Implications for Research, Policy, or Practice. Understanding the reasons for this decrease in inappropriate critical care might elucidate how to foster further improvement.

Lung Transplant Pulmonologists' Views of Specialty Palliative Care for Lung Transplant Recipients (S857)

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Objectives

1. Differentiate how lung transplant pulmonologists' views of lung transplantation affect their use of specialty of palliative care (SPC).
2. Contrast lung transplant pulmonologists definitions of specialty palliative care with their patterns of specialty palliative care utilization for lung transplant recipients.

Original Research Background. Lung transplant recipients face foreshortened life expectancies and frequently experience significant symptoms. They may benefit from but rarely receive SPC services. Transplant pulmonologists' views of SPC may be key to understanding SPC utilization for this population but these have not been well characterized.

Research Objectives. (1) Examine how lung transplant pulmonologists view SPC and make decisions to refer transplant recipients to SPC and (2) identify any unique aspects of lung transplantation affecting transplant pulmonologists use of SPC.

Methods. We conducted semi-structured interviews with attending transplant pulmonologists at nine geographically diverse high-volume transplant centers with SPC services in the U.S. and Canada. All interviews were audio-recorded and transcribed verbatim. The multidisciplinary team developed a qualitative codebook using the constant comparative method. Two investigators coded all transcripts, with disagreements discussed and resolved by consensus.

Results. We interviewed 37 transplant pulmonologists. Only 2 participants had never referred a lung transplant recipient to SPC. While most participants correctly defined SPC and differentiated SPC from hospice, approximately half used SPC only when disease-directed therapies failed. This approach was associated with a perception that transplant and SPC are "not convergent paths" because transplant focuses on "survival and aggressive treatment," particularly in the first post-transplant year or when retransplantation is possible. Participants who reported using SPC alongside disease-directed therapies were more likely to view transplant as a "palliative treatment" or a "terminal illness" with an uncertain "rollercoaster" course especially after the onset of chronic rejection.

Conclusion. Despite viewing SPC as more than solely end-of-life care, many transplant pulmonologists view SPC as incompatible with traditional post-transplant disease-directed therapy.

Implications for Research, Policy, or Practice. Efforts to integrate SPC into lung transplantation will require solutions that address transplant pulmonologists perception that transplant and SPC are divergent treatment paths.

The EFFECT (End-oF-liFE-CommunicaTion) Study: Acceptability, Feasibility, and Potential Impact of Using Mortality Prediction Scores for Initiating End-of-Life Goals of Care Communication in the Adult Intensive Care Unit (S859)

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Objectives

1. Describe the role of the Sequential Organ Failure Assessment (SOFA) in calculating mortality risk prediction scores.
2. Articulate the role of mortality risk prediction scores in promoting EOL goals-of-care communication.
3. Describe a patient example in which use of mortality prediction scores promoted earlier EOL goals-of-care communication.

Original Research Background. Uncertainties in prognosis remain a barrier to end-of-life (EOL) communication in the intensive care unit (ICU). Mechanisms for increasing the accuracy and timeliness of EOL goals-of-care communication are needed.

Research Objectives. This study evaluated: 1) the acceptability and feasibility of providers' use of patient mortality prediction scores as part of routine practice, and 2) providers' intentions to change practice, related to goals-of-care communication, as a result of awareness of the scores.

Methods. An explanatory mixed-methods approach was used. Using Sequential Organ Failure Assessment (SOFA), patient mortality prediction scores were provided to ICU providers (12) at a large urban medical university who then completed an acceptability and feasibility questionnaire. Follow-up interviews were conducted to further understand and gain insight into providers' perceptions regarding EOL practice changes as a result of having the scores.

Results. Overall, use of mortality risk prediction scores was acceptable and feasible. There was some disagreement related to the use of SOFA scores as an effective way for determining patient mortality risk. Providers with limited ICU experience were eager and accepting of the scores while those with vast experience found the scores to be an adjunct to their own intuition. All providers acknowledged the benefit of looking at daily scores or 'trends' and the most substantial theme was the need to consider SOFA scores in relation to patient context.

Conclusion. Use of SOFA scores for potentially increasing EOL goals-of-care conversations appears to be most beneficial for providers with limited ICU experience. A case example will be provided for attendees.

Implications for Research, Policy, or Practice. Deficiencies in EOL care communication can compromise quality of EOL care and increase resource utilization. Although large-scale studies are needed to determine the effect on patient EOL outcomes, routine consideration of mortality prediction scores may provide an avenue for more accurate and timelier EOL goals-of-care communication.

For Change You Need a Roadmap: An Implementation Model to Improve Serious Illness Communication Across Health Systems (S860)

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Objectives

1. Describe the three phases of a novel implementation model designed to achieve system-level improvement in serious illness communication.
2. Apply incremental milestones derived from implementation science and organizational change to primary palliative care programs.

Original Research Background. Programs that aim to improve clinician-patient communication about values and goals ('serious illness communication') often focus on skills-training while neglecting the system in which communication takes place. Driving measurable improvements in communication requires organization-level change.

Research Objectives. Develop a novel implementation model for improving serious illness communication across a health system with practical steps for palliative care leaders.

Methods. Researchers and implementers with the Serious Illness Care Program (SICP) at Ariadne Labs (AL) conducted a four-stage process: 1) Assembled an expert panel (n=10) to draft a theory of change. 2) Reviewed the implementation science and organizational change literature. 3) Synthesized learnings into key implementation features and engaged a designer to create a "roadmap." 4) Refined the roadmap with feedback from its application in three systems.

Results. The 'Implementation Roadmap' has three phases: Prepare; Train/Coach; Sustain. Phase one creates a supportive environment for implementation. Actions include engaging leaders and colleagues to gain buy-in, assembling and training a team of champions (trainers + implementation team) with dedicated resources, selecting levers to support practice change, choosing pilot sites, and customizing the program (clinician training/coaching; workflow; EHR template; metrics for monitoring/evaluation). Phase two launches the program in pilot sites with rapid-cycle-improvement. The team trains early-adopter clinicians in serious illness communication who initiate the workflow, resulting in documented conversations with patients. The team uses metrics to track conversations, get feedback, and provide support to frontline clinicians. Phase three expands the program to new sites and plans for evaluation and sustainability, e.g. dashboards, automated triggers.

Conclusion. An Implementation Roadmap provides incremental milestones and practical steps to support palliative care leaders interested in organization-level, measurable improvements in serious illness communication across populations and settings.

Implications for Research, Policy, or Practice. Improving communication for a population requires education plus systems-change; following a roadmap may increase the likelihood of reaching the destination: every patient, every time.

Measuring the Quality of Palliative Care for Patients with End Stage Liver Disease (S861)

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