with newly established palliative care programs and those that closed programs between 2013 and 2016.

Methods. We linked the American Hospital Association Annual Survey to the National Palliative Care Registry for 2013 and 2016. We categorized hospitals as newly establishing a palliative care program, closing a program, or no change. We used 3 multivariate logistic regressions to identify factors associated with each category.

Results. Nationally, the proportion of hospitals with 50 or more beds with a palliative care program increased from 67% in 2013 to 78% in 2016. A total of 278 hospitals established palliative care programs and 61 hospitals closed programs during this period. The proportion of for-profit hospitals with palliative care increased from 23% to 45% compared with nonprofit hospital increase from 78% to 88%. Hospitals with new vs established programs were more likely to be smaller (AOR 8.41, 95% CI 5.49-12.89 for 50-149 vs >300 beds; AOR 3.75, 95% CI 2.43-5.79 for 150-300 vs >300 beds), for-profit (AOR 7.45, 95% CI 4.95-11.19), sole community providers (AOR 3.36, 95% CI 1.97-5.73), and in the South Atlantic. Hospitals that closed palliative care programs had similar characteristics to hospitals that newly established programs.

Conclusion. Palliative care program implementation is volatile among for-profit and smaller hospitals and varies by region. The impact of these changes on access to palliative care remains a critical area for future research.

Implications for Research, Policy, or Practice. Understanding longitudinal patterns in palliative care program implementation and closure will enable development of technical assistance and resources to maximize access to palliative care.

Development of a Social Work-Led Primary Palliative Care Model in Hospital Medicine (FR481C)

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Objectives

- Describe what is involved in an embedded primary palliative care program.
- Describe how an embedded primary palliative care program model can improve patient outcomes.

Original Research Background. Due to palliative clinician workforce shortages and the growing number of patients with serious illness in need of palliative care, innovative primary palliative care models are essential to meet this population's needs using the existing resources.

Research Objectives. To increase palliative care delivery, enhance appropriate hospice referral and decrease readmissions of seriously ill patients admitted to the hospitalist service.

Methods. To meet unmet palliative care needs of patients admitted to the hospitalist service at Mount Sinai Medical Center, a social worker-led embedded primary palliative care model was developed. The social worker facilitated goals of care discussions, delivery of prognosis, discharge planning, and completion of advance directive documentation.

Results. In 2017, 184 patients received a primary palliative care consultation; those patients seen had an average age of 70 years, 43% were female and the median Karnofsky performance status of 40%, as compared to 20% for those seen by specialty palliative care. Overall, 51% of the patients seen met palliative care solid tumor oncology trigger criteria, 20% were triaged from the specialty palliative care team and 15% were direct referrals from hospitalists. Of those evaluated, 5% had documented goals of care in the electronic medical record before the consultation and 92% after the consultation. The hospice referral rate was 25% and the specialty palliative care referral rate was 25%. Reasons for referral to specialty palliative care were transfer to the palliative care unit (51%) and complex symptom management (49%). Of those who received the consultation, 30-day readmission rate was 5.3%, as compared to those who did not (16%).

Conclusion. Patients seen by the social worker-led primary palliative care team were more functional, suggesting they were seen earlier in their disease course, and had fewer readmissions.

Implications for Research, Policy, or Practice. Primary Palliative Care Models broaden the reach of Palliative Care to patients who are seriously ill.

Promoting Resilience in Stress Management (PRISM): A Prevention Model for Palliative Care (FR481D)

Nancy Lau, PhD, University of Washington/Seattle Children's, Seattle, WA. Miranda Bradford, MS, Seattle Children's Research Institute, Seattle, WA. Angela Steineck, MD, Seattle Children's Hospital, Seattle, WA. Claire Wharton, BS, Seattle Children's Hospital, Seattle, WA. Samantha Scott, BA, Seattle Children's Research Institute, Seattle, WA. Courtney Junkins, PsyD, Seattle Children's Research Institute, Seattle, WA. Joyce Yi-Frazier, PhD, Seattle Children's Research

Institute, Seattle, WA. Abby Rosenberg, MD MA MS, Seattle Children's Hospital, Seattle, WA.

Objectives

- Evaluate Promoting Resilience in Stress Management (PRISM) as a prevention model for pediatric palliative care.
- Translate research findings to clinical practice working with patients with serious medical illnesses, emphasizing the importance of real world implementation.

Research Background. Adolescents and young adults (AYAs) with cancer are at high risk of poor quality of life and negative psychosocial outcomes. Promoting Resilience in Stress Management (PRISM), a brief, 1:1, skills-based intervention, has demonstrated efficacy in improving quality of life and alleviating distress for AYAs. In this secondary analysis of data from a recent randomized trial, we examined PRISM's role in preventing the development of negative psychosocial outcomes.

Methods. One hundred English-speaking AYAs (ages 12-25 years) with cancer were randomized to receive PRISM vs Usual Care (UC). At enrollment and 6 months later, AYAs completed validated Patient Reported Outcomes (PROs) measuring resilience (CDRISC-10), hope (Snyder hope scale), quality of life (PedsQL), and distress (Kessler-6). Individual patient response trajectories from baseline to 6-month follow-up were categorized as "improved" (>10% increase in PRO scores), "stable" (+/- 10% change), or "deteriorated" (>10% decrease in PRO scores) for each PRO.

Results. Seventy-four patients (36 PRISM, 38 UC) completed baseline and 6-month PROs assessments. A positive response to PRISM persisted even after AYAs were stratified by demographics of gender, age, and race. Individual patient trajectories across all PROs measured suggested PRISM recipients generally experienced either symptom improvement or remained stable over time, whereas UC participants tended to deteriorate over time. The cancer-specific PedsQL provides an illustrative example of group-wide categorical trends such that fewer PRISM recipients "deteriorated" compared to UC (5.6% vs 15.8%, respectively), and more PRISM recipients "improved" compared to UC (33.3% vs 13.2%, respectively).

Conclusions and Implications. PRISM seemed to work equally well across demographic groups. Individual trajectories and group-trends suggested that PRISM may prevent deterioration in resilience, hope, quality of life, and distress. Thus, PRISM may serve as a viable prevention model for pediatric palliative care. Future research will explore the implementation of PRISM as "entry level" psychosocial standard of care for all AYAs with cancer.

4:30–6 pm

Interactive Educational Exchange

Using Simulation to Teach Interprofessional Communication in Palliative Care (FR482A)

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Objectives

- Compare and contrast different types of palliative care simulation described in the literature.
- Identify opportunities within one's own institution to develop similar coursework.
- Create learning outcomes for the use of simulation in palliative care education.

Background. Simulation has become a common education modality across most health professions but is not widely adopted in palliative care education. In a recent review, Smith et al. (2018) found several examples in the literature of end-of-life communication training for nurses and nursing students. However, less than 25% of the thirty articles reviewed included team-based simulation encompassing nursing, social work, and medical students. Simulation provides students a tangible experience in interprofessional palliative care prior to workforce entry.

Audience. The Foundation for Interprofessional Collaborative Practice course incorporates learners from the UT Austin Schools of Pharmacy, Medicine, Nursing, and Social Work and would be appropriate for additional disciplines including psychology and chaplaincy.

Approach. This two-semester experience places students in small interprofessional teams which meet monthly. In the first part of the palliative care module, learners participate in a three-hour large group session with small group breakouts based on materials adapted from the iCOPE curriculum (Head, et al. 2014).