing palliative care to patients in a safety-net setting.

Coaching Palliative Care Conversations: Evaluating the Impact on Resident Preparedness and Goals of Care Conversations (QI735)

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Objectives

1. Describe a novel coaching intervention to improve palliative care skills of resident physicians.