into new nursing orientation in the hospital setting. Interest from staff lead to the formation of a palliative care committee at the hospital.

Working Together in Seattle, Washington: Impact of a Collaboration of Providence Hospice Team and Long-Term Care Facility with COVID-19 Outbreak on Patient Care (QI710)

Catherine Jin, MD, Providence Hospice of Seattle.

Objectives

1. Collaborate with long term care facility.

Background. During the 2020 COVID-19 pandemic, by the end of May, >35,000 deaths related to Covid-19 were recorded in care facilities, accounting for 42% of US deaths attributed to COVID-19. Transferring sick resident to local hospitals was often the first response to COVID-19 outbreak in long term care facilities (LTC) to reduce spread and manage symptoms.

Aim Statement. Collaboration between hospice and LTC will reduce hospital transfer, provide goal-concordant care, treat residents in their residence, provide hospice expertise in symptom management to maximize comfort, streamline communication for family, and provide quality care without further COVID-19 spread.

Methods. LTC identified symptomatic residents with positive COVID-19 and referred to hospice if goal was comfort and prognosis was <6 months. LTC isolated all COVID-19+ residents in one unit. Providence Hospice expedited the referral process, hospice team evaluated all residents in person daily focusing on symptom management, educating LTC staff and family on infection control, and providing extra communication, psychosocial and spiritual support for residents' families.

Results. On 3/29/2020, 35 residents out of 42 had symptomatic COVID-19 infection. 25 enrolled in hospice. None were transferred to hospital. 10 died within 2 months. By 6/12/2020, 6 out of 25 residents improved and discharged from hospice. Goals of care were documented for all 25 residents. 10 out of 10 residents who died used the hospice comfort kit prior to death. Symptom Management included oxygen, BiPAP, medications and clysis. Hospice Chaplain and Social worker made 78 Zoom visits and 248 telephone calls involving resident and their families. On 3/29/2020, 17 LTC staff were COVID-19+. With proper PPE, only 3 more LTC staff and zero hospice staff became COVID-19+.

Conclusions and Implications. Collaboration between LTC and hospice can reduce hospital transfer, COVID-19 spread, and stress on the staff and family. Simultaneously, hospice can provide quality symptom management in resident's own living environment until either end of life or recovery.

Development of a New Centralized System for the Management of Opioid Therapy for the VA Palliative Care Clinic (QI711)

Camila Diaz, MD, Transitions LifeCare. Jessica Ma, MD, Durham VA Health Care System. William Bryan, PharmD, Durham VA Health Care System. Shajuana McMillan, PharmD, Durham VA Health Care System. Toni Cutson, MD, Durham VA Health Care System.

Objectives

1. Describe the health system related causes leading to misses or near misses related to opioid prescriptions in palliative care clinic.
2. Identify current methods of practice by which opioid refills are requested by patients.
3. Describe a standardized tool to track opioid prescriptions and anticipate opioid refill requests.

Background. There is a paucity of data evaluating systems for management of opioid medications in the palliative care clinic population, which is unique due to changing symptoms and prognoses. At the Durham Veterans Administration (VA) palliative care clinic, there is no standardized system for opioid tracking or refill requests. This leads to redundant refill requests and missed or late opioid refills that can have adverse patient outcomes.

Aim Statement. To develop a centralized tool to aid outpatient palliative care providers track and manage patients on opioid medications.

Methods. A dashboard was developed to track opioid prescriptions and anticipate refills. This dashboard includes palliative care patients and their recent opioid prescriptions, medication doses, and date of fill, prioritized by anticipated refill dates. The dashboard is reviewed weekly and patients with appropriate monthly medications are prescribed refills. We followed opioid refill requests and adverse events such as withdrawal, overdoses, and acute pain crises pre- and post-intervention implementation.

Results. The Durham VA outpatient palliative care clinic sees approximately 740 clinic visits annually. Pre-dashboard implementation revealed a weekly average of 23.6 (SD 9.2) opioid refill requests. Several patients requested opioid refills after the medications had run out and 1 patient was seen in the ED for pain crisis. Two weeks after dashboard implementation, refill requests were reduced by 1/3. The dashboard identified 3 patients due for refills without a refill request and four patients that were lost to follow up.

Conclusions and Implications. This opioid prescription dashboard fills the gap for palliative care providers to keep track of opioid medications in large