2. Identify other patient-centered outcomes as a result of proactive palliative care consultation, including rate of completion of advance directives, rate of state-authorized portable orders (SAPO) completion, and rates of in-hospital and community deaths.

Background. According to NCCN and ASCO guidelines, there is evidence that early palliative care consultation in patients with advanced cancer led to significant improvement in quality of life, mood and longer survival as compared to patients receiving standard care.

Aim Statement. To improve the rate of palliative care consultation by 20% in patients with advanced cancer over a 15 month period at Buffalo Veterans Affairs Medical Center (VAMC).

Methods. Buffalo VAMC is an academic center affiliated with the University at Buffalo. We provide both outpatient palliative and oncology services. In 2017, we decided to seek proactive palliative care consultations (PPCC) with advanced cancer patients; defined as stage 4 lung cancer, any pancreatic cancer, or any cancer with more than 1 emergency, hospital or ICU admissions. Based on our root analysis our intervention was a meeting between palliative and oncology services once a week since 01/01/2017 to 3/30/2018 at the VA and reviewing the oncology cases on weekly basis with average 80-100 patients per week. From 163 patients requested to be seen by palliative team, oncologists approved 63 proactive palliative consults with denial rate of 60%.

Results. PPCC resulted in an increase of referrals by 33% over a 15 month period. Of those patients seen by outpatient palliative care, 92% died in a community setting (hospice or home) while those identified but denied PPCC died in the community setting only 50% of the time. Interestingly, patients whose PPCC were denied but were later seen by the palliative care team during a hospital admission died in the community 91% of the time. In addition, advanced directives and SAPO increased by 30% and 65% respectively.

Conclusions and Implications. Seeking proactive palliative care consultation in patients with advanced cancer led to an increased outpatient referral rate with a simultaneous decrease in in-hospital mortality.

Repeal and Replace: Overcoming Institutional Biases to Implement a Safe and Efficacious End-of-life Opioid Infusion (QI705)

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Objectives

1. Contrast pharmacology-based end-of-life opioid infusion guidelines with commonly observed real-life practice.
2. Illustrate the challenges to implementing and measuring the impact of an institution-wide opioid project.

Background. End-of-life opioids, when delivered exclusively via rapidly-titrated infusions without bolus doses, can lead to ineffective symptom control early and toxic levels late. Despite best practice guidelines based on steady-state pharmacology, our institution regularly delivered morphine using only an "every thirty minute" titratable drip with 20mg/h max. Multiple systemic issues including a collective mindset resistant to change perpetuated this unsound practice an average of nine times per month in 2016.

Aim Statement. Improve safety and efficacy in end-of-life infusion-based opioid treatments

Methods. In 2017, through a series of presentations, we generated interdisciplinary buy-in to remove the dangerous order and build a consensus replacement order set. In our plan, morphine or fentanyl infusions are nurse-titrated using objective FLACC (pain) and RDOS (dyspnea) assessments after at least four half-lives. Infusion max doses were halved and linked to q15minute bolus doses equal to the infusion dose. Education included narrated e-learning (nursing) with pre/post survey to assess understanding and in-person, including Grand Rounds, and via email (pharmacists and providers).

Results. Pre-intervention, end-of-life patients receiving the rapidly-titratable morphine infusion often reached high rates (median 550% of initial infusion rate) in a matter of hours (median = 5.25) while PRN boluses were available and used in only 35.7% of cases (n= 28). Initial post-intervention analysis showed safer maximum levels (median 160% of initial infusion rate) with slower time to maximum infusion rate (median 29 hours) while PRN boluses were available and used in 69.6% of cases (n = 22).

Conclusions and Implications. Institution-wide change was achieved by addressing barriers at every level of implementation of the opioid order set from pharmacist to nurse to ordering provider. Basic safety and efficacy measures have improved, but more in-depth case review analysis is needed to assess fidelity of provider ordering and nursing execution.