billable (e.g. care coordination) minutes were recorded. Descriptive statistics were conducted. The overall ratio of NB:B minutes and ratios by diagnosis type and vital status were calculated. One-way ANOVA and chi-square tests were used to assess differences in the NB:B ratios.

Results. Out of 98 patients, PPO had billable visits on 54 (55%) and assisted without billing in the care of 44 (45%). Twenty-four (25%) patients are deceased; vital status did not differ by diagnosis type ($p=0.29$). Patients had solid tumors (ST; 42, 43%), brain tumors (BT; 33, 34%), leukemia/lymphoma (L/L; 21, 21%), and other diagnoses (2, 2%). Overall NB:B ratio was 1.03. NB:B ratios differed among diagnoses ($p<0.0001$), with L/L the highest at 2.5 compared to ST (0.9), BT (0.8) and other (0.5). Deceased patients had a higher ratio of NB:B minutes than alive patients ($p<0.0001$; 1.9 vs 0.8).

Conclusion. Care coordination in PPO clinic is time-intensive and grows with clinic volume. For patients with L/L and those who were deceased, non-billable minutes outpaced billable clinical minutes.

Implications for Research, Policy, or Practice. When devising a PPO outpatient program, this NB:B ratio should be accounted for in physician time, and personnel devoted to patient and family assistance.

The Gang's All Here: All-Inclusive Interprofessional Education in a Palliative and Hospice Center (S809)

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Objectives

1. Describe the interprofessional education process that included non-clinical staff.
2. Discuss tools utilized to measure readiness for interprofessional learning, team collaboration, burnout and knowledge.
3. Describe outcomes of the interprofessional educational intervention.

Original Research Background. Nursing assistants (NAs), housekeepers, dietary staff, volunteer coordinators, and clerical staff are integral team members in inpatient palliative and hospice settings, but may not be included in interprofessional education.

Research Objectives. The primary aim of this study was to evaluate the impact of interprofessional education on collaborative work practices. Secondary aims included: knowledge changes, job burnout, and retention.

Methods. Staff in a new palliative and hospice care center participated in a 12-session interprofessional education program. Participants' preparation included discipline specific reading materials. Session format focused on group exercises to maximize interaction among disciplines. All participants were evaluated pre/post education and at 3-month follow-up using the following tools: Readiness for Interprofessional Learning Survey (RIPLS), Assessment of Interprofessional Team Collaboration Survey (AITCS), and Maslach Burnout Inventory (MBI). Registered nurses (RNs) and NAs also completed knowledge surveys. RNs also completed the End of Life Professional Caregivers Survey (EPCS).

Results. RNs ($n=15$), NAs ($n=4$), housekeepers ($n=2$), cooks ($n=3$), a volunteer coordinator ($n=1$), and clerical staff ($n=3$) participated in the education. A significant increase in participant AITCS and EPCS scores was observed post education and sustained through 3-month follow-up (AITCS 16.4 percent increase at 3-month, $p<0.0001$; EPCS 17.7 percent increase at 3-month, $p<0.0001$). RNs (15.7 total point increase 95% CI (6.3, 25.1)) and NAs (4.3 total point increase 95%CI(0.3, 8.2)) both demonstrated significantly improved scores on knowledge surveys and, and after 3 months, reported significantly reduced emotional exhaustion (20.0, 95%CI (14.9, 25.2)) and depersonalization (6.0, 95%CI (3.2, 8.9)).

Conclusion. Our interprofessional education intervention has improved overall team function, which may ultimately affect patient outcomes and experience with care.

Implications for Research, Policy, or Practice. The education's sustained impact will be evaluated at 6 months follow-up. Interprofessional education will be studied among diverse groups within the broader medical center and region.

General Practitioners' Barriers and Facilitators to Opioid Prescription in Medellin, Colombia (S810)

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