clinical data (diagnosis, length of stay, ICU use, PC referral), and discharge disposition. Additional data was abstracted for deceased patients: location of care, location of death, goals of care (GOC) and advanced care planning (ACP) documentation. Descriptive statistics were used to characterize the sample. A multivariable logistic regression was used to obtain associations between PC involvement.

Results. Of the 5169 total NSG patients whose mean age was 58.9 (±16.13) years and length of stay was 5.3 (±5.4) days, only 201 (3.9%) patients had PC referrals. Patients with a PC referral were older ($p<0.01$), had longer hospital stays ($p<0.01$), were more likely to be referred to hospice ($p<0.01$), and were more likely to die during the hospitalization ($p<0.01$). From those patients who died during the hospitalization (n = 121), 97 (80%) had PC referrals. The most common causes of death in this group were traumatic (35.5%) or non-traumatic (39.7%) brain hemorrhages. Patients who had a longer length of stay (odds ratio = 1.51; 95% CI = 1.21−1.88, $p<0.01$) were more likely to be referred to PC. Patients with a PC referral died on the palliative care unit ($p<0.01$), had nurse-controlled analgesia use ($p<0.01$), DNR order ($p<0.01$), and GOC documentation ($p<0.01$).

Conclusions and Implications. PC is usually consulted for the sickest patients. Standardized screening for palliative care may be needed to identify these patients sooner.

Improving Outpatient Life-Sustaining Treatment Documentation at the West Haven Veteran's Affairs Hospital (QI704)

Lindsay Vendetta, MD, University of Washington. Kaoru Harada, MD, Icahn School of Medicine at Mount Sinai.

Objectives

1. Identify appropriate patients to discuss advance care planning in outpatient setting.
2. Illustrate barriers to having these discussions through the PDSA process.

Background. The Veteran's Affairs (VA) healthcare system recently implemented the Life Sustaining Treatment (LST) Plan to promote a patient-centered approach to end-of-life decisions. Unfortunately, a majority of these conversations occur in the inpatient setting when patients are acutely ill.

Aim Statement. We sought to improve LST completion rates in the outpatient setting by 20% since implementation through resident and patient driven interventions over 6 months.

Methods. Patients with CAN scores greater than 90 in one clinic were identified. Patients who had a completed advance directive were excluded, and baseline LST completion rate was calculated. Our first intervention included an email notification to providers identifying patients with CAN scores greater than 90. Our second intervention involved distributing LST brochures while patients were waiting for their appointment.

Results. We identified 185 patients with CAN scores greater than 90 in this clinic. Sixty patients were excluded because of completed advance directives. Mean CAN score was 93.2 + 3.6. Two out of 125 patients had LST completed in the outpatient setting, for a baseline rate of 1.6%. Following our resident driven intervention, one LST was completed in the outpatient setting with a completion rate of 0.9% (1/110). Our subsequent patient driven intervention did not yield any further completion of the LST form.

Conclusions and Implications. Neither the provider nor patient driven interventions improved LST completion rates. Completing LST documentation has proven difficult in the outpatient setting, likely due to time constraints in clinic. The LST form is still new to the outpatient setting, and more education is needed for both patients and staff regarding its components. Increasing completion of LST will likely require further interdisciplinary coordination.

Palliative Care in a Pandemic: A Retrospective Chart Review of the Impact of Early Palliative Care Consultation During the COVID-19 Pandemic in the Acute Care Setting (QI705)

Rachel Sabolish, NP, Porter Adventist Hospital and Centura Health. Jennifer Wilson, APRN CNS, Porter Adventist Hospital. Hollie Caldwell, PhD RN, Porter Adventist Hospital.

Objectives

1. Describe an approach to obtaining early palliative care consultation in an acute care setting.
2. Describe interventions to address goals of care during a pandemic.

Background. COVID-19 is a pandemic with approximately 20% of patients infected requiring hospitalization, and 50% of patients experiencing disease progression to ARDS do not survive. Dying in the hospital is associated with more suffering, and during a pandemic carries additional distress due to rapid decline requiring urgent conversations about escalation of care during social isolation. Our community hospital has 197-beds, including 36-bed ICU, with a dedicated Palliative Care Advance Practice Nurse (APN) service. In collaboration with physicians, Palliative Care APNs developed a strategy to provide early palliative care consultation to every COVID-19 patient under investigation (PUI).

Aim Statement. The purpose was to determine the impact of early palliative care consultation in the hospital.

Methods. Obtaining palliative care consultation involved rounding on COVID units and requesting goals of care consults on all PUIs. Consultation included identifying decision-makers, counseling on medical condition, CPR and intubation, goals of care, escalation of care, and transition to comfort care when appropriate. Outcomes measures from existing reports were reviewed for all patients from March 1, 2020, to May 31, 2020.

Results. There were 394 Palliative Care consults between March and May of 2020. 63 patients were not seen due to staffing and 25 patients were not included due to provider request not to address goals of care. Consultation resulted in establishing a decision-maker in 345 patients (98.2%) and 137 patients (45%) changed their code status. After meeting with palliative care, 131 patients (44.2%) changed their goals of care and one-fourth (75 patients, 25.5%) transitioned to comfort care. Fifty-three patients (17.7%) died in the hospital and thirty-nine patients (12.9%) discharged with hospice.

Conclusions and Implications. Due to the rapid decline associated with COVID-19, early palliative care consultation is key to providing patients and families with an opportunity to discuss their wishes for care to avoid unnecessary suffering, and to better utilize resources to prevent further stress on the healthcare system.

Rapid Response to Inpatient Medical Power of Attorney Completion: A Dedicated Social Work Intervention During COVID-19 (QI706)

Sarguni Singh, MD, University of Colorado. Katie Herrmann, LCSW, University of Colorado. Wendy Cyriacks-Walker, BSN RN ACM-RN, UCHealth. Jeanie Youngwerth, MD FAAHPM, University of Colorado. Kathleen Bickel, MD MPhil MS, University of Denver School of Medicine. Hillary Lum, MD, PhD, University of Colorado School of Medicine and VA Eastern Colorado Geriatric Research Education and Clinical Center.

Objectives

1. Describe the design and implementation of a social work-led intervention to improve Medical Durable Power of Attorney completion for hospitalized patients during the COVID-19 pandemic.
2. Illustrate the use of effective change management strategies.

Background. The high risk of mechanical ventilation with COVID-19 requires health care systems to innovate advance care planning (ACP) delivery for hospitalized patients to promote receipt of goal-concordant care.

Aim Statement. To increase the proportion of hospitalized patients with a Medical Durable Power of Attorney (MDPOA) form available in the electronic medical record (EMR) in parallel with the rising number of COVID-19 hospitalizations.

Methods. Human-centered design was used to develop a social work (SW) intervention. Care Managers were asked to routinely consult SW if there was no MDPOA form available in the EMR. Twenty-eight SWs staff our 650-bed hospital at a ratio of 1 SW to 36 patients. Change management strategies were chosen and tailored to address SW implementation barriers. Data was collected using an automated report in our EMR which identified a weekly list of hospitalized patients with an MDPOA. Analysis of the difference in proportion of patients each week with an MDPOA was done using a statistical process control p-chart.

Results. Weekly baseline data was collected from January 5—April 5, 2020. The intervention started April 12th and data were collected for 12 weeks. At eight weeks, the number of SW consults overwhelmed the inpatient SW team and the intervention was amended to focus on high-risk patients. Despite needing to focus the SW intervention on high-risk patients only, the baseline weekly average of hospitalized patients with an MDPOA increased from 30.1% patients to 42.8% after intervention implementation, with correlating evidence of special cause variation.

Conclusions and Implications. In anticipation of future surges of COVID-19 admissions, health systems need to implement effective ACP processes in the acute care setting. Change management strategies can rapidly address the needs of overwhelmed health systems and should focus on identifying staffing models that are effective and sustainable.

Identifying the Gaps: Assessment of Hospice and Palliative Care Educational Needs for Internal Medicine and Family Medicine Residents (QI708)

Paul Zimmerman, MD, University of North Carolina at Chapel Hill. Sean Gaffney, MD, University of North Carolina. Katherine Aragon, MD, University of North Carolina at Chapel Hill. Catherine Quintana, DNP, UNC Health.

Objectives

1. Describe the design and implementation of a palliative care educational needs assessment for internal medicine and family medicine residents.
2. Identify and interpret the palliative care educational needs of internal medicine and family