Introduction
Older adults with cancer do not have sufficient access to palliative care services in the outpatient setting resulting in poorer quality of life (QOL). Consequent to knowledge deficits regarding the purpose and role of palliative care, palliative care referrals are placed late in the disease trajectory further decreasing patient access to care and QOL. Individuals with an oncological diagnosis experience an array of symptoms secondary to the nature of their disease and/or its treatments. These symptoms are often poorly managed due to lack of care coordination, which can result in further complications or hasten death [3]. Earlier referrals to palliative care in the community for cancer patients can lead to increased QOL, decreased health related expenses and decrease referrals to palliative care in the community for further complications or hasten death.

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Purpose
The purpose of this quality improvement (QI) project was to increase patient knowledge and acceptance of palliative care, increase patient satisfaction with care and improve the quality of life (QOL) of cancer patients through the development of a clear clinical pathway within one organization.

Aims
• To determine the effects of a palliative care education program specific for symptom management and enhanced quality of life on patient knowledge as measured by PCPS pre-test and post-test questionnaires administered at the educational sessions.
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• To determine the effects of a PCPRS program on the QOL and patient satisfaction with care of newly diagnosed (within 8 weeks of diagnosis) cancer patients as measured by PCPS pre-post test.
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Methods
Pre/post design QI in the South-Atlantic Region of the U.S.A. Convenience samples for the education (n=8) and palliative integration (n=12) interventions consisted of persons enrolled at the organization of interest aged 65 or older with a cancer diagnosis within 8 weeks of initial palliative care consult.

Measures
Clinical Intervention
• QDOL: FACT-G - 27 item questionnaire
• Patient satisfaction with care: FACT-TS-PS – 29 item questionnaire

Educational Intervention
• Educational content: PCPS – 14 item questionnaire.
• Patient preference for palliative care: PCPS – 14 item questionnaire.

Sample
Two convenience samples – all Spanish native-speaking Hispanics

Inclusion criteria:
• Clinical intervention (recruited via referrals): n=12
  • ≥65 years old
  • New cancer diagnosis followed by oncologist
  • Any cancer at any stage
• Educational intervention/recruited at chemotherapy centers: n=8
  • ≥65 years old
  • Receiving long infusion at chemotherapy center

Interventions
Educational intervention:
• Provided one-time live educational evidence-based 15-minute lecture sessions produced by Palliative Care (PC) APRN in Spanish.
• Individuals were administered written Spanish translated validated questionnaires (PCPS and PCPS) prior to the intervention and immediately after.

Clinical Intervention:
• Recruited individuals earlier in the cancer disease trajectory (within 8 weeks of initial diagnosis) through the Care Coordination Palliative Referral System (CPPRS).
• The program had a PC team evaluating individuals’ needs and coordinating/placing appropriate referrals according to the evaluations.
• Written Spanish validated (FACT-TS-PS & FACT-G) tests were administered at baseline and then again at 12 weeks.

Results
The project found that with the educational intervention there was an increase in knowledge of palliative care (p=0.027) despite not increasing preference for palliative care (p=0.613). The clinical intervention found that participants were more satisfied with their care (p=0.038) despite no significant improvements in their QOL (p=1.000).

Conclusions
The project demonstrated the positive impact earlier implementation of palliative care could have on overall satisfaction with care. The project also found that palliative care education increases participant knowledge of palliative care and helped de-stigmatize end-of-life care for this culturally homogeneous population.

Discussion
This project’s educational intervention concentrated on educating older adults with cancer and it improved member knowledge of palliative care despite not improving preference. These results support that the educational intervention successfully increased knowledge of palliative care in participants. The increase in knowledge for participants of the project helped nurture stakeholder buy-in for additional educational seminars for the entire member population. Increasing members’ knowledge of palliative care may help de-stigmatize these services within the organization and eventually affect member preferences for palliative care.

Medicare incentivizes member satisfaction with care through the Medicare Advantage funds. The clinical PCPRS intervention showed that palliative care increased participant satisfaction with their care despite any negative changes in QOL or disease progression. The organization has been able to recognize the positive impact that early palliative care has had on participants of this project and their satisfaction with care. Stakeholders may now be willing to reinvest these additional funds to help ensure the sustainability and growth of PCPRS.

The PCPRS has been able to clinically demonstrate its significance for the organization by addressing symptoms periodically and earlier in comparison to how symptom recognition and management had been previously accomplished. The program has increased the amount of appropriate hospice referrals by identifying individuals who qualify for these programs earlier in their disease and helping de-stigmatize hospice through education. This has resulted in significant cost-savings for the organization, where now hospice funds can be allocated to focus on QOL rather than the continuation of non-curative aggressive treatments.

References: