

The Annual Assembly of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association: Education Schedule With Abstracts

March 14-17, 2018 • Boston, MA

Wednesday, March 14

8 am–5 pm

AAHPM & HPNA Preconference Workshops

Hospice Medical Director Update and Exam Prep (P01)

Ronald J. Crossno, MD HMDC FAAFP FAAHPM, Kindred Healthcare, Rockdale, TX. Kathleen Faulkner, MD FAAHPM, Good Shepherd Community Care, Newton, MA. Edward W. Martin, MD MPH HMDC FACP FAAHPM, Home & Hospice Care of Rhode Island, Cranston, RI. Earl Quijada, MD HMDC, Kaiser Permanente Home Health, Riverside, CA.

Objectives

- Employ the clinical, regulatory, leadership, and administrative skills and ethical knowledge required in the role of hospice medical director.
- Describe the hospice medical director's role on the interdisciplinary care team and within the hospice organization.
- Analyze regulatory issues affecting the hospice medical director and find strategies to fulfill these requirements.

Join peers and national experts to explore and further develop the skills needed to successfully navigate today's hospice environment. This intensive review will serve as part of your preparation for the Hospice Medical Director Certification Board exam and is based on the exam blueprint (www.hmdcb.org). The workshop also serves as a great orientation for those new to the hospice field or as a critical update for all hospice practitioners and managers.

VitalTalk: Intensive Small Group Training—Addressing Goals of Care (P02)

Objectives

- Respond empathetically to the patient's expression of emotion.
- Elicit details about the patient's values.
- Make a recommendation about the treatment plan that best meets the patient's values.

As a palliative care consultant from any professional background, discussing goals of therapy when things

are not going well is the most common reason for an inpatient consult. Discussing goals of care is difficult because it requires the consultant to accomplish a number of interrelated, emotional tasks in a short period of time: deliver bad news, assess what is important to the patient, and make a recommendation about how to best proceed. Using a mix of short didactic talks and experiential practice, this workshop will help participants develop a toolkit of skills useful for handling these difficult conversations. This workshop will be unique in that learning will occur predominantly in small groups (one faculty member: eight to ten participants) to allow participants to practice the skills, observe others, and give feedback. The groups will be multidisciplinary, led by faculty with experience in facilitation, and teach skills appropriate for all palliative care clinicians.

8 am–5:30 pm

AAHPM & HPNA Preconference Workshops

Palliative Nursing Leadership Intensive (P03)

Constance Dahlin, MSN ANP-BC ACHPN® FAAN FPCN, Hospice and Palliative Nurses Association, Pittsburgh, PA.

Objectives

- Differentiate essential nursing leadership qualities.
- Apply 5 areas of palliative nursing leadership throughout workforce venues.
- Develop an individualized leadership competency plan to maximize knowledge, transfer and application.

Leadership in palliative care is characterized by leading others with a clear vision of palliative care initiatives, motivating and inspiring others to achieve excellence in care, positively relating to others to create healthy work environments, and changing the behavior of others to work collaboratively in palliative care (Speck, 2006). Palliative nursing leadership is neither defined nor grounded by level of nursing practice nor education but rather on qualities. These leadership qualities may be attained by any nurse at any level from the

bedside nurse, the nurse group leader or organizer, to the nurse in a designated leadership position. The skills of nurse leaders focus on a broad view of nursing and the ability to respond to change proactively, rather than reactively, in anticipating the future landscape (Wolf, 2012). Many organizations have focused time and resources to enhance leadership skills in their staff. These initiatives usually focus on dedicated nurse leadership positions, such as administrators, managers, directors, or executives; however, leadership extends beyond these roles. Leadership within hospice and palliative must exist throughout the spectrum of nursing roles from nursing assistant, to licensed vocational/practical nurse, to registered nurse, and advanced practice registered nurse. To be successful, the nurse leader must assess their personal leadership capabilities prior to moving towards team development and competence. Through didactic, role play, and interactive media, this session will articulate the value of palliative nursing leadership, describe the characteristics of leaders, explore leadership of nurses at all levels of nursing practice, across the spectrum of nursing including clinical, management, education, research, and policy, and delineate necessary skills of the palliative nurse leader.

ACHPN[®] Certification Review: Advanced Practice Registered Nurse (P04)

Jennifer Gentry, MSN ANP-BC GNP ACHPN FPCN, Duke University Hospital, Durham, NC. Bronwyn Long, DNP MBA ACNS-BC ACHPN AOCNS, National Jewish Health, Denver, Co.

Objectives

- Provide participants with a framework to prepare for Advanced Certified Hospice and Palliative Nursing (ACHPN[®]) Examination
- Provide participants with a process to assess strengths and weaknesses of content for the ACHPN[®] Examination

The purpose of this HPNA Endorsed ACHPN[®] Review Course is to promote education of the APRN seeking augmentation of their professional development through specialty hospice and palliative advanced registered nursing certification. This one-day, provider-directed, provider-paced, live intensive course is designed to assist with preparation for the advanced hospice and palliative nurse certification exam through didactic course presentation with active learner engagement, case study examinations, practice exam questions and self-check/reflection to highlight self-identifying topics that require further preparation and study in advance of sitting for the ACHPN[®] examination. The ACHPN[®] Review Course provides a review of the

content areas based upon the Hospice and Palliative Credentialing Center (HPCC) detailed test content outline. The educational content may also be used to increase the hospice and palliative advanced registered nurse's knowledge of palliative nursing. Our HPNA faculty are national subject matter experts with career experience in hospice/palliative care and certified by the Hospice and Palliative Credentialing Center in the specialty of Hospice and Palliative Care.

8–11:45 am

AAHPM & HPNA Preconference Workshops

HPM Fellowship Directors Program: Managing the Good, the Bad, and the Ugly—Expert Strategies for the Assessment and Remediation of Palliative Care Fellows (P05)

Jane deLima Thomas, MD, Harvard Interprofessional Palliative Care Fellowship, Boston, MA. Laura Edgar, EdD CAE, Milestones Development at ACGME, Chicago, IL. John Herman, MD, Massachusetts General Hospital and the Partners HealthCare, Boston, MA. John Co, MD, Brigham and Women's and Massachusetts General Hospitals and the Partners HealthCare, Boston, MA. Sarah H. Arnholz, JD, Partners HealthCare, Boston, MA. O'Neil Britton, MD, Massachusetts General Hospital, Boston, MA.

Objectives

- Recognize how to use the Milestones, run an effective Clinical Competency Committee, and improve faculty development in using assessment tools.
- Identify the range of issues that need to be addressed in situations involving struggling trainees, including legal, administrative, and health-related issues.

The fellowship directors program will provide participants with the opportunity to learn about the latest advances in fellow-level education and to develop connections with other palliative care educators. This year's program will focus on the assessment and remediation of palliative care fellows, two of the biggest challenges program directors face. First, the Executive Director of Milestones Development at the ACGME will lead a session about using the Milestones, leading an effective Clinical Competency Committee, and performing faculty development using the Milestones and assessment tools. Next, institutional leaders representing the perspectives of director of an Employee Assistance Program, GME director, hospital

legal counsel, and hospital Chief Medical Officer will discuss considerations and strategies for dealing with struggling trainees. By the end of the seminar, participants will have tools to help them perform more accurate and helpful assessments, and to intervene and remediate underperforming fellows.

AAHPM Leadership Forum: Ignite—Using StrengthsFinder Leadership Strategies to Increase the Performance of You and Your Team in Palliative Care and Hospice Settings (P06)



Christina Rowe, MSOL, The Collaborative LLC, Denver, CO.

Objectives

- Distinguish between the 34 Talent Areas of Strengths for self and other team members.
- Evaluate where individuals are in their development, and devise plans to encourage growth and improve abilities to apply talents.
- Create actionable solutions to career and team challenges with a strengths-based approach to create consistent positive outcomes.

Would you like to discover what makes you stand out? This half-day session will focus on utilizing a strengths-based approach to create consistent and positive outcomes to everyday challenges in hospice and palliative care settings. Strengths are the unique combination of talents, knowledge, and skills that every person possesses. Participants will complete a StrengthsFinder assessment which will help to identify personal strengths to focus on to become a more effective leader. They will also learn how to develop these strengths in order to do what they do best every day. Research will be presented demonstrating strengths-based methods heighten personal and team engagement, clearer communication, understanding, and overall productivity. This session will include both large and small group discussions, self-reflection, and scenario-based activities. Participants will learn strategies and tactics for applying a strengths-based approach to individual and team challenges.

Providing Palliative Care to Patients and Families with Pre-Existing Mental Health and Substance Use Issues (P07)



Gary L. Stein, JD MSW (moderator), Yeshiva University Wurzweiler School of Social Work, New York, NY. Vickie Leff, LCSW BCD ACHP-SW, Duke University Hospital, Durham, NC. Harold Alan Pincus, MD, Columbia University/New York-Presbyterian Hospital, New York, NY. Stacy S. Remke, MSW LICSW ACHP-SW, University of Minnesota School of Social Work, Minneapolis, MN. Russell Hilliard, PhD

LCSW, Seasons Healthcare Management, Inc., Rosemont, IL.

Objectives

- Assess how mental health issues and substance use may be impacting patients' and families' ability to cope with serious illness.
- Identify which areas of concern may be reasonable to address in the limited time available for assessment and intervention.
- Develop and advocate for an Integrative Behavioral Health model that incorporates mental health and addiction issues, effective program models and policies, and evidence-based assessment and treatment strategies

Managing mental health and addiction in hospice and palliative care is a critical component of quality care for patients facing serious illness who also have pre-existing behavioral and/or substance use issues. Reports underscore the high prevalence and burden of behavioral health disorders, particularly in the presence of other physical health conditions. Despite this concern, patients can experience fragmented care that leads to suboptimal services and outcomes, including poor patient and family satisfaction, and higher costs. While effective integrated care models have been described and tested, very few integrated models have adequately been described in the context of serious illness care. Some of the challenges are: how to assess and define interventions that work with existing mental health and substance issues that present as barriers to patient, family, or team goals; how to support the most functional aspect of behaviors, while tending to the goals of palliative care; how to interpret trusted therapeutic interventions to fit what are often very time- and access-limited situations; and how to assist other providers in managing reasonable expectations and goals with patients and families with pre-existing mental health and substance problems. The clinical social worker on the interdisciplinary palliative care team has the mental health expertise, and skill set, to provide these services.

First, we will provide an overview of the existing landscape, including historical and epidemiological background, and current service models. An Integrated Behavioral Health model will consider strategies for promoting mental health and addiction care in palliative care settings. Opportunities and challenges for improving care will be considered.

Second, we will assess how mental health and substance abuse may be impacting the patient and family's abilities to cope. This includes identifying what areas of concern are reasonable to address in light of the limited time to assess the situation and effectively intervene. Provider education will be considered to help avoid labelling and stereotypes.

Third, we will consider how mental health and substance use issues can impact the provision of pediatric palliative care. This includes concerns about addiction when strong opioids are needed. We will discuss family dynamics, implications for interprofessional team practice, adapting best practices in addictions treatment to a palliative setting, and ethical issues.

The ABCs of MOC and Exam Prep (P08)

AAHPM MOC Advisory Committee

Christopher M. Blais, MD MPH FACP FAAHPM, Ochsner Medical Center, New Orleans, LA. Daniel Pomerantz, MD MPH FACP, Montefiore New Rochelle Hospital, New Rochelle, NY. Miguel A. Paniagua, MD FACP, National Board of Medical Examiners, Philadelphia, PA. Lauren Mazzurco, DO, Eastern Virginia Medical School, Norfolk, VA. Kira Skavinski, DO, University of California, San Diego Health Sciences, San Diego, CA.

Objectives

- Describe the general MOC requirements and AAHPM resources available for MOC
- Access and review HPM blueprint for HPM examination.
- Participate in test-taking skills and content review using HPM-PASS exam questions in a board review format.

In 2018, the first recertification examination in HPM will be offered to members certifying in 2008. The purpose of this session is to provide a high-level overview of the MOC process, examination blueprint, and AAHPM resources available to those taking the examination. Most of the session will be spent reviewing selected questions from the HPM-PASS product and include the use of an Audience Response System as a platform to discuss the correct answers and rationale. Additionally, attendees will receive information of techniques to improve exam-taking skills.

Tsunami Preparedness: Developing Dementia-Capable Palliative and Hospice Care Skills (P09)

Amy McLean, ANP-BC, Hospice of the Valley, Phoenix, AZ. Maribeth Gallagher, DNP PMHNP-BC FAAN, Hospice of the Valley, Phoenix, AZ.

Objectives

- Discuss essential considerations in caring for the person with dementia along the trajectory of the disease from diagnosis to death.
- Identify and explain the core elements to be addressed in a plan of care for those choosing palliative dementia care.

- Create personalized, evidence-based care plans to maximize quality of life, and prevent or minimize distressing behaviors.

As our population of aging baby boomers, sometimes dubbed the “silver tsunami,” continues to swell, so do their risks of developing some form of dementia. Alzheimer’s, the most common type of progressive and terminal dementia, is the 6th foremost cause of death in America with current prevalence of 5.5 million estimated cases (Alzheimer’s Association, 2017). The Alzheimer’s death rate soared by 55% between 1999 and 2014, and continues to climb, impacting all races, ethnicities, and genders (Centers for Disease Control and Prevention, 2017). In 2014, dementia accounted for 14.8% of primary terminal diagnoses of hospice admissions in the U.S. (National Hospice and Palliative Care Organization, 2015).

The unprecedented numbers of people living and dying with dementia underscore the imperative for widespread development of dementia-capable palliative and hospice care clinicians who can skillfully guide and support both patients and their families along the journey of dementia in a collaborative manner that avoids futile, burdensome interventions that can add to suffering, while focusing on promoting measures that uphold the person’s goals and sense of well-being.

This workshop will cover evidence-based care for persons with dementia beginning with diagnosis through end-of-life. Particular emphasis will be given to effective, person-centered, palliative dementia care practices that address a wide range of physical and psychosocial needs, in order to maximize comfort and optimize quality of life for those living with dementia and their families. Attendees will have an opportunity to refine care planning, education, and goal setting conversations.

Case studies will be utilized to define comfort care, including medication simplification, assessment and management of pain and delirium, understanding and responding to distressed behavior, and compassionate environments and approach styles. Working in small groups, attendees will practice creating personalized, non-pharmacological care plans focused on maximizing quality of life, as well as preventing or minimizing distressed behaviors.

Right-Sizing Medication Regimens in Serious Illness: Doing the Prescribing and Deprescribing Dance (P10)

Mary Lynn McPherson, PharmD MA MDE BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Kathryn A. Walker, PharmD BCPS CPE,

University of Maryland School of Pharmacy and Med-Star Health, Baltimore, MD. Jennifer Pruskowski, PharmD BCPS CGP CPE, University of Pittsburgh School of Pharmacy, Pittsburgh, PA. Shaida Talebreza, MD AGSF HMDC FAAHPM, University of Utah School of Medicine, Salt Lake City, UT.

Objectives

- Describe considerations when prescribing and de-prescribing medications in serious illness including goals of care, remaining life expectancy, treatment target and lag time until benefit.
- Given an actual or simulated patient with a serious illness, demonstrate a critical thinking process for prescribing and de-prescribing medications
- Given an actual or simulated patient with a serious illness, model best practices in communication when right sizing the medication regimen

Experience and research has shown that up to 50% of more of medications taken by patients with a serious illness may be considered inappropriate. Participants in this program will learn how to critically evaluate a medication regimen, and make thoughtful decisions about continuing or discontinuing medications. We will discuss the Good Palliative-Geriatric Practice algorithm, and the Model for Rational Prescribing for Patients. We will apply these models to a series of case-based vignettes that incorporate consideration of medication benefit and burden, goals of care, remaining life expectancy, treatment target, and lag time until benefit. Most importantly, participants will learn how to and practice having conversations with other health care providers, patients, families and caregivers about “right-sizing” the medication regimen in serious illness. This preconference is a MUST for any practitioner in hospice or palliative care.

Building a Palliative Care Clinic: Lessons from Real Life (P11)



Esme Finlay, MD, University of New Mexico, Albuquerque, NM. Mary Buss, MD MPH, Beth Israel Deaconess Medical Center, Boston, MA. Kristina Newport, MD FAAHPM, Hospice & Community Care, Lancaster, PA. Victoria Gurfolino, MSN PMHNP-BC, Beth Israel Deaconess Hospital, Boston, MA. Michelle Owens, DO, Baylor Scott & White Health, Round Rock, TX. Leo Newhouse, MSW, Beth Israel Deaconess Medical Center, Boston, MA. Christopher Jones, MD HMDC FAAHPM, University of Pennsylvania Perelman School of Medicine, Philadelphia, PA. Laurel Kilpatrick, MD, Baylor Scott & White Health, Round Rock, TX.

Objectives

- Compare different examples of successful palliative care clinics in order to design a model suited to your practice setting.

- Describe essential aspects of operating a palliative care clinic including: a business plan, marketing strategy, opioid and prescribing policies, clinic workflow and staffing.
- Apply appropriate methods of billing & coding to maximize productivity.

As the benefits of early palliative care are increasingly recognized, expanding into the outpatient arena is a logical next step for many programs. However, palliative care remains far less prevalent in the ambulatory setting than in the hospital, and practice models vary widely (Hui et al., 2010). Drawing on the real-life challenges and successes of several programs that employ different models of care and operate in a variety of healthcare settings, this workshop will equip participants with the tools to build or expand a palliative care clinic practice. The workshop will focus on the core considerations needed to design, implement and expand a successful outpatient palliative care program. The models discussed will include academic & non-academic programs, and embedded, co-located & free-standing clinics. The first half of the workshop will use didactic and interactive teaching methods to review basic information for determining the optimal practice model and location of the clinic, engaging key stakeholders, the basics of creating the business proposition, anticipating staffing and productivity expectations (including utilizing a multidisciplinary team) and considerations for integrating into the broader healthcare system. The second half of the workshop will use a small group format and participants will rotate through 3 of 6 stations, which will offer a more in-depth discussion of staffing, clinic management principles (including referral management and creation of policies & procedures), measuring success, and managing clinic expansion. All participants will be provided with information for each of the stations, and by the end of the workshop will have an actionable resource toolkit to take back to their home institution. The final portion of the workshop will include a session on billing and coding, and facilitators from established outpatient palliative care programs will share their successes and challenges.

The Opioid Crisis and Palliative Care: Tools and Strategies to Help Turn the Tide (P12)



Kashelle Lockman, PharmD MA, University of Iowa College of Pharmacy, Iowa City, IA. Pina Patel, MD, Ohio State University Wexner Medical Center, Columbus, OH. Kathleen Broglio, DNP ACHPN ANP NP CHPN FPCN, Dartmouth Hitchcock Medical Center, Lebanon, NH. Justin Kullgren, PharmD, Ohio State University Wexner Medical Center, Columbus, OH.

Brook Calton, MD, University of California, San Francisco, San Francisco, CA.

Objectives

- Identify the potential impact of opioid use in Palliative Care on the opioid crisis.
- Evaluate a palliative care patient's risk for opioid misuse, abuse, and diversion.
- Develop an opioid stewardship proposal for ambulatory Palliative Care that incorporates four different components of opioid risk management.

Given the ongoing public health crisis of the opioid epidemic, clinicians encounter increased scrutiny when prescribing controlled substances. Palliative Care clinicians are squarely faced with the challenges of balancing patients' comfort and the greater societal concerns from the misuse, abuse, and diversion of opioids. This preconference workshop harnesses the expertise of clinicians from diverse settings and disciplines in Ambulatory Palliative Care to share their experiences in opioid risk assessment and management for palliative care patients receiving chronic opioid therapy. This high-yield, interactive workshop will provide interdisciplinary members of outpatient palliative care teams with practical tools to initiate or improve opioid risk management at their practice site.

Throughout this workshop, participants will learn about and apply opioid risk management tools to simulated patients, inspired by cases from the front-lines of daily outpatient palliative care practice. Risk factors for opioid misuse, abuse, and diversion will be discussed and participants will learn strategies to incorporate opioid risk tools into a busy clinical practice. Prescription drug monitoring programs and opioid treatment agreements will be reviewed as components of safe opioid prescribing. In addition, urine drug screening and naloxone coprescribing will be explored as elements of opioid stewardship. Participants will develop skills in choosing and interpreting urine drug screens as well as addressing unexpected results. A pragmatic protocol for coprescribing naloxone to appropriate patients will be introduced. A clinician from an experienced ambulatory Palliative Care team will discuss integration of these tools into a "Universal Precautions" approach for all patients prescribed opioids. Results of the first year of implementation will be shared, and challenges and opportunities of embedding this practice into a busy palliative care setting will be highlighted. The workshop will conclude with an interactive panel discussion of strategies to effectively manage pain in high-risk patients.

8:30 am-Noon

A Morning at the Museum: Using Art to Find Meaning and Enhance Teaching (P13)



Cosponsored by Boston Museum of Fine Arts.

Laura Morrison, MD, Yale University School of Medicine and New Haven Hospital. Gordon Wood, MD FAAHPM, Northwestern Memorial Hospital, Chicago, IL.

Objectives

- "See deeply" when examining a piece of art and describe how similar strategies could be used in hospice and palliative care clinical settings.
- Gain insight into an aspect of meaning from the participant's clinical work through a work of art.
- Describe how to use museum teaching strategies with hospice and palliative care trainees, learners in other disciplines, and practicing clinicians and team members in the participant's home setting.

AAHPM is excited to present this unique half-day preconference session at the Boston Museum of Fine Arts. The workshop will allow attendees to experience "museum teaching" through a collaboration between the museum's educators and palliative medicine faculty who are pioneering the use of museum teaching in hospice and palliative care at institutions across the country. Museum teaching encompasses a variety of strategies in which medical and museum educators take their learners to museums and use art to impart lessons around observation and reflection. This teaching has been studied with many audiences, including medical students, residents and faculty as well as nurses and interprofessional groups. Well-designed trials show a variety of positive outcomes including improved observation skills, empathy and awareness of multiple perspectives.

This preconference workshop has two aims. First, attendees will experience museum teaching in order to improve their own observational skills and connect to meaning in their practice. Second, attendees will learn how they can use these methods to run similar sessions for learners and colleagues in their home setting. Only 50 spots are available and registration includes the price of admission, transportation to the museum, a light breakfast and a snack, as well as time to enjoy the art and share this unique experience with colleagues.

1:15–5 pm

AAHPM & HPNA Preconference Workshops

Jump Starting Culture Change—Engaging Students, Trainees, and Clinicians in a Transdisciplinary Approach (P14)



Toluwalase (Laśé) Ajayi, MD, University of California, San Diego, San Diego, CA. Emmie Gardner, MSW LCSW, Intermountain Healthcare, Salt Lake City, UT. Dominic Moore, MD FAAP, University of Utah and Primary Children's Hospital, Salt Lake City, UT. Jennifer Reidy, MD FAAHPM, University of Massachusetts Medical School, Worcester, MA. Alicia Wierenga, MSN NP, University of Massachusetts Medical School, Worcester, MA.

Objectives

- Identify ways that transdisciplinary learner education leads to institutional cultural change.
- Integrate generalist palliative care principles into curricula for learners of different disciplines at different levels of training.
- Create a process for evaluating educational efforts and measuring institutional change.

The subspecialty consultation represents a powerful educational opportunity for referring teams, including learners of all disciplines. Increasing attention to palliative care education has created major opportunities for improving education about the principles of hospice and palliative medicine. Optimizing these educational efforts can lead to successful institutional culture change, ingraining palliative medicine as an institutional norm as well as cultivating generalist palliative medicine principles. This faculty development half-day session will start with an overview of how teaching students and residents from different disciplines establishes and spreads palliative care principles within different institutions. Then, the presenters will focus on how to integrate generalist palliative medicine principles into the learners' curricula. This part of the session will hone in on the different types of cultural change that can be brought about with educational pursuits, and how to map said pursuits into the learner's educational blue print. Participants will leave this session with concrete tools for starting and expanding their educational programs for student and resident trainees. They will also leave with a general knowledge of how to evaluate the effect of their educational efforts.

**AAHPM Leadership Forum:
*Ignite—Utilizing DISC Behavioral Styles to Increase Leadership and Team Effectiveness in Palliative Care and Hospice Settings (P15)***



Lisa A. Bouchard Data Dome, Inc., Atlanta, GA.

Objectives

- Understanding the DISC Methodology—Recognizing your strengths and limitations as a leader.
- Understanding Your Team—How to best manage, motivate, and communicate with them.
- Understanding Your Patients (and Family)—Raising awareness of their needs, concerns, and how to make better decisions together.

Palliative care and hospice settings can be filled with stress, change, and tension. What separates the best organizations from the struggling are strong leaders that focus on building highly productive teams. This half-day session will focus on utilizing the DISC Behavioral Styles methodology to take your leadership skills and team to the next level. Awareness of behavioral styles directly impacts trust, collaboration, and engagement. Participants will complete a personalized DISC profile, which will help to determine how to best leverage their style to build the most effective team. They will also learn how to adapt their communication to the specific style needs of both team members and patients, leading to stronger relationships, better decisions, and unprecedented results.

Managing Pain in the Face of Substance Misuse: Practical Approaches and Tools in the Palliative Care and Hospice Settings (P16)



Bridget Scullion, PharmD BCOP, Dana-Farber Cancer Institute, Boston, MA. Benjamin Kematick, PharmD, Dana-Farber Cancer Institute, Boston, MA. Daniel Gorman, NP, Dana-Farber Cancer Institute, Boston, MA. Douglas Brandoff, MD, Dana-Farber Cancer Institute and Brigham Women's Hospital, Boston, MA. Kathy Selvaggi, MD, Butler Memorial Health System, Butler, PA. Michele Matthews, PharmD CPE BCACP, MCPHS University and Brigham and Women's Hospital, Boston, MA. Larissa Lucas, MD, Care Dimensions, Danvers, MA. Amanda Moment, LCSW, Dana-Farber Cancer Institute and Brigham Women's Hospital, Boston, MA.

Objectives

- Identify strategies for assessing patients to determine the potential use of opioids in the manage-

ment of pain in the palliative care patient with a history of or active substance use disorder.

- Create a best practice approach utilizing available tools to minimize the risk to both the patient and the clinician when treating patients with substance use disorder with opioids.
- Discuss patient case examples to illustrate challenges including clinician distress in the care of this patient population.

The pendulum is swinging again but where should it land? The use of opioids for the treatment of pain has been endorsed and renounced countless times over centuries. What is the role of opioid-containing pain medications in the palliative care setting? Where does the palliative care end and chronic pain due to serious illness begin? How can we apply lessons learned in the chronic pain setting to address the management of patients with a history of, or current, substance use disorder in the setting of advanced illnesses such as cancer? How and when do we set a new course of therapy for patients who have been treated with high doses of opioids in the long-term palliative care or hospice setting? These questions and more have been postulated and many of us are faced with treating patients who present as high risk for development of substance use disorder including those with a history of substance misuse or ongoing misuse and abuse. This session is designed to build the participants' knowledge and comfort with managing these patients using evidence-based established tools and best practices as outlined through patient cases. In this interactive workshop, participants will review current best practices including opioid risk tools, including integration of PDMP review into clinical care, use of medication management agreements, when to incorporate urine toxicology screening, provision of naloxone for patients deemed high risk for overdose, management of patients who present to palliative care or hospice on methadone maintenance or suboxone therapy. We will look to participants to share their experiences and strategies they have utilized.

***Overcoming Barriers to Better Billing:
Maximizing Revenue to Sustain and Grow
Your Palliative Care Program (P17)***

Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI. Christopher Jones, MD HMDC FAAHPM, Perelman SOM at the University of Pennsylvania, Philadelphia, PA. Charles von Gunten, MD



FACP FAAHPM, OhioHealth, Columbus, OH. Jean Acevedo, LHRM CPC CHC CENTC, Acevedo Consulting Inc., Delray Beach, FL.

Objectives

- Describe the expanding array of professional fee billing codes available to palliative care providers across inpatient, outpatient, facility and home settings.
- Identify opportunities to align billing and coding practices with clinical workflow, including complexity- vs time-based billing, using multiple complementary codes for specific encounters and leveraging interdisciplinary team members to optimize coding.
- Develop specific strategies to maximize code use and billing revenue to your practice.

Professional fee billing revenue is essential to sustain and grow interdisciplinary palliative care teams. While often perceived as burdensome and peripheral to patient care, billing and coding practices—when optimized—can help expand your team's ability to provide high-quality care to the patients and caregivers you serve. Ineffective billing and coding can limit growth, and even threaten your team's viability.

This interactive, half-day workshop is designed for palliative care teams practicing outside of the hospice benefit. It will focus on maximizing billing revenue using a steadily expanding set of CPT[®] codes available through the Medicare Physician Fee Schedule. These new codes describe services frequently provided by palliative care teams, including advance care planning, chronic care management, complex chronic care management, transitional care management and prolonged non face-to-face services, among others. The workshop will also take a deep dive into Evaluation and Management (E/M) coding techniques relevant to palliative care teams, emphasizing complexity- vs. time-based billing, use of multiple codes to describe complex patient encounters, documentation requirements, minimizing clinician burden, and capturing interdisciplinary team member work where possible.

Participants will engage with expert physician and billing professional faculty throughout the workshop, through both information sharing and case-based learning. Content will be tailored to participant needs and stress relevance across practice settings. At the end of the workshop, participants will be better prepared to develop or refine their approach to billing and coding—and to

survive and thrive in a changing reimbursement landscape.

Caging the Beast: Wrestling with Difficult Pain Syndromes in Serious Illness (P18)



Mary Lynn McPherson, PharmD MA MDE BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA. Paul A. Sloan, MD, University of Kentucky, Louisville, KY.

Objectives

- Describe the clinical presentation and management of opioid-induced hyperalgesia.
- Describe best practices for managing pain in patients with impaired liver, reduced renal function, or both.
- Assess and treat pain in nonverbal critically ill patients.
- Manage pain in patients with serious comorbid issues such as sleep-disordered breathing, dialysis, or previous drug/alcohol abuse.
- Discuss the potential benefits of combining different opioids to achieve enhanced analgesia.

The majority of pain associated with serious illness can be adequately managed with usual and customary therapies including non-pharmacologic interventions, non-opioids, opioids, and co-analgesics. Occasionally practitioners encounter patients with special circumstances or comorbid conditions that make it difficult to control pain. This case-based, evidence-based presentation will take the learner on a journey that addresses difficult poorly-responsive opioid pain, complicated neuropathic pain, opioid-induced hyperalgesia, and pain management in renal/hepatic impairment. Additional examples include pain in patients with sleep-disordered breathing, nonverbal patients receiving intensive care, and the management of pain in highly opioid/alcohol-tolerant patients. The faculty will also briefly discuss the implications of research questioning the utility of using two different opioids simultaneously to maximize pain relief. Palliative care practitioners in the trenches need this presentation to get the tough job done!

Navigating Your Specialty Palliative APRN Career (P19)



Anessa M. Foxwell, MSN CRNP AGACNP-BC ACHPN, Hospital of the University of Pennsylvania, Philadelphia, PA. Barbara Reville, DNP ANP-BC ACHPN, Dana-Farber Cancer Institute, Boston, MA. Margaret Root, MSN RN CPNP-AC CHPPN, University of

California, San Francisco and Benioff Children's Hospital, San Francisco, CA. Laura Tycon, MSN RN FNP-BC, University of Pittsburgh Medical Center, Pittsburgh, PA.

Objectives

- Review the scope of the current Palliative Advance Practice Registered Nurse (APRN) workforce and list available options for education and training in specialty practice.
- Introduce the HPNA Professional Practice Guide as a tool to aid in job seeking, contract negotiation, and necessary infrastructure supports.
- Integrate a plan for professional development as a Palliative APRN to optimize professional growth, commit to career sustainability, and contribute to others' professional growth.

Nurses enter our field from many avenues and experiences—we must ask ourselves how best to align our interests and leverage our experience. In this workshop, the Palliative Advance Practice Registered Nurse (APRN) in hospice and palliative care will explore the current state of the workforce, including gaps in training and professional support, and review best practices and expert opinions on how to approach barriers and ensure a sustainable professional practice. The APRN will gain insight into options for educational preparation, navigating a new or existing APRN role, contract negotiation, and committing to career-long professional development. Faculty will integrate the perspectives of nurse practitioners and clinical nurse specialists on the essential building blocks for a fulfilling career at any stage for the Palliative APRN. This presentation will be interactive for the participants, using video technology, small group discussion and case studies addressing career paths and prospects for Palliative APRNs in various setting, including practicing in the community and at academic medical centers.

We Built It...They All Came...Now How to Keep from Drowning? Pediatric Palliative Care Program Development 202: Skills in Your Toolbox for Growth and Sustainability (P20)



Tammy Kang, MD, Texas Children's Hospital, Houston, TX. Debra Lotstein, MD MPH FAAP, Children's Hospital Los Angeles, Los Angeles, CA. Lisa Humphrey, MD, Nationwide Children's Hospital, Columbus, OH. Jeffrey Klick, MD, Children's Healthcare of Atlanta, Atlanta, GA. Conrad

Williams, MD FAAP, Akron Children's Hospital, Charleston, SC.

Objectives

- List the components of both a hospital operating budget and a pediatric palliative care (PPC) program operating budget.
- Identify strategies for maximizing clinical revenue.
- Describe key factors important for pediatric palliative care program sustainability and growth.

In a 2012 survey, 69% of children's hospitals reported having a pediatric palliative care (PPC) program. Most of these programs offered inpatient consultation during the work week only, with a variable number of consults annually depending on hospital bed size and number of funded PPC staff. Most of these programs reported being highly dependent on hospital funding. In addition, there was wide variability in program staffing resources with the mean FTE of physicians at 0.45, social workers at 0.29 and chaplains at 0.16. More notably, 41% of programs reported having no physician support, 36.6% were without support from advance practice nurses, and 66% had no social work support.

The rate of new PPC programs being developed peaked in 2008. While the significant increase in the total number of PPC programs is worth celebrating, in reality many programs are under resourced thereby threatening the longevity of the program or its functionality. The next decade of PPC growth and development will require a focus not just on new program development, but on expanding and sustaining existing programs.

This session will focus on the second phase of palliative care program development: Now that your program has been formed, how do you sustain your program and grow to meet expanding clinical needs and academic demands?

In this workshop, specific issues related to PPC program sustainability and growth will be addressed including: 1) Finances: understanding hospital and program operating budgets; 2) Clinical revenue: identifying common billing and coding issues; 3) Leadership skills: building negotiation skills and managing conflict; 4) Program development strategies: maintaining relevance, and finding creative ways to use existing resources and philanthropy.

Oncologist in My Pocket: What the Hospice & Palliative Clinician Needs to Know About Hematology/Oncology (P21)

Kristina Newport, MD FAAHPM, Hospice & Community Care, Lancaster, PA. Shanthi Sivendran, MD,

PENN Medicine at Lancaster General Health, Lancaster, PA. Thomas LeBlanc, MD MA MHS FAAHPM, Duke University School of Medicine, Durham, NC. Sara Kim, PharmD BCOP, Mount Sinai Hospital, New York, NY. Joshua Jones, MD MA, University of Pennsylvania Health System, Philadelphia, PA.

Objectives

- Verbalize the need for increased knowledge of topics in Hematology/Oncology.
- Define and describe the language and assessment tools utilized by Hematologist/Oncologists.
- Describe available treatment and prognosis for advanced solid tumor malignancies with emphasis on emerging treatments such as immunotherapy and targeted treatments.


Hospice and palliative care (HPC) clinicians are increasingly called upon to care for patients receiving active treatment for hematologic or oncologic malignancies due to growing evidence that early palliative care improves survival, symptoms, mood, cost, and patient satisfaction. To ensure the success of upstream HPC involvement, it is imperative HPC clinicians competently care for the patients in question and "speak the language" of the hematologist/oncologist. Current HPC training and certification does not guarantee competency in these areas. In fact, HPC clinicians may not have had any direct exposure to hematology/oncology care before entering the field while at the same time, care of patients with hematologic or oncologic malignancies is increasingly complex. Novel therapies emerge rapidly with mechanisms and side effects that differ from traditional chemotherapy and allow for treatment of patients with more limited performance status. This workshop will ensure HPC clinicians are equipped with the essentials needed to approach the care of these patients, including; terminology, treatment options, prognostic uncertainty, targeted therapies, hematology/oncology emergencies, financial toxicity, radiation therapy, hospice coverage of cancer care, caregiver support, expected side effects of treatments and navigating relationships with hematologists/oncologists.

The workshop will target attendees' specific needs and questions, with real-time adjustment of the curriculum to fulfill their goals and provide appropriate resources. This second generation workshop builds on the well-attended 2017 session with improvements based on participant feedback. Upon completion of this workshop, HPC clinicians will have the clinical tools necessary to develop an approach to the care of patients with hematologic or oncologic malignancies along the continuum of cancer care.

Thursday, March 15

7–8 am

Concurrent Sessions


A Trial of Early Palliative Care for Serious Illness: Results from the LifeCourse Lay Health Care Worker Intervention (TH300) 

Eric Anderson, MD, Allina Health, Minneapolis, MN. Anne Betzner, PhD, Allina Health, Minneapolis, MN. Paige Bingham, MBA, Allina Health, Minneapolis, MN. Jessica Taghon Allina Health, Minneapolis, MN.

Objectives

- Understand how a trained lay health worker can uniquely address the needs of individuals in late life.
- Describe the effect of the intervention on two patient-reported outcomes and on total cost of care.
- Name two key steps for integrating novel palliative interventions into a clinical practice setting.

Patients and caregivers facing serious chronic illness in late life struggle to navigate the currently fragmented healthcare system. Services such as home care, palliative care, and hospice offer critical, person-centered support, but are underutilized and often only offered during certain episodes of late life care. LifeCourse is a cost-effective, whole person approach that integrates monthly home visits with a community healthcare worker, called a care guide, throughout the last 2-3 years of life. Home visits cover domains laid out in best practice palliative care guidelines and include spiritual, emotional, physical and legal/financial. Care guides use question sets and standardized assessments to help patients articulate what matters most to them. Patients and families are also connected to needed medical and community resources. Results from a quasi-experimental cohort research study have shown that patients participating in LifeCourse report better care experiences and have less decline in quality of life. Hospice length of stay was increased and patients had fewer hospital inpatient days and fewer ICU stays when compared to those receiving usual care. This lowered utilization contributed to healthcare cost savings and resulted in an 8:1 return on investment. Based on these results, LifeCourse is successfully implemented in a large Midwestern healthcare system, in specialty, primary care, and hospital based clinics, as well as in care management. LifeCourse is also currently implemented in a federally qualified healthcare home.

Harnessing the Power of Telemedicine in Palliative Care from Childhood to Adulthood: The Why and How (TH301) 

Toluwalase Ajayi, MD, Scripps Health and Rady Children's Hospital, San Diego, CA. Ami Doshi, MD, Rady Children's Hospital, San Diego, CA. Rachel Thienprayoon, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Kimberly Bower, MD HMDM FAAHPM, Rady Children's Hospital, San Diego, CA. Michelle Tate, RN BSN, Cincinnati Children's Hospital Medical C, Cincinnati, OH. Robin Short, RN BSN, Rady Children's Hospital, San Diego, CA.

Objectives

- Explain the rationale for incorporating telemedicine into the care of palliative care patients and its associated benefits.
- Describe common challenges, proven strategies, and best practice recommendations for successful and sustainable integration of a telemedicine program into palliative medicine programs.
- Appreciate the ease of telemedicine and discuss patient-centered benefits of implementing telemedicine into palliative care practice.

Although Pediatric Palliative Care (PC) Programs are increasing in number across the country, “deserts” still exist in which access to PC interdisciplinary teams is challenged. Many families elect home-based PC, and the expectation of travel to a clinic or hospital for appointments is not universally appropriate, practical or patient-centered. Many children who receive PC are medically fragile and dependent on technology. Transporting these patients can increase stress, adversely impact quality of life, and increase caregiver burden and the risk of infectious exposure. The result is poor adherence with follow-up and, at times, delays in seeking care during acute illness.

In this presentation we will propose a concise, evidence-based, and patient-tailored approach to overcoming these obstacles through the utilization of telemedicine (TM) encounters. Common challenges in the development and implementation of PC TM programs will be shared. Two pediatric institutions will compare and contrast the evolution of their TM programs, describe strategies employed to overcome challenges, and share outcomes. Through a case-based approach we will address billing, technological aspects, privacy and security of data, team engagement and program sustainability. We will demonstrate the ease of a TM encounter live during the session, and explore the perspective of a young adult PC patient in how TM has enhanced his care. A panel discussion will focus on successful and collaborative solutions to optimize care for children at home through TM and invite questions, success stories and challenges in the

use of TM from attendees. Audience members will gain insight and appreciation for how TM can broaden and improve patient care, and will obtain concrete ideas for overcoming challenges in developing PC TM programs in their home institutions.

Fetal Positions—Empowering the Role of Palliative Care in Maternal-Fetal Treatment Centers (TH302) 

Christopher Collura, MD, Mayo Clinic, Rochester, MN.

Objectives

- Appraise the role of the palliative care provider in maternal-fetal treatment centers.
- Review common life-threatening fetal congenital anomalies that may benefit from maternal-fetal intervention.
- Formulate an operational plan to integrate palliative care services into fetal care centers.

Prominent developments in maternal-fetal intervention have prompted the growth of regional fetal care centers. This growth has increased access to fetal surgery and has introduced a new framework in decision-making for parents: while considering the anticipated likelihood of death or disability posed by the underlying fetal anomaly on the future child, does the proposed benefit of invasive prenatal intervention outweigh maternal-fetal risks? The paradigm is fraught with psychosocial challenges and requires judicious facilitation of goals of care.


Regardless of prenatal surgical intervention, the severity of many fetal conditions is life-threatening. The fetal treatment consultation becomes ground zero in an arduous clinical course for families. The need for comprehensive perinatal palliative care services is ever-present. Directives from obstetric and pediatric professional organizations outline family-centered options for palliative care in the case of many congenital illnesses, but the role of palliative care specialists remains ill-defined.

This session will empower palliative care providers to establish the need for enhanced integration in fetal care centers. It will provide a review of fetal disease including congenital diaphragmatic hernia and critical congenital heart disease that may be treated through maternal-fetal intervention. Seminal trials of antenatal surgical intervention and the state of the science of fetal surgery will be described. Ethical challenges in the risk-benefit calculus of maternal-fetal treatment and shared decision-making will be considered.

The session will propose operational strategies for perinatal palliative care to partner with multi- and interdisciplinary providers across maternal-fetal medicine, neonatology, surgery, nursing, and social work.

This will include recommendations for timing the palliative care consult and best practices for individualized case review to ensure optimal value-driven care recommendations.

The progress in maternal-fetal intervention presents unprecedented advances in the care of babies with congenital disease. Palliative care should be central in the family-centered care delivery dynamics.

Should I Unplug the Phones Again: Understanding Government Hospice Audits and “Pre-Tecting” Your Organization Through Robust Provider Documentation (TH303) 

Patrick White, MD HMDC FACP FAAHPM, Washington University School of Medicine, St Louis, MO. Howard Young, JD, Morgan, Lewis & Bockius LLP, Washington, DC. Amy Jacobs, BSN RN CHPN, BJC Healthcare, St Louis, MO. Christopher Jones, MD HMDC FAAHPM, Perelman SOM at the University of Pennsylvania, Philadelphia, PA.

Objectives

- Describe 3 common legal avenues federal and state investigators and Medicare contractors use to target hospice organizations.
- Discuss commonly encountered barriers to adequate nursing documentation in hospice care.
- Demonstrate 4 evidence-based tools useful for supporting prognosis in patients near the end of life.

Since the inception of the Medicare Hospice Benefit, hospice has grown to serve over 1.6 million people per year at an annual cost of over \$15.8 billion dollars. This high price tag has led to increased scrutiny by federal and state regulators over the past decade. Documentation by bedside and interdisciplinary team clinicians represents the vast majority of data in these inquiries. Unfortunately, nurses, nurse practitioners, and physicians have been trained to document clinically relevant information without always understanding the impact that this documentation will have during payer audits sometimes years later.

How can hospice clinicians further not only their clinical information needs but also protect the organization should an audit occur in the future? In this concurrent session, a healthcare law attorney with 25 years of healthcare and hospice experience will partner with a hospice's nurse manager and 2 HPM physicians who have reviewed hundreds of thousands of pages of hospice records under government audit to share strategies to support effective documentation of eligibility. The False Claims Act and hospice-focused program integrity initiatives will be examined and the role of recovery audit contractors (RAC) and zone program integrity contractors (ZPIC) will be

presented. Our nursing leader will address barriers to effective nursing documentation, which constitutes the vast majority of clinical information, including difficulties with technical Local Coverage Determinations, struggles around complex prognostication, and limitations inherent to hospice electronic medical record systems. During the second half of the interdisciplinary presentation, the physician team will present 4 evidence-based tools and articles that cut across disease states that will inform prognostic abilities of physicians completing Certification of Terminal Illness (CTI) documentation and support their prognostic claims. They will use examples from real cases showing well- and poorly written face-to-face and CTI notes, reworking those with opportunities for improvement using the presented tools to reinforce audience learning.

Counting Sheep: A Rational Approach to Managing Insomnia (TH305)



Jennifer Pruskowski, PharmD BCPS CGP CPE, University of Pittsburgh School of Pharmacy, Pittsburgh, PA. Alycia Dalbey, PA, University of Pittsburgh Medical Center, Pittsburgh, PA. Eric Prommer, MD HMDC FAAHPM, University of California, Los Angeles and VA HPM Program, Los Angeles, CA. Neal Weisbrod, MD, University of California, Los Angeles and VA, Los Angeles, CA.

Objectives

- Review the associated factors and necessary diagnostic factors for insomnia.
- Compare nonpharmacological interventions with pharmacological agents for insomnia.
- Design rational therapeutic plans for patients suffering from insomnia.

Insomnia is defined as the subjective perception of difficulty with sleep initiation, duration, consolidation, and/or quality of sleep that occurs despite adequate opportunity for sleep. Insomnia correlates with patient satisfaction and with quality of life and is underreported. It causes patients discomfort and suffering, and leads to increased fatigue, pain intolerance, irritability and depressive mood, psychological distress and daytime impairment. The general pathophysiology of primary insomnia centers on hyperarousal during sleep. Research shows that multiple neurotransmitters and cytokines influence wakefulness and represent appealing pharmacotherapeutic targets. The primary goal of insomnia treatment should be first to look for and relieve any underlying disorder leading to sleep disturbance. This requires multimodal treatment, including both pharmacologic and non-pharmacologic therapies. Nonpharmacologic therapies consist of combining attention to sleep hygiene and cognitive-behavioral therapy. Pharmacologic

treatments consist of an ever growing array of approved and off label therapies. Approved therapies include benzodiazepine agonists, benzodiazepines, melatonin receptor agonists, tricyclic agents, and orexin receptor antagonists. Off-label therapies include antidepressants, antipsychotics, antiepileptic analgesics, and herbal products. Each of these agents benefit patients at various points of the sleep cycle and their appropriate use helps to tailor drug management for each patient. Understanding drug pharmacokinetics helps to tailor drug management to the type of sleep disturbance such as sleep latency or sleep maintenance. This multidisciplinary session consisting of palliative care specialists and clinical pharmacists will enable attendees to: 1.) Understand the pathophysiology of insomnia and how to take a sleep history. 2.) Learn how to systematically look for reversible causes of insomnia. 3.) Understand the pharmacology of drugs available to treat insomnia and where they work in the sleep cycle. 4.) Develop pharmacologic treatment plans for treating insomnia in the ICU, patients with dementia, mood disorders and neurodegenerative disorders.

Five Steps to Build an Effective Payer-Provider Partnership for Innovative Palliative Care Models (TH306)



Jatin Dave, MD MPH, New England Quality Care Alliance, Watertown, MA. Parag Bharadwaj, MD FAAHPM, Sentara Healthcare, Norfolk, VA. Tom Gualtieri-Reed, MBA BA, Spragens & Associates LLC, Chapel Hill, NC. Dana Lustbader, MD, ProHEALTH, New York, NY. Bruce Smith, MD MACP, Cambia Health Solutions, Seattle, WA.

Objectives

- Describe the value of Palliative Care from the payer and provider perspective to achieve quadruple aim.
 - Discuss how palliative care can help achieve the Quadruple Aim.
 - Describe actions payers are taking to integrate palliative care into payment models, care management programs, and benefits.
 - List five steps to build effective payer-provider partnerships to support those with serious illness.
- Recent changes in the health care environment with shifting and shared risk have created unique opportunities for payers and palliative care providers to partner in the care of the most medically complex individuals. There is an increasing focus on the quadruple aim: better care, better health, lower costs and improving the work-life of those who deliver care. Considering the added value of palliative care and challenges in adequate volume-based reimbursement for palliative care, such payer-provider

partnerships are essential for creating sustainable models of palliative care across settings.

Through success stories, data, case examples, and group discussion, this session will focus on five steps palliative care can take to build effective payer-provider partnership to support the quadruple aim. Our speakers will describe how effective palliative care provider-payer partnerships can be created in variety of settings including home, hospital, and a provider group–led Accountable Care Organization.

The first step is to compare mutual priorities and needs from the provider and payer perspective, so the presenters will share strategies to align priorities to create innovative partnerships. The second step is to consider a pilot for payer-provider partnership that can help support palliative care across the continuum. Presenters will provide details of different types of models across the care continuum, including chronic care of the medically complex and palliative care and hospice models. The third step is to implement the program and measure outcomes. The fourth step is to identify barriers in building effective payer-provider partnerships and practical strategies to overcome those barriers. The final step is to scale the program and consider next steps including alignment of incentives and leadership.

The materials presented will be brainstormed in small and large group discussions facilitated by the session's faculty. Participants will have time to develop and work on plans for their own organizations.

Neurology 101: Wrapping a Palliative Head Around Neurologic Disease (TH307)

Matthew Mendlik, MD PhD, University of Pennsylvania Health System, Philadelphia, PA. Jessica McFarlin, MD, University of Kentucky, Lexington, KY. Vickie Leff, MSW LCSW BCD, Duke University Hospital, Durham, NC.

Objectives

- Discuss the expected prognosis of patients with three different types of neurologic illness.
- Select appropriate therapy for three symptoms that are unique to patients with neurologic illness.
- Identify causes of caregiver distress associated with advanced or terminal neurologic conditions and describe two strategies to minimize distress.

What is it about neurologic disease that can be uniquely terrifying? What fears about neurologic disease are unwarranted and can be addressed early in the course of illness? How can symptom management and support of caregivers lead to better quality of life for families affected by these illnesses?

Understanding and coping with neurologic disease can be daunting for those afflicted, their caregivers,

and even their medical team. Disease rarity and the unpredictability of both illness evolution and response to therapies can cause significant distress to caregivers. Many Palliative Care (PC) practitioners and hospice providers have little experience with conditions like amyotrophic lateral sclerosis, movement disorders such as Huntington's Disease or Parkinson's-like illnesses, and rapidly progressive dementias. This is due to both rarity of disease entities and low rates of referral to PC and hospice. This lack of experience can increase distress for providers and staff who find themselves caring for patients with these illnesses during times of complex decision-making or significant symptom burden.

This concurrent session will highlight areas of opportunity identified by neurologists trained in PC to expand knowledge about neurologic illness, improve symptom management, and approach extreme distress among patients with neurologic disease and their caregivers. We will address fundamental properties that can make discussing neurologic disease diagnosis and progression with patients and families uniquely challenging. An exploration of treatment options and available data will help clarify misconceptions about symptom management and end-of-life experience in well-known but rare neurologic diseases. Examples of challenging discussions will illustrate opportunities for improved communication with patients and caregivers.

Two neurologists who practice PC and hospice medicine full-time, as well as a social worker with much experience supporting families with neurologic disease will lead this case-driven discussion.

Paper Session (TH308)

Improving End-of-Life Quality Through the Implementation and Testing of a Ketamine Protocol for Reduction of Depression and Pain (TH308A)

Kimberly Shea, PhD RN CHPN, University of Arizona, Tucson, AZ. Janice Pucko, MS RN CNL, Casa de la Luz Hospice, Tucson, AZ. Melissa Koon, MSN NP APRN FNP-BC, Casa de la Luz Hospice, Tucson, AZ. Joseph Solien, PharmD BCPP BCGP, OnePoint Patient Care Pharmacy, Tempe, AZ. Rebecca J. Powell, MD ABIM, Casa de la Luz Hospice, Tucson, AZ. Nancy E. Henning, BSN RN CHPN, Casa de la Luz/University of Arizona, Tucson, AZ.

Objectives

- Utilize existing clinical and scientific knowledge to substantiate the use of ketamine for depression and pain.
- Describe pharmacological actions of ketamine.

- Discuss the stepwise approach to using a protocol for safe and effective ketamine administration.

Background. Pain management is the cornerstone of hospice care. However, many patients lack optimal pain control. One reason is likely the co-occurrence of depression. Depression is estimated to affect up to 85% of patients that experience pain. Due to the delayed onset and lack of efficacy of standard antidepressants, depression in hospice is not well palliated. A host of research suggests ketamine as a promising solution in rapidly reducing symptoms of both pain and depression. However, the transient benefits, the need for repeated IV access and concerns for adverse effects are perceived barriers in the utilization of ketamine.

The purpose of this quality improvement project was to explore the safety and efficacy of implementing an administration protocol for oral ketamine when used for pain and/or depression at end of life.

Method. An interdisciplinary team of Hospice Medical Director, Nurse Practitioner, Nurse Case Manager, Social Worker and Pharmacist collaborated to develop a protocol to standardize safe administration and titration of oral ketamine. A convenience sample of 10 patient/caregivers experiencing depression and/or pain unresponsive to usual management were educated about, offered and consented to use of oral ketamine. Team members managed and evaluated protocol implementation.

Results. Seven patients experienced a decrease in pain, depression or both. Two patients did not experience any effects, even with careful longitudinal titration. One patient immediately experienced restlessness. Ketamine was only effective for pain/depression associated with COPD or Cancer. Effects were rapid (within 3 days) or nonexistent.

Conclusion. Preliminary results support safe, effective use of ketamine for depression and/or pain when administered according to a well-designed protocol. Fully powered studies are needed.

Implications for practice. The use of ketamine may quickly reduce the anguish of depression and/or pain that can impede communication between loved ones resulting in poor quality of life during end of life.

Examining the Prevalence of Cancer Related Distress Among a Group of Urban-Dwelling Veterans (TH308B)



Joanna Martin, MD, Jesse Brown VA Medical Center, Chicago, IL. Desiree Azizoddin, PsyD, Jesse Brown VA Medical Center, Chicago, IL. Joshua Hauser, MD,

Northwestern University and Jesse Brown VA Medical Center, Chicago, IL. Lauren Rynar, MS, Jesse Brown VA Medical Center, Chicago, IL. Susan Payvar, PhD, Department of Veterans Affairs, Chicago, IL. Hidayatullah Munshi, MD, Northwestern University Feinberg School, Chicago, IL. Robert Molokie University of Illinois at Chicago and Jesse Brown VA Medical Center, Chicago, IL.

Objectives

- Identify factors contributing to distress in a patient population of Veterans receiving oncologic care.
- Discuss identification and intervention of veterans that are at high risk of having unmet needs and significant distress.

Background. The National Comprehensive Cancer Network and American College of Surgeons Commissions on Cancer requires cancer centers to evaluate psychosocial distress and provide appropriate triage and treatment for all patients (Standard 3.2).

Aim Statement. In an attempt to provide standardized care, a needs-based screening tool was implemented within a VA oncology clinic. Prevalence of biopsychosocial concerns among patients was examined.

Methods. Participants completed the “Patient Screening Questions for Supportive Care” by The Coleman Foundation (n=51). The majority of patients were men (87%), mean age 70 (SD=9.45), primarily African American (71.4%) presenting with cancer of the lung (16%), prostate (14%), Pancreas (11%), Multiple Myeloma (11%), and others. Positive, elevated scores resulted in clinical follow-up by both a palliative care physician and psychologist. Descriptive statistics and multiple regressions were completed to assess prevalence and potential predictors of psychosocial concerns.

Results. The mean psychological distress score was 6.4 (SD=3.45), indicating moderate distress, with 14% of patients reporting moderately severe distress (n=7, score>10). Age, diagnosis, stage of disease, and race were not significant predictors of symptoms of depression, respectively (b=0.014, 0.134, 0.742, 0.294, p>.05). The majority of patients indicated a desire to learn more about their diagnosis (66%), their treatment (54%) and how to communicate wishes relating to treatment (43%). Participants endorsed the following physical symptoms most frequently: Dry mouth (30%), dry skin (30%), tingling in extremities (29%), diarrhea (27%), swollen arms/legs (23%), and sexual intimacy (23%). Patients endorsed concerns for nutrition (30%) specifically for weight loss and lack of appetite (34%), and pain with 36% being in pain currently and 33% reporting moderate to severe

pain at its worst. Additionally, 37% experienced significant fatigue, and notable difficulty with activities of daily living.

Conclusions and Implications. Veterans receiving oncological care reported significant cancer-related physical and emotional distress and unmet needs, potentially irrespective of demographic factors. Utilizing a screening tool and integrating Palliative Care and Psychology into VA oncology clinics may improve coordination of clinical services and enhance patient-centered supportive oncology care.

A Quality Improvement Project to Reduce Substance Misuse-Associated Discharges in an Outpatient Palliative Care Clinic: Establishment of the Interdisciplinary High Alert Risk Team (HART) (TH308C)



Diane Portman, MD FAAHPM, H. Lee Moffitt Cancer Center, Tampa, FL. Ritika Oberoi-Jassal, MD HMDC, H. Lee Moffitt Cancer Center, Tampa, FL. Kathryn Loufman, RN, H. Lee Moffitt Cancer Center, Tampa, FL. Joshua Smith, MD, H. Lee Moffitt Cancer Center, Tampa, FL. Lucy Akins, RN, H. Lee Moffitt Cancer Center, Tampa, FL. Sarah Thirlwell, MSc MSc(A) RN CHPN AOCNS, Moffitt Cancer Center, Tampa, FL.

Objectives

- Specify the challenges of outpatient clinic care for patients who engage in or are at risk for substance misuse.
- Define an interdisciplinary approach to optimize support and retention of clinic patients and providers when controlled substances are prescribed and misused.

Background. Illicit substance abuse and controlled medication misuse are common in medical practice, jeopardize patient safety and may negatively impact providers. Inflexible low-tolerance policies regarding substance misuse may adversely affect anticancer care, particularly for patients with a high symptom burden. From 2014-2016, 19.9% of Moffitt Cancer Center Palliative Care (PC) clinic patients were non-compliant with controlled medication policy and 47 (4.6%) were discharged from 2015-2016. Clinic personnel were dissatisfied with clinic processes for support of patients and providers in the setting of substance misuse.

Aim Statement. Reduce substance misuse-related clinic discharges and associated clinician dissatisfaction.

Methods. In 2016 an interdisciplinary workgroup was convened to identify challenges, barriers and inconsistencies in provider, patient and process characteristics of substance misuse-related clinic discharges. Gap analysis pinpointed opportunities for improvement. The High Alert Risk Team (HART) was established to

support patients at risk for aberrant behaviors and their clinicians. Roles include patient education by nursing, safety-oriented prescribing arrangements with physicians, patient relations representation to advocate and set expectations and social worker counseling and support.

HART policy, user-friendly controlled substance agreements, patient screening, compliance monitoring, patient and provider support, and documentation were developed and implemented. Discharges compared to patient volumes were tracked and provider satisfaction with the quality improvement project was surveyed.

Results. A total of 1,621 outpatients have been seen in the PC clinic from 2015-2017. Substance-related PC clinic discharges have decreased overall from 25 (6.53%) in 2015 to 9 (1.48%) through July, 2017. Discharge rates still vary among clinicians. All clinic survey respondents (n=9) affirmed that care of patients with high risk behaviors and support of personnel have improved since HART implementation.

Conclusions and Implications. A team-based quality improvement approach successfully reduced outpatient PC clinic substance misuse-related discharges and increased team satisfaction. Provider and patient characteristics likely account for variation in discharge rates among specialists and will be further explored.

Reasons for Cancellation and No-Show in an Outpatient Palliative Care Clinic (TH308D)



Lauren Marcewicz, MD, Atlanta Veterans Affairs Medical Center, Atlanta, GA. Tina Sylve, RN. William Roush, APRN-BC, Atlanta Veterans Affairs Medical Center, Atlanta, GA. Margaret Riley, MN RN FNP-C, Atlanta Veterans Affairs Medical Center, Atlanta, GA.

Objectives

- Identify 3 reasons why palliative care patients may have difficulty accessing outpatient palliative care.
- Distinguish between potentially modifiable and unmodifiable factors influencing patient ability to access outpatient palliative care.

Background. The Atlanta VA Medical Center (VAMC) has a robust outpatient palliative care program that conducts approximately 250 new consults per year. However, approximately 25% of our patients no-show to or cancel appointments the same day. Palliative care patients are often sicker than a general outpatient population, and may have unique barriers to accessing outpatient palliative care.

Aim Statement. We aimed to collect information on all patients who missed or cancelled within 2 days of their appointments to gain better understanding of barriers to accessing outpatient palliative care and identify areas where interventions might improve access.

Methods. Patients who cancelled within 2 days prior to their appointment or who no-showed were called and asked their reasons for cancellation or no-show. Patient answers to this question were recorded on a tracking questionnaire as one or more of 14 possible reasons.

Results. From March–June 2017, 183 patients either cancelled or no-showed to appointments; reasons were collected on 37.2% (n=68). The most common reason (39.7%, n=27) for cancellation or no-show was that patients were too ill to come to their appointment, with 74% (n=20) of these being admitted to the hospital. Transportation difficulties (23.5%, n=16) and issues with either appointment times or coordinating with other appointments (22.0%, n=15) were other main reasons. Nine patients (13.2%) either did not understand why they were referred to palliative care or were not interested in a palliative care appointment.

Conclusions and Implications. Acute illness was one of the most common reported barriers to accessing outpatient palliative care. Since palliative care patients often have chronic illness, this may be unmodifiable. However, patients also struggle with logistical issues, such as getting to appointments and coordinating care with other services. These are potentially modifiable barriers, and interventions to improve access to care at the Atlanta VAMC should focus on these issues.

8:15–10 am

Plenary Session

Good Enough Now: How Doing the Best We Can with What We Have Is Better than Nothing (101)



Jessica Pettitt, MEd CPS, Eureka, CA.

Objectives

- Learn a 3 part framework or model for taking responsibility for how they show up.
- Develop skills for a significant and powerful (and free) method to change culture around difficult topics and see others as differently right.
- Utilize personal patterns to recognize them in others so we can leave room for edits in our stories.
- Personally recognize our “kryptonite” and how it habitually limits our behaviors, responses, and beliefs as well as fuels us to build momentum when we need it the most.

Let’s face it, there are people and topics that at some point are just off limits. You just can’t handle it or them right now. Even worse, often it is a difficult topic that you have to bring up with a difficult person. What

if you could engage in these conversations with more confidence, humor, and ease? No matter the person or topic at hand, you are your best tool for conversations that matter. Understanding yourself and others as differently right gives you the tools to intentionally design teams, groups, and partnerships that can bring value to a single project or topic. We are all frustrating to someone, and at times even to ourselves. Once you know who and how you are, you can reclaim responsibility for these behavior response patterns and leave room for others to do the same. Before you know it, you are having better conversations and fuller relationships with those around you. I promise—it is that easy.

10:45–11:45 am

Concurrent Sessions

In Pursuit of Excellence: Post-Licensure Interprofessional Education in Palliative Care (TH311)



DorAnne Donesky, PhD ACHPN ANP NP CHPN, University of California, San Francisco, San Francisco, CA. F. Amos Bailey, MD FACP FAAHPM, University of Colorado Hospital, Aurora, CO. Ardith Doorenbos, PhD RN FAAN, University of Washington, Seattle, WA. Regina Fink, PhD RN APN AOCN CHPN OCN FAAN, University of Colorado Anschutz Medical Campus, Aurora, CO. Caroline Hurd, MD, University of Washington, Seattle, WA. Lisa Kitko, PhD RN, Penn State University College of Nursing, University Park, PA.

Objectives

- Compare and contrast profession-specific palliative care competencies.
- Participate in the final round of a Delphi process and provide feedback and comments on proposed standards for program quality for post-licensure interprofessional palliative care education.
- Describe three models of post-licensure interprofessional palliative care education.

Most currently practicing clinicians have no formalized palliative care (PC) education. The Joint Commission and National Academy of Medicine recognize the need for PC across care settings. Some university-based educators are developing educational programs for both clinicians and current students to meet the PC workforce shortage; however, most PC education has been developed for a specific discipline. PC is a team specialty; therefore, education with other professions on the PC team is an important part of practice preparation. We are using a Delphi process to develop consensus among interprofessional PC educators and clinicians in the following areas: 1) optimal PC post-

licensure educational program characteristics and curriculum components; 2) definitions of key terms; and 3) criteria, standards, and evaluation for quality PC educational programs. Standards for program quality and consistency will be published and may be used to inform a voluntary program recognition process for endorsement of excellence for post-licensure PC interprofessional education.

Through a needs assessment, PC competencies for each core profession were compared to the National Consensus Project for Quality Palliative Care guidelines. In 2017 at the AAHPM/HPNA assembly, an interprofessional steering committee of educators, who have already developed interprofessional PC educational programs specifically for practicing clinicians, met to begin the process of developing criteria and standards for quality interprofessional PC programs. All participants provided suggestions for overall categories that were then refined. Educators and clinicians representing the core professions of PC education and practice were then engaged in a Delphi process to refine the categories and develop sub-criteria and definitions. These categories, criteria, and definitions will be presented during this session with an opportunity for further discussion and input from assembly attendees. We will also use three current programs as examples on how these criteria are being implemented.

California's End of Life Option Act: What Can We Learn from One Year of Legalization? (TH312)



Barbara Koenig, PhD RN, University of California, San Francisco, San Francisco, CA. Laura Petrillo, MD, San Francisco Veterans Affairs, San Francisco, CA. Cindy Cain, PhD, University of California, Los Angeles, Los Angeles, CA. Felicia Cohn, PhD, Kaiser Permanente Orange County, Anaheim, CA. Judy Thomas, JD, Coalition for Compassionate Care of California, Sacramento, CA.

Objectives

- Describe California's experience legalizing physician aid-in-dying, highlighting best practices and areas for improvement.
- Reflect on the role of hospice and palliative care in responding to the law, both by responding to PAD requests and influencing institutional and state policies.
- Explore areas for further research to improve care for patients at the end of life.

California will soon mark one year of legalized physician aid-in-dying (PAD). Although not the first state to enact PAD, it is the largest and most diverse. We will report the results of a project tracking the implementation of the law through: 1) "convening" key stakeholders from around the state, and 2) empirical research. Our experience provides lessons for other

localities, including recent adopters such as Colorado, and those considering legalization.

We will document California's experience through three aims: 1) convening 120 multidisciplinary California stakeholders to share their experience with policy development, to discuss key issues raised during implementation, and to create a set of common data elements to be collected by health systems across the state; 2) developing and administering a survey to California institutions to understand the range of policy responses and provider attitudes; 3) executing an ethnographic study of 20 cases of PAD requests in order to capture a narrative account of the experience from the patient, family member, and provider perspectives. The session will present the "lessons learned" during the statewide stakeholder meeting and a summary of results from our empirical work. We will highlight the role of hospice and palliative care clinicians both in responding to PAD requests and in developing policies for their institutions. The panelists will raise the following questions: How should the act fit into the existing range of "options" at the end of life? How do we balance the provider right to opt-out of participating with patient interest for access to a participating provider, and what is the role of palliative care? What is the standard for providing end-of-life care that may obviate patient requests for PAD? Ethical practice demands that we track implementation, only then can we provide the best care for patients approaching the end of life.

If We Knew Then What We Know Now: Lessons Learned from Payer-Provider Partnerships for Community-Based Palliative Care (TH313)



Kate Meyers, MPP, California Health Care Foundation, Oakland, CA. Michael Rabow, MD FAAHPM, University of California, San Francisco, San Francisco, CA. Kathleen Kerr, BA, Kerr Healthcare Analytics, Mill Valley, CA.

Objectives

- Understand how organizational mission and culture impact opportunities for and barriers to payer-provider partnerships in community-based palliative care (CBPC).
- Describe specific processes, policies, and approaches that support successful payer-provider partnerships.
- Review the key advice from payer-provider partners to those planning such relationships.

Despite evidence of the benefits of community-based palliative care (CBPC), growth of these services has been slowed by a lack of sufficient funding sources. To address this problem, the California Health Care Foundation has supported a planning and implementation process for six teams of payer and provider

organizations partnered with the goal of improving care for seriously ill individuals by increasing access to CBPC. Participating providers include large academic medical centers, hospices, and a specialty palliative care practice, while the payers include national insurers, regional insurers, and a Medicaid managed care plan. Payer-provider teams participated in a six-month planning process, during which they developed operational and financial plans for delivering CBPC, followed by an implementation phase, during which contracts were executed and clinical services were delivered. This kind of collaboration between payers and providers is an emerging trend in CBPC, with ample opportunity to learn from early efforts.

In this session we will review “lessons learned” about the process of developing and enacting an agreement to deliver CBPC, as described by the payers and providers who participated in the initiative. Topics include: partner engagement (useful information to gather in advance and characteristics that may signal a successful match); processes (key staff to engage and issues related to bridging differences in organizational culture); agreement terms (issues that required the most negotiation and compromise); implementation experiences (facilitators and barriers to optimal care delivery); assumptions that payers or providers had that proved untrue; and advice participants have for others looking to do similar work.

Session attendees will be invited to participate in discussions addressing these topics, with an emphasis on how the experiences, perceptions and reflections presented may be applied to local efforts to promote access to CBPC through payer-provider partnerships.

Secrets of Getting Your Interdisciplinary Journal Article Published (TH314)



David Casarett, MD MA FAAHPM, Duke University, Durham, NC. Betty Ferrell, PhD RN CHPN FAAN FPCN, City of Hope National Medical Center, Duarte, CA.

Objectives

- Employ key strategies to write a compelling introduction that makes the case for a manuscript’s importance.
- Craft a manuscript that anticipates common concerns of editors and reviewers.
- Employ key strategies to maximize the readability and appeal of interdisciplinary journal articles.

Background. Writing a journal manuscript for a single audience is relatively straightforward. Physicians, nurses, and social workers (for instance) have specific implicit and explicit expectations for an article’s style and content. Those expectations are expressed and interpreted through the comments of a journal’s reviewers, and the decision of its editor. When authors seek to write manuscripts that cross professional, research, and practice boundaries, addressing the

audience becomes much more complex. How do you meet the expectations of a diverse set of reviewers, and an editor who may not be familiar with the customs and issues of another discipline? How do you satisfy researchers who expect in-depth methods descriptions but also clinicians who want to understand a study’s clinical importance? How do you develop implications for practice and policy that address important cross-cutting issues for an interdisciplinary audience? How do you give voice to your disciplinary perspective in a manner that can be heard by others with a different view?

Session. In this session, three experienced researchers assume the roles of author, reviewer and journal editor. We share our tips for writing successful manuscripts that cross disciplinary boundaries and settings, and which will appeal to a diverse population of reviewers, editors, and readers. We describe key elements of a manuscript, including the abstract, introduction, methods and results, and discuss how to make them accessible to a diverse audience. We pay special attention to “non-traditional” manuscripts that describe the results of reviews, meta-analyses, and quality improvement projects. We address translational issues specifically focusing on how research informs practice and ways to communicate that to readers from various disciplines.

Conclusion. Participants will gain concrete, usable skills for writing an interdisciplinary manuscript.

From the Pre-Verbal Infant to the Non-Verbal Adult: Increasing Your Delirium Recognition and Treatment Skill Set in Challenging Pediatric and Adult Patients (TH315)



Natalie Jacobowski, MD, Children’s Hospital of Philadelphia, Philadelphia, PA. David Buxton, MD, Center for Palliative Psychiatry, Richmond, VA. Jessica Casas, MD, Texas Children’s Hospital, Houston, TX.

Objectives

- Identify two elements of delirium assessment of infants and young children that can be generalized to the assessment of non-verbal adults.
- Apply the two primary screening tools for delirium in children under five years of age.
- Identify one pharmacologic and non-pharmacologic treatment approach for delirium in young children.

Delirium is highly prevalent in palliative care and at the end of life, and it occurs in patients of all ages, from infants to the elderly. Infants and young children pose a particular challenge in delirium assessment, as they lack the baseline verbal and cognitive skills to participate in the typical mental status assessments used for adults and older verbal children. Non-verbal adults with developmental

delay, intellectual disability, and advanced dementia pose similar challenges. This panel (which includes adult and child psychiatrists as well as adult and pediatric hospice and palliative medicine physicians) will focus on the assessment and treatment of delirium in pre-verbal children as well as non-verbal children and adults. Specifically, we will provide training on the use of the two primary screening tools for assessing delirium in infants and children under five years of age and practice the use of these tools using video examples. The panel will also discuss how aspects of these pediatric delirium screening tools can be translated to the adult patient population in the assessment of non-verbal adult patients with developmental delay, limited verbal ability, and dementia. In addition, we will review the unique delirium treatment concerns for very young patients, adults with intellectual disability, and adults with advanced dementia in the palliative and hospice setting. Given the limited literature on pediatric delirium treatment, the panel will review the evidence and provide expert recommendations on non-pharmacologic and pharmacologic treatment of delirium in infants and young children. Through case examples and experience within both psychiatry and palliative care, the presenters will discuss common challenges to delirium treatment and strategies for education of both medical teams and families.

Taking Psychedelics Seriously (TH316)

Ira Byock, MD FAAHPM, Providence Institute for Human Caring, Redondo Beach, CA. Charles Grob, MD, Harbor-University of California Los Angeles Medical Center, Los Angeles, CA.



Objectives

- Identify types of suffering of a psychological, emotional, social, spiritual, or existential nature that are potential indications for supervised therapy involving psychedelic medications, as well as important contraindications to this class of drugs.
- Apply findings from the evidence base of clinical research of psychedelic therapies to the treatment of persistent depression, existential suffering in terminal illness, and severe PTSD (post-traumatic stress disorder).
- Discuss the public health concerns, ethical, and socio-political issues pertinent to research and clinical use of psychedelics.

Severe psychological and existential suffering robs people of meaningful quality of life and brings some to desire to end their lives. Currently available treatments for depression, anxiety, and spiritual distress

often fail to alleviate suffering among people who are seriously ill. Renewed research involving psilocybin, MDMA and similar psychedelic compounds suggests that this class of drugs has important therapeutic potential in treatments for persistent, non-physical suffering.

Psychedelic properties of specific plants (mushrooms and cactuses) have been used for centuries by indigenous cultures to induce expanded states of consciousness and spiritual experiences. Research sponsored by the National Institute of Mental Health during the 1950s and early 1960s showed the potential for drugs of this class to markedly alleviate depression and existential suffering among people with cancer. However, non-medical use of these drugs and associated social upheavals resulted in psychedelics being classified as Schedule 1 drugs and banned from medical use. Recent studies by Dr. Grob and others have shown substantial improvements in mood, hopefulness, and well-being when these medications were administered to carefully screened patients under medical supervision as adjuncts to psychotherapy. A growing number of published studies with findings of high efficacy and few side effects have rekindled serious consideration of their therapeutic value and interest in pursuing regulatory changes to enable further research of their clinical use.

Cases of people with treatment-resistant depression and PTSD will be presented. Rates of effectiveness of current therapeutic approaches and side-effect profiles of available anti-depressants and anxiolytics will be discussed.

Dr. Grob will review the pharmacology, clinical trials, and neurobiology of psychedelics, including evidence from functional imaging. Dr. Byock will discuss the clinical indications, contraindications, and side-effects of these medications. Both faculty will discuss the socio-political, legal and regulatory challenges of prescribing and using psychedelics in carefully monitored ways.

Walking the Line Between Hope And Hype: Palliative Care in the Era of New and Expensive Neuromuscular Therapies for Children and Adults (TH317)



Garey Noritz, MD, Nationwide Children's Hospital, Columbus, OH. Chris Feudtner, MD PhD MPH, The Children's Hospital of Philadelphia, Philadelphia, PA.

Objectives

- Recognize the latest developments in the care of patients with neuromuscular disease.
- Analyze several of the decision-making and potential ethical challenges of providing a mixture of disease-directed and palliative care of patients with DMD and SMA in this new era.

- Discuss personally encountered challenges in providing a mix of disease-directed and palliative care to patients with neuromuscular disease.

Children with progressive neuromuscular diseases may receive palliative care services as they have a limited life expectancy and a high burden of physical and psychosocial symptoms. The past year has been an exciting one in this arena. For the first time, disease-specific therapies have been approved for patients with Duchenne Muscular Dystrophy (Eteplirsen) and Spinal Muscular Atrophy (Nusinersen). Although the data leading to the approval of these drugs are encouraging (although more clearly for Nusinersen than Eteplirsen), there are no long-term safety data, nor do we know the magnitude of sustained benefit. These drugs are extraordinarily expensive—both cost several hundred thousand dollars a year.

The provision of palliative care to these patients will be altered by the existence of these new drugs. We are going from an era of purely supportive care to one in which families and providers may choose one of the new therapies with its associated burdens: Eteplirsen is delivered by weekly IV injection, Nusinersen by quarterly intrathecal injection; travel to the medical center; and the cost of the medication as well as administration—costs that may be born in part by the family.

Families are rightly excited about this new era of therapy and are likely to strongly advocate for starting—and continuing—treatment with their medical team and insurer. We do not yet know, however, how long patients will benefit by taking these therapies, nor whether, absent clear benefit, they should be stopped. In this way, palliative care of these patients will become more similar to patients with cancer or renal failure, when the palliative care team must help families and other team members weigh the potential benefits and burdens of continued disease-directed treatment. Palliative care providers will need to help sort through issues of informed consent, parental autonomy, unreasonable expectations, and futility.

Joining Forces with the Emergency Department: Successful Programs, Initiatives, and Emerging Practices (TH318)

Rebecca Goett, MD, Rutgers New Jersey Medical Center, Newark, NJ. Sangeeta Lamba, MD, Rutgers New Jersey Medical School, Newark, NJ. David Wang, MD, Scripps Health, San Diego, CA. Kate Aberger, MD, St Joseph Regional Medical Center, Paterson, NJ. Richard Schultz, RN, St. Joseph's Healthcare System, Paterson, NJ.

Objectives

- Describe successful emerging palliative care ED integration programs, models and initiatives and the lessons learned during their implementation.

- Identify process improvement strategies that advance shared decision making, documentation and coordination of early palliative care in the ED.
- List take home strategies and tips to implement in order to better support the needs of the seriously ill/ dying patient and the family members in their own ED.

The majority of the seriously ill visit the Emergency Department (ED) and often the number of ED visits increase in the last few months of life. The ED also sets the future trajectory of in-hospital care and disposition; therefore, ED palliative care interventions offer an underutilized opportunity to engage seriously ill patients and their families for shared decision making. Based on recent research and initiatives such as IPAL-EM, models of ED palliative care integration have emerged as successful initiatives that move palliative care upstream to the ED. This interdisciplinary panel has real-life experience with advancing palliative care-ED integration programs within their institutions. We plan to discuss strategies that worked and what didn't to help attendees develop processes for improving the care for dying and seriously ill patients in their own EDs. We will also discuss EMS-hospice collaborations, electronic documentation and Smart-Phrases to support MWM (Measuring What Matters) goals and enhance advance care planning. In addition, we will explore screening models for emergency providers and electronic trigger tools such as P-CARES at the University of California San Francisco to identify palliative care needs in all patients being admitted through the ED. Finally, the challenges of navigating which ED patients are best served through "primary team palliative care" versus "specialty-level palliative care" will be highlighted. Interdisciplinary team panelists will analyze successful programs such as the "Life Sustaining Management Alternatives" program that include nurse champions and navigators to identify under-recognized palliative care needs in ED patients. Best practice protocols and processes such as a designated ED comfort room for patients who are actively dying or transitioning to either home or inpatient hospice will be discussed. By learning emerging and successful ED-palliative care initiatives, attendees will gain valuable take-home tips to jump-start similar programs in their own institutions.

A Year in Review: Six Hot Topics in Surgical Palliative Care (TH319)

Kimberly Kopecky, MD, UW Hospitals and Clinics, Madison, WI. Marlene Johnson, RN, VH Hospital, Madison, WI. Paul Hutson, PharmD BCOP, UW Madison School of Pharmacy, Madison, WI

Objectives

- Cite recently published literature regarding the evidence for palliative care interventions in surgical patients.



- Discuss areas of active surgical palliative care investigation in the context of common treatment dilemmas faced while caring for seriously ill patients with surgical disease.
- Use the conclusions of six recent publications to make evidence-based treatment recommendations for surgical patients with serious underlying illness.

Surgical patients have considerable palliative care needs owing to the nature of surgical illness itself, as well as the potential for treatment-related suffering. While a 2016 review highlighted the limited evidence base for palliative care interventions in surgery, emerging research has fortunately begun to fill in the knowledge gaps related to prognostication, communication and decision making, and palliative care service delivery for patients with surgical problems. This educational session will highlight six recently published papers or abstract presentations that expand the evidence base for surgical palliative care. Specific topics for discussion will include surgeon-patient communication in high-stakes surgical decision making, patterns of care in hospitalized vascular surgery patients at the end of life, and optimal treatment strategies for malignant bowel obstruction in older adults. In the spirit of facilitating cross-society content sharing, additional topics will be selected among those presented at the Palliative Care Scientific Forum of the American College of Surgeons Clinical Congress in October 2017, as well as from the newly published literature, offering a sneak peek into the latest emerging surgical science related to palliative care.

To provide clinical context, the session will be grounded in clinical case presentations. The panel will include a specialty palliative care RN who will introduce the cases; a palliative-trained surgeon and our team pharmacist will review the pertinent research and its findings; and a specialty palliative care social worker who will discuss how the highlighted research informed each case and its outcome. Audience participation will be encouraged for an interactive discussion of each case incorporating the diverse panelist perspectives. Additional commentary will touch on psychosocial assessment strategies, advance care planning approaches and challenges, alternative pharmacologic options to control disease-specific symptoms, and caregiver education strategies applicable to the surgical patient population.

Paper Session (TH320–TH321)

The “Promoting Resilience in Stress Management” (PRISM) Intervention for Adolescents and Young Adults: A Pilot Randomized Controlled Trial (TH320A)

Abby Rosenberg, MD MS MA, Seattle Children’s Hospital, Seattle, WA. Miranda Bradford, MS, Seattle

Children’s Research Institute, Seattle, WA. Victoria Klein, BS, Seattle Children’s Hospital, Seattle, WA. Nicole Etsekson, MPH, Seattle Children’s Hospital, Seattle, WA. Claire Wharton, BS, Seattle Children’s Hospital, Seattle, WA. Michele Shaffer, PhD, University of Washington, Seattle, WA. Joyce Yi-Frazier, PhD, Seattle Children’s Research Institute, Seattle, WA.

Objectives

- Describe a novel, brief, age-appropriate, skills-based psychosocial intervention designed to build resilience resources among Adolescents and Young Adults (AYAs) with serious illness.
- Describe the results of a pilot Randomized Controlled Trial of the PRISM intervention among AYAs with cancer.

Original Research Background. Adolescents and Young Adults (AYAs) with cancer are at risk for poor psychosocial outcomes, perhaps because they have yet to learn the skills needed to navigate the burdens of illness.

Research Objectives. We aimed to determine if a novel, brief, age-appropriate, skills-based intervention would improve psychosocial outcomes.

Methods. “Promoting Resilience in Stress Management” (PRISM) is a manualized, brief intervention targeting stress management, goal-setting, cognitive reframing, and meaning-making. It consists of 4, 30-60 minute, in-person, 1:1 sessions plus a facilitated family-meeting. English-speaking AYAs (ages 12-25 years) with new or newly recurrent cancer were randomized to receive either PRISM or non-directive usual psychosocial care. Participants completed patient-reported outcome (PRO) surveys at the time of enrollment and 6 months later. We used mixed effects regression modeling to estimate associations between PRISM and the primary outcome (patient-reported resilience, measured by the Connor-Davidson Resilience Scale [CDRISC-10]) and secondary outcomes (health-related quality of life [PedsQL 4.0 Quality of Life Inventory], hope [Snyder Hope Scale], and psychological distress [Kessler-6 Psychological Distress Scale]) at 6 months.

Results. N=100 AYAs enrolled (78% of approached, n=50 PRISM, n=50 usual care) and 92 completed baseline responses (48 PRISM and 44 usual care). Of those who completed baseline, 73% were aged 13-17 years and 27% aged 18-25 years, and 43% were female. Attrition was similar in each arm and primarily due to medical complication and/or death; n=36 (72%) PRISM and n=38 (76%) usual care participants completed 6-month PROs. After adjusting for baseline scores, PRISM was associated with improvements in all instruments: Resilience (+2.3, 95% CI 0.7, 4.0), quality of life (+6.3 (95% CI -0.8, 13.5), hope (+2.8, 95% CI 0.5, 5.1), and distress (-1.6, 95% CI -3.3, 0.0).



Conclusion. A targeted intervention targeting skills for AYAs with cancer was effective in improving patient-centered outcomes.

Implications for Research, Policy, or Practice. Standardized psychosocial interventions have potential to improve AYA quality of life.

Changes Over Time in Good-Parent Beliefs Among Parents of Children with Serious Illness: Two Year Cohort Study (TH320B) 

Douglas Hill, PhD, Children's Hospital of Philadelphia, Philadelphia, PA. Jennifer Faerber, PhD, Children's Hospital of Philadelphia, Philadelphia, PA. Karen Carroll, BS, Children's Hospital of Philadelphia, Philadelphia, PA. Victoria Miller, PhD, Children's Hospital of Philadelphia, Philadelphia, PA. Wynne Morrison, MD MBE, Children's Hospital of Philadelphia, Philadelphia, PA. Pam Hinds, PhD RN, Children's National Health System, Washington, DC. Chris Feudtner, MD PhD MPH, Children's Hospital of Philadelphia, Philadelphia, PA.

Objectives

- Describe how "good parent beliefs" of parents of children with serious illness change over time.
- Identify factors that predict which parents change their good parent beliefs.

Original Research Background. Parents of seriously ill children hold personal beliefs about what they should do to be good parents. Whether and how these beliefs change over time is unknown.

Research Objectives. Assess whether good-parent beliefs changed and test whether baseline levels of hope and affect were associated with change.


Methods. 124 parents of hospitalized children completed baseline measures regarding hopeful patterns of thinking and positive and negative affect, and of good-parent beliefs, which were also measured at 12 months and 24 months. We used latent transition analysis to identify groups of parents with different good-parent beliefs, and assessed change in group at 12 and 24 months.

Results. We identified two groups of parents at baseline: 1) parents whose highest priorities were the child's feeling loved, quality of life, and comfort (n=61); and 2) parents whose highest priorities were advocating for the child and making informed medical decisions (n=63). At 12 months, 30 parents (24.2% of the sample) moved into the child feels loved group and no parents transitioned to the advocacy group. By 24 months, 11 more parents transitioned to the child feels loved group and 3 to the advocacy group (an additional 11.3% of the sample). Change at 12 months was associated with baseline hopeful thinking (OR=2.42, p=0.047) and marginally with negative affect (OR=2.04, p=0.12). Change at 24

months was associated with baseline hopeful thinking (OR=2.68, p=0.013) and positive affect (OR=2.19, p=0.041).

Conclusion. Most parents have stable good parent beliefs over time. Among those who change, hopeful patterns of thinking appear to be predictive, while negative and positive affect have potentially important but more complex relations.

Implications for Research, Policy, or Practice. Decision support for parents of children with serious illness should attend to potential change in good-parent beliefs over time, and the role of hopeful patterns of thinking and affect warrant more study.

Family Satisfaction with Symptom Management Practices and Child Comfort During Pediatric Hematopoietic Stem Cell Transplant (TH320C) 

Christina Ullrich, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Deena Levine, MD, St. Jude Children's Research Hospital, Memphis, TN. Anran Li, BA, Boston Children's Hospital, Boston, MA. Clement Ma, PhD, Dana-Farber Cancer Institute/Boston Children's Hospital, Boston, MA. Joanne Wolfe, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Rachel Holder, BA, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Discuss patterns of family satisfaction with respect to symptom management practices during HSCT.
- Describe family satisfaction regarding child comfort during HSCT.
- Delineate area of future research to elucidate the relationship between family satisfaction with symptom management and satisfaction with child comfort.

Original Research Background. Hematopoietic stem cell transplant (HSCT) is intensive treatment; pediatric HSCT recipients are at high risk for symptoms. However, the level of family satisfaction with symptom control is unknown.

Research Objectives. To assess patterns of family satisfaction with symptom management during HSCT.

Methods. Families with a child undergoing HSCT between 2014 and 2017 at two large academic centers were enrolled in a longitudinal study of child symptoms. Baseline clinical data were abstracted from the medical record; demographic data were self-reported. Family satisfaction with symptom management was assessed at week four of HSCT using the FAMCARE-2 scale. Likert scale responses were very satisfied (VS)/satisfied/neutral/dissatisfied/very dissatisfied. For children <12 years the parent completed the FAMCARE-2, older children completed it themselves. Results were summarized using descriptive statistics.

Responses were dichotomized, with “very satisfied” and “satisfied” categorized as “satisfied”.

Results. Forty families (29 parent, 11 child surveys) were included. Median child age was 13.7 years (range=5.4-24.5); 68% were female. Children had cancer (73%) or non-malignant disease (28%). Most (87%) underwent allogeneic transplant.

Regarding satisfaction with the team’s approach to symptoms, 95% reported satisfaction (79% VS) with the care team’s attention to the child’s description of symptoms, and 92% reported satisfaction (53% VS) with the speed with which symptoms were treated. In addition, 87% were satisfied (68% VS) with the information they received about how to manage the child’s symptoms. Fewer (82%) reported satisfaction (40% VS) with information they received about potential treatment side effects. Only 75% reported satisfaction (35% VS) with the child’s comfort during HSCT.

Conclusion. Families are generally satisfied with the team’s approach to symptoms though room for improvement exists. Their satisfaction with care does not necessarily translate into satisfaction with child comfort during HSCT.

Implications for Research, Policy, or Practice. Further research exploring the determinants of child comfort, including family expectations and barriers to optimal symptom control, is needed.

Providing Pediatric Palliative Care in Non-Urban Areas of Illinois: Challenges Identified and Recommendations for Process Improvement (TH320D)

Kimberly Downing, JD RN, Greater Illinois Pediatric Palliative Care Coalition, Evanston, IL. Kelly Michelson, MD MPH, Ann and Robert H. Lurie Children’s Hospital, Chicago, IL. Patrick Murday Undergraduate Student, University of Notre Dame, Notre Dame, IN. Erin Gaab Arsala, PhD, University of California, Merced, Merced, CA.

Objectives

- Identify 3 barriers to the provision of care in rural areas for children with life-limiting illnesses and their families.
- Describe 3 approaches to improving the provisions of care in rural areas for children with life-limiting illnesses and their families.
- Describe 2 potential mechanisms for supporting the existing pediatric palliative care resources in rural communities.

Original Research Background. The absence of formal data about pediatric palliative care in non-urban areas has hindered development of appropriate supportive resources to improve access to services.

Research Objectives. To identify pediatric palliative, hospice and bereavement resources, care gaps, and

barriers to service provision in four key non-urban regions of Illinois.

Methods. We conducted semi-structured focus groups or interviews with parents and healthcare providers from four Illinois non-urban population hubs. Regional champions (e.g., hospice administrator, Social Worker developing a hospital-based pediatric supportive care program) led recruitment. We analyzed the data using a grounded theory approach focusing on issues relevant to non-urban communities.

Results. We conducted 12 focus groups/interviews with 8 bereaved parents, 4 non-bereaved parents, and 18 healthcare professionals (6 nurses, 2 doctors, 4 Social Workers, 6 “other”) representing hospital, palliative/hospice care, homecare, or family support organizations. While some participants praised the current services, expressed concerns predominated. Themes identified included: attitudes about pediatric palliative/hospice care and local resources; inadequate care coordination; limited skill/comfort of local healthcare professionals; limited resources for healthcare team members and families; inadequate information about existing resources; need to travel to obtain care. Areas for process improvement focused on enhancing existing resources through better access, utilization and quality, and improving care coordination. Approaches proposed included educational efforts for families and professionals, introducing local and distant resource experts for families and professionals (e.g. navigators, mentors), utilizing technology (e.g. telehealth), providing more symptom management and diagnostic testing locally, and improving funding.

Conclusion. Improving pediatric palliative/hospice care delivery in non-urban areas of Illinois will require efforts that match people with existing services and maximize resource utilization and quality.

Implications for Research, Policy, or Practice. Improving non-urban pediatric palliative/hospice care will require engagement of local and distant experts as well as funding to expand services.

Assessing the Palliative Care Needs of Elderly Patients Seen at The University College Hospital, Ibadan, Nigeria (TH321A)

Eunice Omoyeni, MBBS PGD DIPPALMED (UTC) MPHIL, University College Hospital, Ibadan, Oyo State, Nigeria. Liz Gwyther, MBChB FCFP MSc Pall Med, University of Cape Town, Cape Town, South Africa.

Objectives

- Highlight the identified palliative care needs of the elderly.
- Explore the current use of the hospital palliative care team in the care of geriatric patient.

Original Research Background. Nigeria the most populated nation in Africa (over 170 million), growth rate of 2.5% with 5% of the total population aged 60 and above with potential for a rapid growth rate of the older population. The implication is difficulty in meeting the various needs of the elderly with limited healthcare professionals and care homes.


Research Objectives. 1) To describe characteristics of elderly patients seen in the selected clinics and 2) To assess the needs of the patients as relates physical, spiritual and psychosocial wellbeing.

Methods. A descriptive cross sectional study was conducted over a 3-month period using an interviewer administered questionnaire after full consent was given by participants. The questionnaire was a combination of the Africa Palliative Care Outcome Scale (APOS), the Edmonton system Assessment Numerical scale and the Hope Spiritual assessment scale. Demographic information and needs in respect to physical, psychosocial and spiritual were obtained. Data was analyzed using IBM SPSS statistics 21.

Results. Four-hundred-twenty-four participants completed the questionnaire. Most patients were recruited from the geriatric wards 330(77.8%) with a 2:1 female to male ratio. Most participants fell in the 60 -69 age group. Most common symptom was pain in 240 patients with moderate pain in single or multiple areas. A high percentage, 45.8% were moderately worried about their disease condition and only 66 out of 424 freely discussed this feeling with their family members. Other symptoms observed were nausea, vomiting, anxiety and abdominal discomfort.

Conclusion. The study showed the palliative care needs of the elderly and calls for a collaboration between the palliative care team and the physicians in the geriatric unit for better management of the needs of the elderly.

Implications for Research, Policy, or Practice. Palliative care service should be made a priority and training of health professionals interested in this field should be supported to increase the resources to meet the needs of a growing elderly population.

Assessing Racial Disparity in Palliative Care Consultation and the Impact of Consultation on Hospice: A Multi-Hospital Analysis (TH321B) 

Stacie Levine, MD FAAHPM, University of Chicago, Chicago, IL. Sean O'Mahony, MD MS FAAHPM, Rush University Medical Center, Chicago, IL. Tricia Johnson, PhD, Rush University, Chicago, IL. Aliza Baron, AM, University of Chicago, Chicago, IL.

Kishore Bobba, MD, Sinai Health System, Chicago, IL. Kayla Innis, MSW LCSW, Swedish Covenant Hospital, Chicago, IL.

Objectives

- Discuss disparities in palliative medicine and hospice utilization.
- Evaluate the impact of race/ethnicity and palliative medicine consultation on hospice utilization.

Original Research Background. Racial disparities in health care access and quality are well documented for some minority groups. However, compared to other areas such as disease prevention, early detection, and curative care, research in disparities in palliative care (PC) is limited.

Research Objectives. To evaluate whether PC consultation and hospice use differed by race/ethnicity for hospitalized patients at the end of life, and measure the association between PC consultation and use of hospice.

Methods. The sample included 3,980 patients admitted to three urban hospitals with an inpatient palliative medicine service and were discharged to hospice or died during their hospital stay from 2012-2014. A multilevel binary logistic regression model that accounted for hospital-level clustering of patients was fit to test the association between PC consultation use and race/ethnicity controlling for other patient and hospital characteristics. Another multilevel binary logistic regression model was fit to the association between discharge to hospice with race/ethnicity and PC consultation, controlling for other patient and hospital characteristics.

Results. The sample was 45% Caucasian, 39% African American and 17% Hispanic, and 17% (n =682) had a primary diagnosis of cancer. Thirty-four percent received a PC consultation during their hospital stay, and 40% were discharged to hospice. In the multilevel models, race/ethnicity was not associated with receipt of a PC consultation or discharge to hospice. Patients with a PC consultation were 5 times as likely to be discharged to hospice as patients without a consultation ($p < 0.001$).

Conclusion. Contrary to previous studies, no evidence of significant racial/ethnic disparities in the use of either PC or hospice was found. However, there was significant variation across hospitals in the use of both services.

Implications for Research, Policy, or Practice. Future work should focus on increasing the use of palliative medicine consultations within the hospital for patients, regardless of race or ethnicity.

Evaluating Disparities in Hospice Utilization for Cancer Patients Living in the Deep South (TH321C)



Yasemin Turkman, PhD RN APRN, University of Alabama Birmingham, Birmingham, AL. Courtney Williams, MPH, University of Alabama Birmingham, Birmingham, AL. Bradford Jackson, PhD, Center for Outcomes Research JPS Health Network, Fort Worth, TX. James Dionne-Odom, PhD RN, University of Alabama at Birmingham, Birmingham, AL. Elizabeth Kvale, MD, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL. Maria Pisu, PhD, University of Alabama at Birmingham, Birmingham, AL. Marie Bakitas, DNSc NP-C FAAN, University of Alabama at Birmingham, Birmingham, AL. Gabrielle Rocque, MD, University of Alabama at Birmingham, Birmingham, AL. Richard Taylor, DNP, University of Alabama at Birmingham, Birmingham, AL. Deborah Ejem, PhD, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- List 3 characteristics of cancer patients in the Deep South who are less likely to use hospice.
- List 1 hospital characteristic that is associated with late hospice care for cancer patients in the Deep South.

Original Research Background. Hospice utilization is an indicator of high-quality end-of-life cancer care. Within the Deep South, there are significant racial disparities in hospice use. Identifying patient and hospital characteristics that affect hospice utilization is a critical first step in understanding how to address these disparities.

Research Objectives. Characterize disparities in Deep South cancer patients' hospice use within a navigation program and examine associations with patient- and hospital-level factors.

Methods. This was a secondary analysis within the evaluation of the University of Alabama at Birmingham Cancer Community Network navigation program for Medicare beneficiaries in 5 Deep South states. Included are cancer decedents ≥ 65 years, 2012-2015, 20% of whom received navigation. Outcomes are 'no hospice' within 90 days of death, or 'late hospice' within 3 days of death. Patient characteristics included: age at death, race, sex, cancer type, and navigation. Hospital characteristics included: palliative physician presence, inpatient hospice beds, and hospice facility ownership. We estimated relative risks (RR) and 95% confidence intervals of 1) no vs any hospice, and 2) late vs any hospice among those receiving hospice care.

Results. Of 12,725 decedents, 5,487 (43%) received no hospice. No hospice was more frequent among non-whites (50% vs. 42%); males (44% vs. 42%);

non-navigated (45% vs. 38%), and at hospitals without a palliative physician (45% vs. 43%). In adjusted analyses, risk for no hospice was higher in non-white (RR 1.20), male (RR 1.07), non-navigated (RR 1.18), and not at a hospital with a palliative physician (RR 1.15). Among 7,238 (57%) hospice recipients, risk of late hospice was higher at hospitals with ownership of hospice facilities (RR 1.33).

Conclusion. Patient and hospital characteristics are associated with disparities in hospice utilization in the Deep South.

Implications for Research, Policy, or Practice. Results inform future work on mechanisms of disparities and navigation as an intervention.

An Assessment of Palliative Care Educational Needs and the Development of Advanced Practice Nursing in Israel (TH321D)



David Collett, APRN, Memorial Sloan Kettering Cancer Center, New York, NY. Shelli Feder, PhD APRN FNP, Yale University School of Medicine, New Haven, CT. Eliana Aaron, DNP, EMA Care, Teaneck, NJ. Samantha Conley, PhD RN FNP-BC, Yale University School of Nursing, West Haven, CT. Dena Schulman-Green, PhD, Yale University, West Haven, CT.

Objectives

- Describe the landscape of palliative care in Israel.
- Articulate key factors promoting and limiting APRN development in Israel.
- Describe core educational needs in palliative care in Israel.

Original Research Background. In Israel, palliative care (PC) services and educational opportunities are limited. Only 10% of decedents in the country receive PC. Israel recently introduced the PC advanced practice registered nurse (APRN) role to address this need.

Research Objectives. To describe the development of the PC APRN role and to assess perceived PC competencies and educational needs among PC nurses in Israel.

Methods. To assess PC competencies and educational needs, we administered the end-of-life Professional Caregiver Survey to PC nurses. We used ANOVA to analyze survey data. To explore the development of the PC APRN role, we interviewed key Israeli stakeholders in government, healthcare, and academia, and we gathered PC educational, organizational, and legislative documents. We used content and document analysis to analyze data.

Results. For the EPCS, the sample (n= 105) was 94% female, had a mean age of 48 ± 11 years, and 83% were Jewish/Israeli. Thirty-nine percent reported PC training in nursing school, and 35% felt their

workplace provided sufficient PC education and resources to nurses. Those with advanced degrees and who received post-graduate PC training had higher mean scores across EPCS domains ($p < .05$ for all). Interviews revealed beliefs that Israel lagged behind other countries regarding availability and access to PC, a desire for greater public awareness about PC, and a need for increased role definition for APRNs. Main themes in the documents included a recognition of the growing need for PC services and a need for qualified nurses, including APRNs, in PC.

Conclusion. Israel faces challenges to implementation of the PC APRN role, including lack of training pathways and workplace support, and scope-of-practice issues.

Implications for Research, Policy, or Practice. Israel must balance the desire for increased public awareness of PC with the ability to provide an adequate and skilled PC workforce. The Israel Ministry of Health is using results to inform nursing education and policy.

1:30–2:30 pm

Concurrent Sessions

The Practice of Palliative Medicine in Developing Countries—Part One (TH330)



Cristina Terzi Coelho, MD, Campinas, Brazil. Pornpun Sripornsawan, MD, Hat Yai, Songkhla, Thailand. Mohammad Shahinur Kabir, MBBS MPH, Dhaka, Bangladesh.

Objectives

- Learn how physicians in specific countries provide palliative care to their patient populations often with limited resources.
- Recognize specific cultural and political challenges to developing palliative care clinical, educational and research programs.
- Describe roles of different health care providers practicing palliative care and how they meet the needs of their local populations.

Please join AAHPM's International Scholars for a panel discussion. Each scholar will present for 10-15 minutes on the state of the practice of palliative care in their home country, with an emphasis on the roles of physicians, nurses, and other healthcare providers; the status of education and research in the field; and the unique challenges facing patients and providers. There will be time allotted after each presentation to field questions and dialogue from the audience. Prepare to be educated and inspired by these accomplished individuals who are leading and advancing the field of

hospice and palliative medicine in their countries of origin.

Conversations That Matter: A Deeper Dive Through Head, Heart, and Action (TH331)



Jessica Pettitt, MEd CPS, Eureka, CA.

Objectives

- Application of concepts to frustrating situations.
- Recognition of intent and the patterns that inform intent.
- Reclaiming responsibility of impact on relationships.

This deeper diver continues the conversation from the keynote and allows participants to apply this new communication model to their relationships, team building, hiring practices, marketing plans, and programming ideas.

Not on Our Turf—You Have to Get the Patient Out of Here Before He Dies! Finding a Place for the Good Death (TH332)



Martina Meier, MD, Providence TrinityCare Hospital, Torrance, CA. Shaida Talebreza, MD HMDC AGSF FAAHPM, University of Utah, Salt Lake City, UT. Eric Prommer, MD HMDC FAAHPM, University of California, Los Angeles and VA HPM Program, Los Angeles, CA.

Objectives

- Recognize existing barriers that complicate placement of patients with advanced illness in nonacute settings.
- Identify hospital specific pressures creating placement issues.
- Know when to use GIP or continuous home care appropriately in imminently dying patients and know how to document accordingly.

In Hospice and Palliative Medicine, ensuring a “good death” is part of what we strive for. Finding a dignified place to die for a hospice patient can be challenging in a highly regulated environment. Hospitals, whose quality is often measured by mortality data, strive to discharge patients from the acute care setting. Hospital discharges may be accelerated once patients have chosen “comfort care” or hospice. The expectation is that once patients are designated hospice, hospices will take them no matter what the circumstances. Unfortunately, the patient's destination may also be a highly regulated environment. For hospices, General Inpatient (GIP) claims are being reviewed for appropriateness with more vigor than ever. Hospices have to be extra diligent in ensuring compliance when deciding about a patient's eligibility for GIP. Many patients referred by acute care providers are imminently dying but not GIP appropriate. Hospices commonly feel pressured to take on dying patients who are no

longer stable for transport. Skilled nursing facilities have become reluctant to accept hospice patients, as they see themselves at high risk of being red flagged for some of the natural occurrences close to deaths, including advanced wounds, use of psychoactive medications and weight loss. Finally, home hospice may not be a realistic option due to the complexities of medical care or lack of caregivers. This session will examine issues related to where people die in this regulated environment. A panel of hospice medical directors will present multiple scenarios related to place of death and engage the audience to come up with creative solutions. We will propose regulatory changes and incentives that would facilitate placement of dying patients in nursing homes or other appropriate settings. We will discuss ways to effectively collaborate with our partners in hospitals and facilities in order to provide our patients with a dignified place to die.

Cultivating Opportunities for Reflection: Teaching the Art of Debriefing (TH333)



Patricia Keefer, MD, University of Michigan, Ann Arbor, MI. Nasuh Malas, MD, University of Michigan, Ann Arbor, MI. Morgen Govindan, MD, University of Michigan, Ann Arbor, MI. Terrance Murphy, MD FAAP, Michigan Medicine, Ann Arbor, MI. D'Anna Saul, MD, University of Michigan Hospitals, Ann Arbor, MI. Clare Riotte, DO, University of Michigan, Ann Arbor, MI. Elizabeth Hollenkamp, BSN RN, University of Michigan, Ann Arbor, MI. Janice Firm, PhD LMSW, Michigan Medicine, Ann Arbor, MI.

Objectives

- Identify the elements of an effective debriefing session following a distressing event.
- Describe the process of engaging participants in thoughtful, reflective, and non-threatening discussion while leading a debriefing session.
- Describe strategies to teach and evaluate debriefing leadership training for healthcare professionals.

Health care professionals commonly experience adverse patient events as part of their training and practice, which may include unexpected negative outcomes, challenging patients or families, and patient death. These events can engender strong emotions in members of the interprofessional care team. If not addressed properly, these emotions can negatively affect provider well-being and the care they administer, potentially leading to professional stress, burnout, and mental illness. Several studies have shown the benefits of debriefing after difficult experiences, including positive impacts in teamwork, end-of-life care, and provider stress. While distress following an event crosses professions and experience levels, more junior providers report the greatest need for

support after adverse events. However, there is no clearly-accepted, existing model to educate trainees and providers on the skills and processes required to lead or participate in a debriefing. In response to this gap, the past experiences and perceptions of debriefing were evaluated among a group of trainees and incorporated with the current literature to design an effective debriefing educational intervention. Given clear interprofessional interest in additional training, the model physician-trainee workshop was then extrapolated to use for a wider group of providers. The training consists of an interactive workshop to teach providers the components and skills to lead debriefing sessions after distressing patient events. The elements of this training are particularly relevant to the field of palliative care, as potentially distressing events and deaths are more prevalent in patients with serious illness, and palliative care practitioners are often called upon to assist in debriefs. This session aims to inform providers on best-practices in debriefing sessions as well as to assist providers in empowering their trainees and colleagues to lead debriefs. Through didactics, discussion, and case-based small group simulation, we will teach participants to facilitate training in debriefing within their programs, including real-time feedback and coaching.

Hospice Collaboration and Integration Within Large Healthcare Systems (TH334)



Keith Lagnese, MD HMDC FACP, Family Hospice & Palliative Care, Pittsburgh, PA. Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA. Richard Weinberg, MD, University of Pittsburgh School of Medicine, Pittsburgh, PA. Megan King, RN, University of Pittsburgh Medical Center, Pittsburgh, PA. Barbara Ivanko, LCSW, Family Hospice and Palliative Care, Pittsburgh, PA.

Objectives

- Describe the reasons why large healthcare systems are interested in collaborating or acquiring hospice providers.
- Describe the pros/cons of a hospice aligning with a hospital system/healthcare provider.
- Identify common problems that occur when a hospice is acquired by a healthcare system.

While freestanding hospices still represent nearly 60% of the hospices nationally, large healthcare systems are increasingly interested in integration with hospices. There are a number of different models for a hospice and large health system to work together. They can range from contractual affiliation/joint venture to a merger or asset purchase. We will discuss each model, as well as its positives and negatives aspects.

The reasons for health system interest include improved patient satisfaction and quality metrics-

such as decreased mortality, hospital re-admissions and ICU admissions. Improved post-acute care oversight also allows for provision of a complete continuum of care within a healthcare system. Additionally, an integrated model positions a healthcare system well for the inevitable transition to the future reimbursement model of predominantly bundled payments and Accountable Care Organizations (ACOs). Free-standing hospice organizations continue to face decreased reimbursements, increased regulatory scrutiny, and fewer community resources available to them. These adverse operational realities contribute to closure, consolidation and/or acquisitions of hospices. Hospices are interested in healthcare system integration because of improved access, collaboration, operational support and financial stability. However, bringing together these very different organizations and cultures can be quite challenging. This seminar will discuss the different models of collaboration, their risks and benefits.

Lastly, we provide a real life example of a recent merger/acquisition in Pennsylvania between the largest free standing not for profit hospice in PA (Family Hospice & Palliative Care) with the state's largest not for profit healthcare provider (UPMC Health System). We will explore all relevant barriers, successes, failures, as well as innovations and lessons learned. We will share unique models of implemented palliative homecare transition programs, hospital discharge models and home hospice physician admission visits—all in order to sustain financial viability. We will also review some pre- and post-integration metrics (quality, census and employee retention).

Developing “Goals of Care” for Your Organization: Strategic Planning for the Palliative Care Professional (TH335)

Arif Kamal, MD MBA MHS FAAHPM, Duke Cancer Institute, Durham, NC. Constance Dahlin, MSN ANP-BC ACHPN® FAAN FPCN, Hospice and Palliative Nurses Association, Pittsburgh, PA.

Objectives

- Describe different ways to develop a business, operations, and personnel strategy for medium and long term planning.
- Understand avenues to evaluate internal and immediately-available resources, assets, and strengths and then critically appraise external threats and align future actions in response to organizational priorities.
- Collate input from experts and audience members regarding real-life practical tips for timing and execution of strategic planning.

In an evolving healthcare environment, including rapid changes to evaluation and reimbursement of

care, palliative care clinicians need a robust strategy to sustain their competitive advantage. As clinical programs grow into outpatient practices and venture into community-based settings, they often set out to complete a lengthy and intensive retreat to define a mission and vision. Sometimes they also perform a SWOT analysis, but upon completion, oftentimes clinicians and administrators go back to an uncoordinated, misaligned clinical delivery apparatus. Frankly, these efforts are not fruitful, either because they lack the rigor in approach or use methods not tailored to the needs of palliative care organizations.

Using an interdisciplinary panel of clinicians with backgrounds in palliative care program development, palliative care longitudinal growth, and corporate world business strategy, we will discuss several topics critical to strategic planning. We will cover topics being taught in business schools today, applying these concepts to our palliative care clinical world. Topics covered will include eliminating fluff, aligning with the overall organization's strategy for healthcare, developing strategy using the 5-diamond approach, and differentiating strategic positioning versus operational efficiency.

Further, we will provide attendees real-world palliative care business cases, highlighting important tasks “to implement on Monday” such as: understanding external threats, appreciating internal resources, and using the 9-box matrix for prioritizing efforts.

Our goal is to demystify strategic planning, making it an everyday skill for palliative care professionals to participate in, and use regularly in their operational toolbox.

Drug Abuse and Diversion in Pediatric Palliative Care—What You Should Know, What You Can Do, and What You Can Learn from Our Multisite Experience (TH336)

Elissa Miller, MD, Nemours/AI duPont Hospital for Children, Wilmington, DE. Lisa Humphrey, MD, Nationwide Children's Hospital, Columbus, OH. Rachel Thienprayoon, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH.

Objectives

- Describe using pediatric-specific data the importance of safe opioid prescribing practices by pediatric palliative care providers.
- Understand the steps needed to create reliable processes for safe opioid prescribing, standardized pediatric risk assessment and care for pediatric palliative patients.
- Describe the steps to take when drug diversion is confirmed for children of all age ranges, including young children, adolescents and young adults.



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Background. Prescription drug abuse is an epidemic in the US, leading to increased government oversight in opioid prescribing. The issue becomes more complicated when minor children are involved. One pediatric palliative care team found that of 62 consecutive children and young adults who were stratified for opioid misuse, >60% were at either moderate or high risk. In 6 cases, the patient was weaned from opioids or the team stopped prescribing due to diversion or misuse behaviors. Thus safe opioid prescribing should be a priority for all pediatric palliative care (PPC) teams.

Discussion. Using a case-based discussion, we will review pediatric-specific opioid abuse data and best evidence around safe opioid prescribing. We will discuss the safe-opioid prescribing “opioid bundle” developed by the Pediatric Palliative and Comfort Care Team (PACT) at Cincinnati Children’s Hospital Medical Center and how it has been rolled out at two additional children’s hospitals. We will talk in-depth about caring for high risk patients, highlighting cases of confirmed diversion and the resulting de-prescribing. We will include cases of minor children with diversion by adult caregivers as well as adolescent and young adult patients participating in drug diversion.

Conclusions. Given the high risk of drug misuse, abuse and diversion, safe opioid prescribing is necessary for all PPC teams. The “opioid bundle” created by PACT is a practical method for PPC teams nationwide to employ in the care of their patients.

Not Just Cutting It—A Successful Interprofessional Cooperation Between Palliative Care, Pain and Neurosurgery in the Treatment of Intractable Cancer Pain (TH337)



Rotem Tellem, MD, Tel Aviv Medical Center, Tel Aviv, Israel. Ido Strauss, MD PhD, Tel Aviv Medical Center and Tel Aviv University, Tel Aviv, Israel. Uri Hochberg, MD, Tel Aviv Sourasky Medical Center, Tel Aviv, Israel. Michal Arad Sobol, RN, Tel Aviv Medical Center, Tel Aviv, Israel.

Objectives

- List three neurosurgical procedures that selectively intervene along the pain processing pathways and to describe their role in the treatment of intractable cancer pain.
- Perform case analysis of different clinical cases of patients with intractable cancer pain and to appropriately make an interdisciplinary based patient selection for different neurosurgical procedures.

There is a great importance to deliver good pain management to cancer patients suffering from advanced metastatic disease. Unfortunately, there are selected

patients for whom pharmacotherapy does not achieve acceptable pain relief or is limited by marked side effects. These patients, may benefit from neurosurgical procedures that selectively intervene along the pain processing pathways. Patients with localized pain can benefit from selective percutaneous cordotomy, while patients who suffer from diffuse pain due to widespread disease are candidates for stereotactic radiofrequency cingulotomy. Patients with intractable abdominal or pelvic visceral pain can benefit from midline myelotomy. A careful patient selection is critical for the success of these procedures. An integrative team consisting of palliative care specialists, pain specialists and a neurosurgeon focused on this task provides a platform to optimize patients’ selection.

We will present our experience from the interdisciplinary evaluation of cancer patients undergoing neurosurgical interventions for intractable pain. We will review the clinical considerations guiding the choice of the therapeutic approach through representative clinical cases.

This concurrent session will provide a review of ablative neurosurgical interventions; the current evidence for their use, their benefits, and risks. Through comprehensive case presentations and analysis, we will discuss patient selection considerations, patient safety and personal preferences guiding the assignment of each procedure to a specific patient.

Winning Hearts and Minds: The Challenges and Successes of Outpatient Palliative Care for Patients with Heart Failure (TH338)



Rachel Klinedinst, ACPN CRNP, University of Pennsylvania, Philadelphia, PA. Laura Tycon, RN NP CRNP, University of Pittsburgh Medical Center, Pittsburgh, PA.

Objectives


- Outline the benefits of palliative care in the management of patients with heart failure.
- Describe common barriers to providing palliative care in the heart failure population.
- Identify key tools necessary for a successful outpatient specialty palliative care clinic for heart failure patients.

Heart failure is the leading cause of death in the United States, and it affects approximately 6.5 million people globally. As a chronic and debilitating disease that may span years or even decades of a patient’s life, heart failure carries the risk of high symptom burden and decreased quality of life for the people it affects. Most—if not all—patients with heart failure will have palliative care needs at some point during their illness.

Emerging evidence demonstrates that palliative care provides substantial benefits for heart failure patients.

Recent guidelines from the American College of Cardiology recommend palliative care as a standard of care for all patients with advanced heart failure. Still, clinicians frequently encounter roadblocks when attempting to integrate palliative care into this population. Due to the unpredictable trajectory of heart failure and other barriers unique to the culture of cardiology, the proper timing of palliative care can be particularly challenging. Often, it is offered too late or not at all. One solution for more timely and effective implementation of palliative care for heart failure patients is the outpatient specialty clinic model.

In this session, two nurse practitioners with experience in both palliative care and cardiology will briefly review current research supporting the value of palliative care for heart failure patients. They will also explore common barriers to integrating palliative care in the heart failure population, including patients with Ventricular Assist Devices (VADs). Finally, they will offer practical guidance on the structure and resources necessary for building and maintaining an outpatient palliative care clinic for heart failure patients. Using case examples and knowledge garnered from their own experience, the presenters will share their own successes and difficulties with providing specialty palliative care in the outpatient setting. Interactive audience discussion will be encouraged.

Where Palliative Care and Nephrology Meet—Complex Decisions in the Older CKD Patient (TH339) 

Dale Lupu, PhD MPH, George Washington University, Washington, DC. Alvin Moss, MD FACP FAAHPM, West Virginia University School of Medicine, Morgantown, WV. Jane Schell, MD, University of Pittsburgh, Pittsburgh, PA. Kathryn Schueller, MD, University of Wisconsin, Madison, WI. Katharine Cheung, MD MSC BA FRCPC, University of Vermont Medical Center, Burlington, VT.

Objectives

- Describe three complex dialysis decisions for kidney disease patients including conservative care, trial of dialysis and dialysis discontinuation.
- Demonstrate communication approaches between palliative care and nephrology clinicians. Foster collaboration on complex cases using role play demonstrations.

Chronic kidney disease (CKD) is increasingly common in the aging population, and the highest incidence of patients starting dialysis is those 75 years of age and older. Patients over the age of 67 face mortality rates as high as 23% at 6 months, though there exists great variability. Older patients with advanced CKD are more likely to have comorbidities including cognitive and functional limitations. Symptom burden is high

and does not consistently improve, and may worsen, after starting dialysis. This cluster of factors complicates decision-making as uncertainty often exists as to whether the benefits outweigh the risks of starting, stopping or continuing dialysis.

As palliative care becomes part of routine nephrology care, palliative care clinicians will work closely with nephrology clinicians to address these complex decisions, and care for this frail population. Many nephrology clinicians do not feel prepared to have conversations about forgoing dialysis and worry that discussing withdrawal from dialysis may cause their patients to lose hope. Many patients express regret over starting dialysis, but may worry that stopping dialysis will disappoint their family or nephrology provider. Opportunities exist for palliative care clinicians to partner with nephrology clinicians and patients to navigate these difficult discussions and decisions. To best facilitate this, palliative care clinicians need to better understand the nuanced perspectives of their nephrology colleagues. By improving this understanding, palliative care and nephrology clinicians can communicate effectively to better support patients.

In this Kidney SIG sponsored session, an interdisciplinary team including palliative care nephrology clinicians will present cases to demonstrate the complexity of decisions for older patients with kidney disease. Nephrology-specific decision tools will be applied to the cases to show their benefit in managing advanced kidney disease. Communication skills to enhance collaboration between palliative care and nephrology will be demonstrated through role-play.

Paper Sessions (TH340–TH341)

Effect of Permanent Feeding Tube Placement on Healthcare Utilization Among Children with Neurologic Impairment (TH340A) 

Katherine Nelson, MD, Hospital for Sick Children, Toronto, Ontario, Canada. Laura Rosella, PhD, University of Toronto, Toronto, Ontario, Canada. Sanjay Mahant, MD MSc FRCPC, University of Toronto/Hospital for Sick Children, Toronto, Ontario, Canada. Astrid Guttmann, MD CM, Institute for Clinical Evaluative Sciences, Toronto, Ontario, Canada. Eyal Cohen, MD MSc, Hospital for Sick Children/ University of Toronto/ Institute for Clinical Evaluative Sciences, Toronto, Ontario, Canada.

Objectives

- Describe the effect of permanent feeding tube placement on healthcare utilization among a population-based cohort of children with neurologic impairment in Ontario.

- Discuss the exposure-crossover method, a relatively new type of epidemiologic study design.

Original Research Background. Permanent feeding tubes are often placed for children with neurologic impairment (NI) because of swallowing dysfunction. Feeding tubes impact the health of children with NI. Few population-based studies have examined the relationship between tube placement and health care utilization.

Research Objectives. To evaluate the effect of tube placement in children with NI on frequency of acute healthcare utilization (as a proxy for morbidity) after the procedure.

Methods. This population-based self-matched study used linked health administrative databases to identify children (0-17 years) with NI undergoing first permanent feeding tube placement in Ontario between 1993 and 2015. We compared days of hospitalizations pre- and post- procedure using an exposure crossover model. Time zero was the date of primary tube placement, induction was eight weeks centered on time zero, and the comparison intervals were the 52 weeks immediately before and after induction.

Results. The cohort included 1,908 children. Most were male (56%), and had a concomitant non-neurologic complex chronic condition (73%). At time of surgery, 44% were 1 to 2 years old. Prior to tube placement, the hospitalization rate was 0.46 days per child-week, which decreased afterwards to 0.32 days per child-week. Sixty-nine children (3.6%) died during follow-up. Approximately 30% of children (n=579) had their individual rates of hospitalization increase after tube placement; they were demographically similar to the rest. In a linear model of individual rates of change, higher baseline rates of hospitalization were the only factor associated with decreased hospitalization after tube placement.

Conclusion. Rates of hospitalization among children with NI were lower after primary tube placement for the cohort as a whole and for a majority of individuals within the cohort.

Implications for Research, Policy, or Practice. Higher hospitalization rates prior to tube placement were associated with greater decreases in post-tube hospitalization, suggesting that the most medically fragile children may benefit the most.

Associations of Parental Demographic and Child Clinical Characteristics with Parental Perceptions of Communication with Children with Advanced Cancer (TH340B)



C. Robert Bennett, CPNP, Vanderbilt University School of Nursing, Nashville, TN. Mary Dietrich, PhD MS, Vanderbilt University, Nashville, TN. Mary

Jo Gilmer, PhD MBA RN FAAN, Vanderbilt University, Nashville, TN. Debra Friedman, MD MS, Vanderbilt University Medical Center, Nashville, TN. Verna Hendricks-Ferguson, PhD RN CHPPN FAAN FPCN, Saint Louis University, Saint Louis, MO. Terrah Foster Akard, PhD RN CPNP, Vanderbilt University, Nashville, TN.

Objectives

- Describe the Parent Adolescent Communication Scale's application toward the pediatric oncology population.
- Understand parent-child communication trends observed in our sample of pediatric oncology families.

Original Research Background. Children with cancer require specialized care for their unique psychosocial needs. The National Cancer Institute's 2016 recommendations advised parents to have open and honest communication about cancer with their children. However, little research has explored dynamics affecting the quality of communication among parents and children with cancer.

Research Objectives. This study examined associations of parental demographics and child illness characteristics with parental reports of communication quality with children with relapsed or refractory cancer.

Methods. Participants included 76 parent-child dyads comprised of 70 (92%) biological parents and children 7 to 18 years of age (M=11.4). Parental demographics, child illness characteristics, and parental responses for "Overall," "Openness," and "Problem" communication scores from the Parent Adolescent Communication Scale were used for this study. Descriptive statistics, t-tests, and Pearson correlations were used to summarize and analyze the data.

Results. No statistically significant relationships of parent gender, race, education, and income with any of the communication scores were observed. Single parents (n=20) reported higher "Overall" (p=0.023, d=0.56) and lower "Problem" (p=0.013, d=0.65) communication scores on average than did married/partnered parents (n=56). Parents of bone marrow transplant recipients (n=19) reported lower "Problem" scores (p=0.011, d=0.67), and higher "Overall" and "Openness" scores than not (p=0.006, d=0.73) and 0.004(d=0.0.78) respectively).

Conclusion. Enhanced communication quality may exist between parents and children with cancer in single parent and bone marrow transplant families compared to married/partnered and non-transplant families.

Implications for Research, Policy, or Practice. Cancer treatment experiences and parent characteristics may impact the quality of

communication between parents and children with advanced cancer. Communication quality in populations such as bone marrow transplant families and single parent households may warrant additional study. Intervention development is needed to support parent-child communication and ultimately enhance the quality of care for these children and their families.

Communicating Prognosis in Life-Limiting Illnesses: Development and Pilot Testing of Communication Guides for Pediatric Providers and Parents in Cystic Fibrosis (TH340C)



Danielle Jameison, BA, University of North Carolina School of Medicine, Chapel Hill, NC. Mary Prieur, PhD, University of North Carolina School of Medicine, Chapel Hill, NC. Elisabeth Potts Dellon, MD, University of North Carolina School of Medicine, Chapel Hill, NC.

Objectives

- Deliver a pediatric patient's prognosis using the tool.
- Integrate a patient's family into the ongoing discussion about prognosis.

Original Research Background. Cystic Fibrosis (CF) is an inherited, progressive, life-limiting disease that, with advances in treatment, patients now live with into their forties. Adults with CF report dissatisfaction in two key components of their treatment: 1) initial provider communication about prognosis and 2) follow-up support to cope with the uncertainty of CF and its progression. Although communicating about prognosis is a milestone in disease management, there is no current guideline or recommendation for it.

Research Objectives. To develop and pilot communication guides that standardize discussions about prognosis in the care of children with life-limiting illnesses.

Methods. Synthesizing input from developmental psychology, research on provider-patient communication, and evidence-based tools used in serious illness care, we developed communication guides for both CF care providers and parents of children with CF. They detail when, how, and what to communicate with children about prognosis. We are currently conducting cognitive interviews with parents and providers for more intensive revision.

Results. Revisions to parent and provider guides were made following feedback from two parents of children with CF and two young adults with CF. All reviewers felt that the guides could successfully facilitate conversations about prognosis. Cognitive interviews

underway with ten parents are exploring 1) timing, including appropriate age range and clinical setting (i.e., a routine clinic visit vs. an inpatient stay), 2) delivery, specifically the face-to-face conversation that surveyed patients prefer, and 3) content, including specific evidence-based structure and verbiage to facilitate discussions about prognosis.

Conclusion. Initial feedback from parents, patients, and CF care providers suggests that communication guides will facilitate discussions about prognosis. Future plans include developing a provider training module, and disseminating the guides for use by CF care teams to promote quality patient-centered care.

Implications for Research, Policy, or Practice. The ultimate goal is to generalize this model, establishing a clinical best practice of early and effective discussions about prognosis in other serious illnesses.

Pediatric Palliative Oncology Patients: Demographics, Treatment and End-of-Life Experiences of a Vulnerable and Understudied Population (TH340D)



Erica Kaye, MD, St. Jude Children's Research Hospital, Memphis, TN. Courtney Gushue, DO, University of Tennessee, Memphis, TN. Samantha Demarsh, Ohio University Heritage College of Osteopathic Medicine, Cleveland, OH. Jonathan Jerkins, MD, University of Tennessee, Memphis, TN. Jennifer Snaman, MD, St. Jude Children's Research Hospital, Memphis, TN. Lindsay Blazin, MD, St. Jude Children's Research Hospital, Memphis, TN. Liza-Marie Johnson, MD MSB MPH, St. Jude Children's Research Hospital, Memphis, TN. Deena R. Levine, MD, St. Jude Children's Research Hospital, Memphis, TN. R. Ray Morrison, MD, St. Jude Children's Research Hospital, Memphis, TN. Justin Baker, MD FAAP FAAHPM, St. Jude Children's Research Hospital, Memphis, TN.

Objectives

- Lead a discussion integrating evidence from the literature in support of development of palliative oncology as a uniquely relevant and informative field of research.
- Review the development of a comprehensive standardized data abstraction tool for the purpose of extracting demographic, disease, treatment, palliative care, and end-of-life data from the medical record using rigorous methodology.
- Describe the illness and end-of-life experiences of pediatric palliative oncology patients and families, including the burden of intensive therapy, timing of palliative care consultation, and location of death.

Original Research Background. The field of pediatric palliative oncology is newly emerging. Children with cancer who receive palliative care represent a unique cohort that is not well described in the literature.

Research Objectives. To describe the characteristics and illness experiences of pediatric palliative oncology patients and to investigate associations between timing of palliative care consultation and location of death.

Methods. A retrospective cohort study of 321 pediatric oncology patients enrolled on a palliative care service who died between 2011 and 2015 was conducted at a large academic pediatric cancer center using a comprehensive standardized data extraction tool.

Results. The majority of pediatric palliative oncology patients received experimental therapy (79.4%), with 40.5% enrolled on a phase I trial. Approximately one-third received cancer-directed therapy during the last month of life (35.5%). More than half had at least one intensive care unit hospitalization (51.4%), with this subset demonstrating significant exposure to mechanical ventilation (44.8%), invasive procedures (20%), and cardiopulmonary resuscitation (12.1%). Of the 122 patients who died in the hospital, 44.3% died in the intensive care unit. Patients with late palliative care involvement occurring less than 30 days before death had higher odds of dying in the intensive care unit over the home/hospice setting compared to those with palliative care involvement occurring 30 days or more before death (OR: 4.7, 95% CI: 2.47-8.97, $p < 0.0001$).

Conclusion. Children with high-risk cancer who receive palliative care experience a high burden of intensive treatments and often die in inpatient intensive care settings. Palliative care involvement occurring less than a month prior to death is associated with increased risk of dying in the intensive care unit.

Implications for Research, Policy, or Practice. Prospective investigation of early palliative care involvement in children with high-risk cancer is needed to better understand potential impacts on cost-effectiveness, quality of life, and delivery of goal concordant care.

Impact of Specialist Palliative Care on Re-Admissions: A “Competing Risks” Analysis to Take Mortality into Account (TH341A)



Brian Cassel, PhD, Virginia Commonwealth University, Richmond, VA. Melissa Garrido, PhD, Department of Veterans Affairs/Mount Sinai, Bronx, NY. Peter May, PhD, Trinity College Dublin, Dublin, Ireland. Egidio Del Fabbro, MD, Virginia Commonwealth University, Richmond, VA. Danielle Noreika, MD, Virginia Commonwealth University, Richmond, VA.

Objectives

- Evaluate the impact of PC on subsequent utilization such as readmissions.

- Ascertain mortality of patients and incorporate that into evaluations of PC impact

Background. Several retrospective cohort studies have suggested that specialist palliative care (PC) reduces hospital re-admission rates. However, in such studies, the association between PC and readmission does not account for the fact that PC patients may be more likely to die after discharge than usual care (UC) patients. People who have already died cannot be readmitted.

Objectives. To examine the association between PC and readmissions while accounting for mortality.

Methods. Retrospective cohort study of hospital admissions (2009-2015) for adults with one or more life-limiting diseases, who died within 1 year. Propensity score weighting was conducted using sex, race, insurance, diagnosis, surgery or ICU admission on first day, and co-morbidities, to compare 1,497 PC patients to 5,264 UC patients ($n=6,671$). We estimated the association between PC and readmissions using a competing risks analysis. By ascertaining death date and treating readmissions and death as competing risks, we are able to analyze the association between PC and readmissions appropriately.

Results. Of the full sample, 18% were readmitted within 30 days, 24% within 60 days and 28% within 90 days. PC patients were more likely to be deceased at each endpoint (all $p < 0.005$), despite propensity score weighting. In the competing risks analysis, the sub hazard ratios for the PC group were 0.56 for 30-day readmission, 0.53 for 60-day, and 0.52 for 90-day (all $p < 0.005$), indicating the re-admission rate is lower in the PC group. Secondary analyses using regression methods were also conducted to highlight important limitations to the standard approach.

Conclusion. PC is associated with reduced readmissions using a competing risks analysis taking cumulative incidence of mortality into account.

Implications. Given the difference in mortality between PC and UC groups, standard regression methods may increase the risk of biased estimates of PC's impact on readmissions. When evaluating the impact of PC on subsequent hospitalizations and costs, mortality should be ascertained and taken into account.

Engaging Oncologists Toward Integrating a Shared Mental Model (SMM) for Palliative Oncology within a Large Academic Oncology Practice (TH341B)



Anne Walling, MD PhD, University of California, Los Angeles, Los Angeles, CA. Anne Coscarelli, PhD, Simms/Mann-UCLA Center for Integrative Oncology, Los Angeles, CA. Wendy Simon, MD, University of California, Los Angeles Health System, Los Angeles, CA.

Neil Wenger, MD MPH, University of California, Los Angeles, Los Angeles, CA. Christopher Pietras, MD, University of California, Los Angeles, Los Angeles, CA. Kauser Ahmed, PhD, University of California, Los Angeles, Los Angeles, CA. Sara A. Hurvitz, MD, University of California, Los Angeles, Los Angeles, CA. Peter Phung, MD, University of California, Los Angeles, Los Angeles, CA. Meghan Nechrebecki University of California, Los Angeles, Los Angeles, CA. Sarah F. D'Ambruso, RN NP, University of California, Los Angeles, Los Angeles, CA. Jennie Kung, University of California, Los Angeles, Los Angeles, CA. Jonathan Wade Goldman, MD, University of California, Los Angeles, Los Angeles, CA. Lee S. Rosen, MD, University of California, Los Angeles, Los Angeles, CA. Alexandra Drakaki, MD, University of California, Los Angeles, Los Angeles, CA. Parvin F. Peddi, MD, University of California, Los Angeles, Los Angeles, CA. Deborah Jean Lee Wong, MD, University of California, Los Angeles, Los Angeles, CA. John A. Glaspy, MD, University of California, Los Angeles, Los Angeles, CA.

Objectives

- Understand approaches to engaging partners in quality improvement projects in palliative care.
- Describe a successful example where our team used these approaches to successfully engage with oncologists in a health system-wide quality improvement effort.

Background. Engaging oncologists to improve palliative care (PC) within oncology clinics is a key first step for partnered quality improvement (QI).

Aim Statement. We aimed to disseminate a successful pilot-tested SMM for the integration of early advance care planning (ACP) and identification of PC needs across a health system's oncologic practice.

Methods. Our multidisciplinary QI team represents leaders in oncology, ACP, PC, psychosocial oncology and quality. To communicate the SMM developed by our team, we held an interactive Saturday session (1-hour didactic, 3-hour small group role-play) that focused on early ACP and the cognitive and emotional aspects of communication. We report self-ratings of oncologists' ability to communicate with patients as well as their readiness, self-efficacy, and need for help to improve communication regarding prognosis, ACP, end of life care and symptom management using a previously validated survey. We computed means and compared matched pairs of pre and post surveys using a paired t-test. We also surveyed participants about whether they would recommend the course to others and planned changes to practice.

Results. All but one oncologist (52/53), 3/4 invited fellows, and 12/14 oncology nurse practitioners participated and 90% of attendees completed pre and post surveys. Participants rated their communication ability

higher (6.7 v. 7.6, $p < 0.01$) on a 10-point scale after the training. Readiness to improve communication in this domain (9.1 v. 9.2, $p = 0.35$) was similar before and after the training. Self-efficacy (1.5 v. 1.5, $p = 0.70$) and needing help to improve (1.6 v. 1.7, $p = 0.37$) were rated highly (1=A lot and 4=Not at all) but did not change with training. All but one participant reported they would recommend the course to others and free text responses about changes they planned to make to their practice based on the training included having earlier ACP discussions and asking open-ended questions.

Conclusions and Implications. Conducting a training to disseminate a SMM of oncology and PC is feasible and valuable.

Advanced Care Planning and End-of-Life Discussions Amongst Resident Physicians In the Primary Care Setting (TH341C)



Suraj Tandon, MD, Weill Cornell Medical College, Queens, NY.

Objectives

- Identify common barriers amongst health care professionals when attempting to conduct ACP discussions.
- Develop tools to enhance confidence levels in health practitioners when conducting patient and family discussions.

Original Research Background. More often than none code status and goals of care discussions are held in the emergency room or ICU during acute patient events. These discussions can often be stressful and difficult to have for both practitioners, patients and their families. Many barriers persist and hinder these discussions from occurring such as limited practitioner experience and training, lack of counselling time, and social and cultural taboos. These feelings can easily be minimized or even avoided if advance care planning discussions are held earlier especially in the primary care setting before such events are likely to occur in high risk patients.

Research Objectives. To assess the effectiveness of an intervention in improving discussions amongst residents and patients in the ambulatory setting about end of life discussion and code status.

Methods. Pre and post-intervention questionnaire was provided to resident physicians in the ambulatory setting determining how many of them conducted ACP discussions and what barriers they perceived. Intervention included simulated patient physician discussion to develop confidence skills in leading ACP discussions.

Results. Zero residents (24 surveyed) had conducted ACP discussions with all of their patients in the primary care setting, 12.5% had discussions with at least

half of their patients, 18.7 % had discussions with less than half of their patients and 68.7% had never had a discussion. Barriers that were perceived by residents included lack of time (81.2%), lack of experience (62.5%), language barrier (50%). Post intervention: 56.2% of residents stated they would likely have future ACP discussions, 31.2% (somewhat likely), 6.25% (not likely, or don't know yet).

Conclusion. Many residents indicated an improvement in self confidence levels and knowledge base in leading discussions.

Implications for Research, Policy, or Practice. Our findings will help identify common barriers to ACP discussions in the primary care setting as well as enhance and educate physicians in training to be more comfortable in leading such discussions.

3–4 pm

Educational Forums

State of the Science in Pediatric Palliative Care (TH351)



Lindsay Ragsdale, MD, University of Kentucky, Lexington, KY. Jennifer Hwang, MD MHS, The Children's Hospital of Philadelphia, Philadelphia, PA. Lisa Humphrey, MD, Nationwide Children's Hospital, Columbus, OH. Elissa Miller, MD, Nemours/AI duPont Hospital for Children, Wilmington, DE. Cheryl Thaxton, APRN MN FNP-BC CHPPN CPNP, University of Texas Southwestern Medical Center, Dallas, TX. Tiffany Webster, MDiv, Legacy Health, Portland, OR. Nicole Parente, LSW, Nationwide Children's Hospital, Columbus, OH.

Objectives

- Describe new, relevant articles to the clinical practice of pediatric palliative care.
- Describe a fact, skill or attitude that you are re-considering based on the information presented at this session.
- Identify a clinical population that your program serves that you could write about to educate the larger pediatric palliative care community.

Pediatric State of the Science at the 2017 Annual Assembly was well received by the audience as a way for practitioners to stay current on the most recent literature affecting our patients. In the spirit of the State of the Science plenary which is part of the Assembly each, we hope to make this a new annual tradition. Our practitioners will endeavor to review the literature published in 2017 which should inform the practice of Pediatric Palliative Care. Our transdisciplinary team of co-presenters includes representatives from medicine, nursing, social work and chaplaincy and will look at the academic literature relevant to the multiple disciplines represented. In

addition to highlighting recent literature, the presenters hope to inspire session participants to consider how new knowledge will influence their practice and how they can personally contribute to the published knowledge base.

Why Do You Want to Know and Why Should I Trust You? Implicit Messaging in Cross-Cultural (Mis)Understandings (TH352)



Marjorie Kagawa Singer, PhD MA MN RN, Vjeyanthi Periyakoil, MD, Stanford University Medical Center, Palo Alto, CA. Ronit Elk, PhD, University of South Carolina College of Nursing, Columbia, SC.

Objectives

- Ability to differentiate and understand the difference between disease and illness.
- Ability and willingness to question one's assumptions of assessing suffering in diverse population groups.
- Creating opportunities in research and clinical care to practice cross-cultural communication skills.

The two objectives of this presentation is to first provide the theoretical background to defining and operationalizing culture for both practice and research, and second, provide example scenarios of cross-cultural encounters that did not go well and why - indicating the questions we need to ask ourselves whenever we encounter patients, families, and colleagues who are different than ourselves or even within our group but from a different gender and or age cohort.

The lecture segment of the presentation will highlight the monocultural lens used in the United States to direct research and practice, and demonstrate why this lens is too constraining to address the needs of our multicultural society as we interact with fellow clinicians, researchers, and, most importantly, patients and their families. I will define culture for health care, and briefly identify steps to help identify where differences make a difference for both practice and research.

This one hour session will be divided into 3 parts: 1) the didactic, lecture presentation, 2) breakout sessions to discuss a scenario and devise interventions/studies/practicums to address solutions, and 3) Large group reconvenes to discuss next steps for the Academy to support their suggestions.

Extreme Measures: Finding a Better Path to the End of Life by Jessica Zitter—Book Club Discussion (TH353)



Facilitated by Leaders of the Humanities and Spiritual-ity SIG.

Objectives

- Discuss end of life topics among clinicians that specialize in the field of Hospice and Palliative Medicine.

- Integrate social and cultural influences in a dialogue with others through independent reading of nonfiction.
- Formulate a self-reflective and critical review common themes of the book.

Session leaders will be assigned to each table to start and facilitate discussion. This will help to ensure that each table is having a productive dialogue. Conversation starting questions will be provided at each table and have been vetted by the Humanities and Spirituality SIG.

4:30–5:30 pm

Concurrent Sessions

Swimming Upstream Successfully: The Nuts and Bolts of Community-Based Palliative Care Programs Operated by Hospices (TH361)

Jeanne Twohig, MPA, Ichan School of Medicine at Mount Sinai, New York, NY. Turner West, MPH MTS, Bluegrass Care Navigators, Lexington, KY. Rikki Hooper, MBA MSN ACHPN FNP, Four Seasons, Flat Rock, NC. Jennifer Ritzau, MD, Hope Hospice and Palliative Care Rhode Island, Providence, RI.

Objectives

- Describe why and how hospice organizations provide natural administrative homes for providing quality, cost-effective community-based palliative care services.
- Identify how community-based palliative care programs' staffing and services are shaped by the administrative structures of the hospice organization and how they differentiate the delivery of hospice services from community-based palliative care services.
- Describe how payment models and reimbursement strategies impact the design of community-based palliative care services provided by hospice organizations.

Hospice organizations across the country are expanding their services to offer palliative care programs as new business lines distinct from their hospice services, and they need to know the essential aspects of planning and service delivery to consider as they develop community-based palliative care programs. This highly interactive session is a sequel to one presented at the 2017 Academy Assembly; the interest in the session indicated a demand for more information on the topic. It is designed as an "open mic" opportunity to explore the ins and outs of how hospices successfully operate community-based palliative care programs. The session will feature representatives from three hospice programs that have successfully designed

and are now offering a wide range of community-based palliative care programs in the home, office, and long-term care settings: Bluegrass Care Navigators (formerly Hospice of the Bluegrass) is a hospice organization serving 32 counties in central, southeast, and northern Kentucky; Four Seasons is a large hospice in western North Carolina; and HopeHealth Services offers hospice and community-based palliative care services in Massachusetts and Rhode Island. Using the format of a town hall meeting, the three panelists will present brief overviews of their diverse programs and their organizations' models. They will then respond to questions from a moderator that probe the practicalities of program design. Facilitated by the interactive dynamics of the town hall open mic format, session participants will be invited to ask questions about administrative structures, staffing patterns, service differentiation, patient identification and transition, and reimbursement strategies. They will have the opportunity to explore with these leaders the benefits, opportunities, and challenges their hospices experience while offering community-based palliative care as part of a hospice organization. Finally, the moderator will summarize take-home messages from the discussion for the audience.

iDeath: Goals of Care for Our Social Media Image (TH362)

David Buxton, MD, Center for Palliative Psychiatry, Richmond, VA. Sarah Rohrer, MSW, CJW Medical Center, Richmond, VA.


Objectives

- Learn the impact of social media on palliative care patients.
- Review new concepts around virtual images of patients to create a basis of how to address it during goals of care meetings.

Social media is ubiquitous in our society and allows us to create a virtual image of ourselves. We can share our life story using multiple platforms including YouTube, Twitter, Facebook, Snapchat and Instagram. In our palliative care patient population, the use of these social media outlets gives narrative to an individual's serious illness; but, the consequences of this exposure, and its perpetuity, to both loved ones and public viewers raises new questions for our society.

One famous example is Ben Breedlove, an 18 year old who was diagnosed with hypertrophic cardiomyopathy at only 13 months old. During the course of his illness, Ben posted 38 videos on YouTube via his channel "Our-Advice4You" (60,000 subscribers) and "Breedlove TV" (32,000 subscribers). Towards the end of his life, Ben posted a secret 2-part video on a secret YouTube channel entitled "This is My Story" utilizing handwritten note

cards to communicate with the audience. He reflected on the impact of having a chronic illness with childhood onset and three subsequent near death experiences. Tragically, he died a week later on Christmas morning and his family discovered the “This is My Story” videos the day after his death. His intimate testimony became an internet sensation with almost 9 million views and has been the subject of blogs, books and television shows. The presenters will share Ben’s dynamic videos and the Internet’s reaction to initiate a dialogue about the effects of social media on palliative care patients. We will introduce new concepts such as virtual advance care planning, e-beneficiaries, virtual ownership, tweeting from the grave and vintage bloggers. Furthermore, participants will discuss how palliative care providers could preemptively discuss patients’ goals of care for their virtual image and how it may affect the bereavement process of their loved ones.

Going from Casual Dating to a Long-Term Commitment: Adding a Pharmacist to Your Team (TH363) 

Kashelle Lockman, PharmD, University of Iowa College of Pharmacy, Iowa City, IA. Ann Broderick, MD MS, VA Medical Center, Iowa City, IA. Jessica Geiger-Hayes, PharmD BCPS CPE, OhioHealth, Columbus, OH. Tanya Uritsky, PharmD BCPS, Hospital of the University of Pennsylvania, Philadelphia, PA. Charles von Gunten, MD PhD FACP FAAHPM, OhioHealth, Columbus, OH.

Objectives

- Describe specialized pharmacist education and training in hospice and palliative care.
- Compare and contrast advanced roles and responsibilities of pharmacists and other disciplines on hospice and palliative care teams.
- Describe advanced pharmacist practice models, including pharmacist prescribing authority through collaborative practice protocols.

Pharmacists’ training in pharmacology, therapeutics, and communication offers a unique skill set and benefit to palliative care and hospice teams. While pharmacists are increasingly becoming integral members of patient care teams in hospice and palliative care, their training and roles are varied and often unfamiliar. To increase awareness of the advanced roles of pharmacists in these sub-specialties, in 2016 the American Society of Health Systems Pharmacists (ASHP) published a statement outlining essential and desired roles for hospice and palliative care pharmacists. The purpose of this session is to clarify the diverse training and roles of hospice and palliative care pharmacists and share strategies for successfully

integrating pharmacists into hospice and palliative care teams.

In this interactive experience-based session, three palliative care pharmacists from different practice sites and with differing roles on their respective teams will introduce the 2016 ASHP statement and discuss how the pharmacist’s role can be customized based on the structure of the team, available resources, unique needs of the institution or practice sites, and state laws allowing for pharmacists to have prescribing authority. Participants will learn how hospice and palliative care pharmacists are trained, from on the job training to formalized residency programs, as well as how their skills complement and differ from other members on the team. Palliative care physicians will provide insight on acquiring and incorporating a palliative care pharmacist into an existing team. By the end of this session, participants will be able to describe the nuances of incorporating a pharmacy partner in multidisciplinary, interdisciplinary, and transdisciplinary hospice and palliative care models.

The second part of this series, “From Unicorns to Workhorses: Interventions and Outcomes of Palliative Care and Hospice Pharmacists” will include an interactive, multidisciplinary case-based session discussing the unique interventions, outcomes data, and future of pharmacists on palliative care and hospice teams.

New Drugs and Drug News: The 411 and Implications for Palliative Care (TH364) 

Mary Lynn McPherson, PharmD MA MDE BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD.

Objectives

- List new drugs approved by the FDA in 2017. For each drug the participant will be able to describe the approved indication, unapproved uses of the medication, common adverse effects and drug interactions.
- Describe the burden-to-benefit ratio and the role of the medication in caring for patients with advanced illness for each new relevant medication approved in 2017.
- Analyze important drug alerts and their relevance to drug therapies commonly used in hospice and palliative care patients.

Description: Up to 100 new drugs and dosage formulations are approved every year by the Food and Drug Administration (FDA). Some of these are new molecular entities, while others are new formulations, new indications, generic drug approvals or labeling revisions. Even if a drug is a “new” molecular entity, it may not be “improved” over molecular entities

already commercially available. In caring for patients with advanced illnesses, practitioners must make prudent drug therapy choices. Part of this decision-making process is a careful assessment of the burden-to-benefit ratio, including the financial burden of using each medication.

This concurrent session is a follow-up to previous year's very popular update on new drugs. For relevant drugs approved in 2017, participants will learn about the FDA-approved indication for using the medication, unapproved uses of the medication (particularly as it applies to palliative care patients), if it is a controlled substance and the schedule (if appropriate), adverse effects, major drug interactions, dosing, and financial implications of drug procurement and monitoring if relevant.

Participants will learn what "NDA Chemical Type" (eg, new molecular entity, formulation, manufacturer, indication or OTC switch), and "Review Classification" (priority, or standard review; orphan drug status) was assigned by the FDA. If available, participants will also learn the "new drug comparison rating" (1-5, 5 highest in terms of drug importance). Most importantly, the participant will learn about the role of the new agent in caring for patients with advanced illnesses, and how this medication compares with medications already available. Public health advisories and drug-related alerts pertinent to end of life care will also be discussed, and their impact on caring for palliative care patients. Inappropriate use of medications in hospice or palliative care may result in suboptimal symptom management. This is a session that every healthcare professional needs to attend!

Finding Words That Matter: Rekindling Our Purpose in Healthcare Through Poem-Making (TH365)

Judith Redwing Keyssar, BA RN, Jewish Family and Children's Services, San Francisco, CA. Michael Rabow, MD FAAHPM, University of California San Francisco, San Francisco, CA.

Objectives

- Express the benefits of poem-making as an adjunct to clinical practice.
- Identify how writing and sharing poetry may help process grief accumulated in the routine work of palliative care.
- Describe a sense of re-connection to what is important and true for them and too often unspoken in our work in palliative care.

"Writing poetry together heals loneliness. What is true for someone on the deepest level is often true for us all. Reading a poem aloud and listening to the poems

of others can heal the alienation which is so much a part of our world." (Rachel Naomi Remen, MD, from Introduction to Poetic Medicine, by John Fox)

The intensity of our work days and lives, and even the busyness of a conference setting, often prevents us from listening to a deeper voice within ourselves. A voice that reminds us what matters most about our lives, our work, our relationships with our patients and colleagues. "Poem-making" is a way to access this voice and allow expression of elements of our clinical practice that we often ignore, or simply do not have time to honor. Sharing poems also can help create community for caregivers and clinicians to explore meaning and relationship, as well as processing grief.

"There is so much left over in our hearts and minds after a day of work. Poetry can create the space for us to reflect, to feel, and to make meaning out of our frenetic experiences caring for patients." (Dr. Michael Rabow)

In this one -hour experiential break-out session we will offer participants a chance to experience a sample of a participatory poetry pilot project currently being offered at UCSF. The "Finding Words that Matter" project is funded by the California Healthcare Foundation and facilitated by Redwing Keyssar, RN and John Fox, Poet, as a collaboration between the UCSF Symptom Management Service, the Palliative Care Program at Jewish Family and Children's Services in San Francisco and John Fox's Institute for Poetic Medicine.

Whose Decision Is It Anyway: What to Do When Adolescents and Parents Don't Agree on a Medical Plan (TH366)

Ilanit Brook, MD MS MSHS, Children's Hospital Los Angeles, Los Angeles, CA. Linda-Maritza Radbill, PhD, Children's Hospital Los Angeles, Los Angeles, CA.

Objectives

- Understand the Mature Minor Doctrine and its legal implications.
- Explore the current understanding of neurocognitive development from late childhood to adulthood.
- Review the definition of Capacity and practice application of capacity tools.

One of the more difficult scenarios in medicine is navigating a medical plan when the patient and family do not agree. This becomes even more complex when the patient is not of legal age but seemingly has capacity to make medical decisions. Legally in the United States, competence is the ability for an individual to participate in legal proceedings or transactions and the mental condition a person must have to be

responsible for his or her actions, which typically occurs at the age of 18. Capacity is the ability of a person to consent to medical interventions. Capacity is often tested and discussed in terms of four aspects; a person must have the ability to understand the information, appreciate the benefits and risks to themselves, reason to a decision, and express their wishes. Medical decisions are typically made between an autonomous patient and a medical professional. This shared decision making is predicated on a patient's capability of making decisions for themselves free from personal limitations or interference from others. The patient works together with the healthcare provider and based on patient personal preferences, adequate information about a medical diagnosis or procedure, and the goal to maximize the positive outcome a decision is made together. Integral in autonomy is the idea that a patient has the capacity to make medical decisions. How can the palliative care team help to navigate to a unified, agreed upon medical plan when there is dissent between an adolescent patient and his/her family. In this concurrent session we will explore current understanding of both the legal and neurodevelopmental aspects of capacity. We will use two cases to highlight a potential path to compromise and will discuss tools that are available to support the case that an adolescent may have capacity to make their own decisions.

Circling the Dragon-Taming Health IT Systems to Measure What Matters (TH367)

Arif H. Kamal, MD MBA MHS, Physician Quality and Outcomes Officer, Duke Cancer Institute, Durham, NC. Joseph D. Rotella, MD MBA, American Academy of Hospice and Palliative Medicine, Chicago, IL. Katherine Ast, MSW LCSW, American Academy of Hospice and Palliative Medicine, Chicago, IL. Marianne Matzo, PhD APRN-CNP AOCNP FAAN FPCN, Hospice and Palliative Nurses Association, Pittsburgh, PA. Lisa C. Lindley, PhD RN, University of Tennessee College of Nursing, Knoxville, TN.

Objectives

- Identify the challenges hospice and palliative care programs face when trying to use electronic health records and other IT systems to improve quality and meet requirements of quality payment programs.
- Describe the mission and evolution of the AAHPM/HPNA Measuring What Matters Electronic Clinical Quality Measures (eCQMs) Working Group.

- Describe the eCQM Group's progress to date on developing specifications for Measuring What Matters measures as electronic Clinical Quality Measures that can be integrated into electronic health records and clinical data registries and outline the work group's future priorities.

In this team presentation, leaders from AAHPM and HPNA will showcase the work of the Measuring What Matters Electronic Clinical Quality Measures (eCQMs) Working Group. They will identify the challenges hospice and palliative care programs face when trying to use electronic health records (EHRs) and other IT systems to measure and improve quality. They will discuss how electronic systems have helped or presented challenges in meeting requirements of quality payment programs and describe how the eCQM Group is tackling them. In particular, presenters will explain why electronic clinical quality measures are necessary for interoperability and integration into a myriad of electronic health records and clinical data registries. Discussion may focus on what a data sheet looks like, how to engage with an EHR vendor, etc. They will highlight the committee's work to date to harness IT systems to measure what matters to patients and families living with serious illness. They will also outline the work group's future priorities and provide ample time for audience questions and comments.

"And Yet It Was a Blessing": Psychodynamic Insights for Well-Being While Coping with Serious Illness (TH368)

Keri Oxley Brenner, MD, Massachusetts General Hospital, Boston, MA. Linda Emanuel, MD PhD, EPEC Project, Chicago, IL. Margaret Cramer, PhD ABPP, Harvard Medical School and Massachusetts General Hospital, Boston, MA. Sarah Sonnefeld.

Objectives

- Highlight moments in coping with terminal illness from the narrative and firsthand reflections of a patient's spouse.
- Identify key insights from psychodynamic theory that provide a useful framework for psychological coping.
- Strategize techniques and best practices in providing stability, wisdom and supportive structures to accompany patients and spouses facing terminal illness.

Some patients and families make striking statements amid the tragedy of illness, such as, "...and yet it was a blessing." It appears that these patients have a sense

of holistic well-being as they approach death, which has developmentally emerged throughout the trajectory of their life-limiting illness. This phenomenon of “Existential Maturity” provides foundational principles to both capture and comprehend the unique nuances that foster psychologically coping. Lessons from traditions such as self-psychology, development and attachment theory provide inroads for better understanding this process. Moreover, clinicians’ awareness of Existential Maturity can enhance patients’ well-being, identity, relationships and quality of life as they face mortality. In this concurrent session, a patient’s spouse will speak from her experience of accompanying her husband through the dying process. Her narrative will serve as a platform for highlighting various psychodynamic processes normative in terminal illness. A friend and psychoanalyst who accompanied the patient and spouse will reveal how the works of thinkers such as Winnicott, Bolwby, Kohut, Erickson and others illuminated the dynamics of their journey with serious illness. Finally, experts in palliative care and psychodynamic theory will provide practical techniques for clinicians to utilize these insights when caring for patients and families.

The groundbreaking elements of this presentation are the firsthand, synthesized reflections from a patient’s spouse and a collaborative discovery of the dimensions of the couple’s experiences that are generalizable to many who face mortality. Moreover, clinicians of all disciplines will acquire skills to apply this framework of Existential Maturity in psychological coping towards a state of thriving at the end of life. As the field of palliative care quickly expands in breadth, this session offers greater depth to the psychological processes of each clinical encounter.

Transplantation Ethics and the Role of Palliative Medicine (TH369)



Christine Toevs, MD, Terre Haute Regional Hospital, Terre Haute, IN. Robert Taylor, MD FAAHPM, Ohio State University, Columbus, OH. Michael Beets, MD HMDC FAAFP FAAHPM, The Hospice of East Texas, Tyler, TX. Dawn Gross, MD PhD FAAHPM, University of California San Francisco, San Francisco, CA.

Objectives

- Discuss the role of patient autonomy in organ transplantation.
- Evaluate the ethical arguments for imminent death organ donation.
- Consider the ethical arguments against imminent death organ donation.

Patient autonomy has been treated as the utmost ethical principle in decision making in medicine and

especially in Palliative Medicine. The ability of patients to make decisions regarding their medical treatment, refusal of treatment, and treatment goals in line with their beliefs has been the core of communication. Organ transplantation changes the patient’s autonomy, and the patient is required to relinquish some autonomy in order to receive a solid organ. Patients have been told they cannot choose DNR, or refuse medical interventions that would prolong their lives and the function of the organ. We will argue, given the resource limitations of organs available for transplant, the societal commitment to organ transplantation and the people affected, that it is completely appropriate to create limits on the autonomy of the recipient. However, these limitations must occur within the context of a fully informed discussion prior to transplant. Palliative Medicine can still offer support for patients and their families during these times, even if we cannot help patients choose autonomous decision to limit therapies after receiving a solid organ.

Currently United Network for Organ Sharing (UNOS) is considering allowing IDD in an effort to increase the supply of transplantable solid organs. Examples of IDD would include: patients with neurologically devastating injuries but not brain dead; patients with ALS on ventilator support or near ventilator support requirements; patients diagnosed with a terminal disease but not yet in the terminal stages of the disease. The ethical arguments in support of IDD are autonomy, altruism, and societal need. The primary argument against IDD is the removal of solid organs would result in death or hasten death, rather than the disease causing death. Given that Palliative Medicine is often intimately involved in the care of these dying patients, an understanding of the issues involved is important.

Paper Sessions (TH370–TH371)

Association Between Pre-Dialysis Functional Status and Risk of Death at One Year After Dialysis Initiation Among Older Adults (TH370A)



Melissa Wachterman, MD MPH, Harvard Medical School, Boston, MA. Amy Kelley, MD MSHS, Icahn School of Medicine at Mount Sinai, New York, NY. Ann O’Hare, MD, University of Washington, Seattle, WA. Nancy Keating, MD MPH, Harvard Medical School, Boston, MA. Stuart Lipsitz, ScD, Brigham and Women’s Hospital, Boston, MA. Omari-Khalid Rahman, MA, Mount Sinai Hospital, New York, NY.

Edward R. Marcantonio, MD SM, Beth Israel Deaconess Medical Center, Boston, MA.

Objectives

- Describe mortality risk over the first year after dialysis initiation among older adults and the significant role that functional impairment plays in increasing it.
- Develop increased ability to engage in discussions about whether dialysis initiation is in line with patient goals and preferences.

Original Research Background. Patient-centered decision-making about dialysis initiation in older adults is enhanced by understanding prognosis on dialysis and patient factors that are associated with mortality. Little is known about whether pre-dialysis functional status is a predictor of mortality after dialysis initiation.

Research Objectives. To examine one-year mortality after dialysis initiation among older adults and its association with pre-dialysis functional status.

Methods. Using data from the 2000 to 2012 Health and Retirement Study (HRS), a nationally-representative longitudinal study of older adults, linked to Medicare claims and the National Death Index, we sample those participants aged ≥ 65.5 years at dialysis initiation. Our primary outcome of interest was risk of death at one year after dialysis initiation, and our primary predictor of interest was functional impairment, i.e., needing assistance with ≥ 1 activity of daily living. We compared unadjusted one-year mortality between those with and those without functional impairment. We then calculated hazard ratios (HR) for risk of death at one year to determine whether functional impairment was associated with mortality after adjustment for age, comorbidity, and race.

Results. Among the 283 participants aged ≥ 65.5 years at dialysis initiation, mortality was 28% at 30 days, 48% at 180 days, and 58% at 365 days. In unadjusted analyses, one-year mortality was significantly higher among those with functional impairment versus those without (73% vs. 54%, $p < 0.01$). In analyses adjusted for age, comorbidity, and race, pre-dialysis functional impairment was significantly associated with greater risk of death at one year (HR 1.59, $p = 0.02$).

Conclusion. Older adults have very high mortality risk over the first year after dialysis initiation, and functional impairment is a significant predictor of death.

Implications for Research, Policy, or Practice. When engaging in discussions about

whether dialysis initiation is in line with patient goals and preferences, clinicians caring for older adults should consider the high post-initiation mortality risk, particularly for those with functional impairment.

Opportunities to Improve Patient Engagement in Dialysis Decisions for Older Adults with Life-Limiting Kidney Disease (TH370B)



Christopher Zimmermann, MD, University of Wisconsin, Madison, WI. Kavita Kanwar, BSN BS, University of Wisconsin, Madison, WI. Toby Campbell, MD MSCI, University of Wisconsin, Madison, WI. Jennifer Tucholka, BS, University of Wisconsin, Madison, WI. Daniel Fox, BS, University of Wisconsin School of Medicine and Public Health, Madison, WI. Sara Johnson, MD, University of Wisconsin, Madison, WI. Amy Zelenski, PhD, University of Wisconsin School of Medicine and Public Health, Madison, WI. Margaret Schwarze, MD, University of Wisconsin, Madison, WI. Roy Allan Jhagroo, MD, University of Wisconsin School of Medicine and Public Health, Madison, WI. Maureen Wakeen, NP, University of Wisconsin School of Medicine and Public Health, Madison, WI.

Objectives

- Identify opportunities to improve patient engagement in decision making during visits with specialist providers.
- Identify how the Best Case/Worst Case tool can help specialists improve patient engagement in conversations regarding life-sustaining treatments.
- List key components of physician-patient conversations that promote patient engagement.

Original Research Background. Older adults who initiate dialysis often passively accept treatment without making an active choice to commit to life-supporting therapy. Interventional strategies that target the dialysis decision-making conversation between patients and their nephrologists may promote earlier access to palliative care, leading to better outcomes.

Research Objectives. To characterize communication about dialysis and evaluate the proof of concept of an intervention to change nephrologist communication.

Methods. Pre/post-intervention study design. We recorded 16 outpatient conversations between nephrologists and patients age 70 and older with an $eGFR \leq 20$ mL/min/1.73 m², not on dialysis. After recording the first 12 conversations, we trained seven nephrologists to use the Best Case/Worst

Case (BC/WC) communication tool to describe treatment options and potential outcomes within the context of the patient's overall health. We used OPTION 5 and qualitative analysis to measure and characterize patient engagement in decision making before and after BC/WC training.

Results. Before training, OPTION 5 scores were low (median 20 out of 100 (IQR 15-35)), suggesting limited patient engagement in decision making. Nephrologists typically discussed lab values and considered when and how patients might receive dialysis. Few acknowledged the option of "no dialysis." After training, nephrologists used BC/WC with fidelity and OPTION 5 scores increased (median 65 (IQR 50-76)). Using the BC/WC tool, nephrologists presented a choice between dialysis and supportive care without dialysis, described how dialysis and other health events might be experienced, provided prognostic information, and used phrases to elicit patients' goals.

Conclusion. Currently nephrologists discuss the mode and timing of dialysis without disclosing prognosis or presenting dialysis as a choice. This leaves limited opportunity for patients to understand the role of supportive care or palliative care concurrent with dialysis. Interventions to support patient engagement in treatment decisions may improve access to palliative care.

Implications for Research, Policy, or Practice. Empirical studies should be designed to test the effect of communication interventions for specialists on the timing and access to palliative care.

The Patient's Lost Voice: Goals of Care Conversations During the Terminal Hospitalization (TH370C)

Seiko Izumi, PhD RN FPCN, Oregon Health & Science University, Portland, OR. Elizabeth Sokolowski, BS, Oregon Health & Science University, Portland, OR. Lauren Hoppert, BSBA, Oregon Health & Science University, Portland, OR. Brie Noble, BS, Oregon State University College of Pharmacy, Portland, OR. Jon Furuno, PhD, Oregon State University College of Pharmacy, Portland, OR. Erik Fromme, MD MSCR FAAHPM, Dana Farber Cancer Institute, Boston, MA.

Objectives

- Describe the purpose of goals of care conversation.
- Describe characteristics of goals of care conversation during the final hospitalization before death.

- Discuss factors associated with earlier goals of care conversations that would improve quality of end-of-life decision making.

Original Research Background. Goals of care conversations (GOCCs) are critical to identify patients' values and preferences and provide end-of-life care that is consistent with patients' wishes. However, little is known about when and how GOCCs happen.

Research Objectives. To describe the frequency and characteristics of GOCCs during hospitalizations where patients died.

Methods. This was a retrospective cohort study of adult (age>18 years) patients who died in an academic medical center in 2015. The demographic and health information of deceased patients were extracted from electronic health records, and provider notes were reviewed to identify conversations with patients and/or family members that documented patient's goals, preferences, and/or values.

Results. Among 533 patients who died in the hospital, mean age was 63 (SD=±16.7) years, 59% were male, and 65% died in an intensive care unit (ICU). Median length of hospital stay was 5 days (interquartile range [IQR] =2-12), and median time from the first GOCC to death was 2 days (IQR =1-5). Twenty-eight percent of patients did not have notes documenting a GOCC. Among the 384 patients who had GOCC documented, 242 (63%) were with surrogate decision makers, and only 142/533 (27%) of patients were able to participate in their own GOCC. Patients who participated in GOCC were less likely to die in the ICU (44.5%) compare to patients who did not participate (71.7%) or had no GOCC (73.8%).

Conclusion. While 72% of patients had at least one GOCC during their terminal hospitalization, only 26.6% of patients were well enough to participate.

Implications for Research, Policy, or Practice. If patients, families, and health professionals want patients' input into their end-of-life care, they can't wait until the patient is in the hospital dying to get it.

Communication with Family Increases Likelihood of Having a Living Will (TH370D)

Martha Francis, MSN RN AOCNP FNP-BC, University of Maryland School of Nursing, Baltimore, MD. John Cagle, PhD, University of Maryland, Baltimore, MD. Erika Friedmann, PhD, University of Maryland School of Nursing, Baltimore, MD. Debra Wiegand, PhD RN



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CCRN CHPN FAHA FPCN FAAN, University of Maryland, Baltimore, MD.

Objectives

- Articulate national rates of advance care planning in contrast to rates described in this study population and state predictors of having a living will for both healthy and seriously ill populations.
- Competent in referencing the importance of communication about death and dying in healthy and seriously ill populations during clinical practice.

Original Research Background. Advance care planning is an important mechanism through which individuals can communicate end-of-life preferences. These preferences are important to families in making end-of-life decisions for patients. Little research has been conducted on why individuals participate in advance care planning and how they communicate preferences to family.

Research Objectives. The purpose of this study was to determine whether previous experiences with communication about death and dying are positively associated with having a living will (LW).

Methods. A cross-sectional survey was distributed to a random sample of members of the American Association of Retired Persons (ages > 50 years) in Massachusetts. The survey included questions about attitudes toward family communication about death and dying. Of 3,000 members approached, 1,447 (48%) completed the survey. Chi square and logistic regression analyses were performed to examine communication predictors of having a LW.

Results. Comfort talking about death [χ^2 (1, n = 1,447) = 19.7, $p < .001$, and being likely to speak freely to family about death and dying [χ^2 (1, 1,447) = 15.9, $p < .001$, were significant predictors of having a LW. In multivariate analyses, sex, older age, comfort with communication, and speaking freely to family about death and dying demonstrated a significant relationship with having a LW.

Conclusion. Family communication about death and dying is associated with completion of a LW. Future interventions to promote family communication in routine clinical care as well as in those with serious illness are important and can ensure that patients' end-of-life preferences are known.

Implications for Research, Policy, or Practice. No single intervention can alleviate all discomfort and uncertainty during discussions about end-of-life care in the setting of acute serious illness, but significant advances can be made through normalizing

communications about death and dying within families and with providers who have the responsibility to mitigate uncertainty and distress.

Associations Between Sociodemographic Characteristics and Unmet Supportive Care Needs in Adults with CF (TH371A)



Laura Obregon, BS, University of Pittsburgh, Pittsburgh, PA. Kwonho Jeong, MS, Center for Research on Health Care (CRHC) Data Center, Pittsburgh, PA. Jonathan Yabes, PhD, University of Pittsburgh, Pittsburgh, PA. Joseph Pilewski, MD, University of Pittsburgh, Pittsburgh, PA. Laura Tycon, RN NP CRNP, University of Pittsburgh Medical Center, Pittsburgh, PA. Zachariah Hoydich, BS, University of Pittsburgh, Pittsburgh, PA. Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA. Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Describe the prevalence of unmet supportive care needs among adults living with cystic fibrosis.
- Identify associations between specific unmet supportive care needs and various sociodemographic variables among adults living with CF.

Original Research Background. Patients with cystic fibrosis (CF) report impaired quality of life. Little is known regarding specific unmet supportive care needs among patients with CF, and their relationship with sociodemographic factors.

Research Objectives. To identify associations between sociodemographic variables and unmet supportive care needs regarding: anxiety, sadness, pain, and uncertainty about the future of living with CF.


Methods. Adults with CF were recruited from an academic CF clinic to complete the Supportive Care Needs Survey (SCNS-34). The SCNS-34 addresses the prevalence of 34 unmet supportive care needs, as well as desire for support to address any unmet needs. Multivariable logistic regression was used to identify associations between sociodemographic variables and unmet supportive care needs, adjusting for demographic and clinical variables.

Results. Of 165 participants (56% male; median age: 29 years), 28% indicated some need for support regarding sadness, 39% for anxiety, 39% for uncertainty about the future with CF, and 37% regarding pain. Insufficient income was associated with needs for support regarding anxiety (OR: 6.48; 95% CI: 2.08, 20.2), sadness (OR: 6.15; 95% CI: 2.04, 18.5), pain (OR: 7.06; 95% CI: 2.22, 22.4), and uncertainty regarding living with CF (OR: 3.43; 95% CI: 1.18, 9.99). Male

gender was associated with lower need for support with anxiety (OR: 0.42; 95% CI: 0.20, 0.88). Older age was associated with increased needs for support managing pain ($p=0.02$). Religiosity was protective regarding needs for support with sadness (OR: 0.41; 95% CI: 0.18, 0.94) and pain management (OR: 0.34; 95% CI: 0.15, 0.78).

Conclusion. Adults with CF report significant unmet needs for support in a number of physical and emotional domains; many of these associations were associated with various sociodemographic characteristics, most notably, income.

Implications for Research, Policy, or Practice. For optimal uptake, palliative care programs serving patients with CF must be developed in a way that is sensitive to patient sociodemographic, particularly ability to afford additional copayments.

Perceptions and Experiences of Patients and Informal Caregivers in Advanced Chronic Obstructive Pulmonary Disease: An Exploratory Study (TH371B) 

Tanja Fusi-Schmidhauser, MD, Ente Ospedaliero Cantonale, Bellinzona, Switzerland. Katherine Froggatt, PhD, Lancaster University, Lancaster, UK. Nancy Preston, PhD BSc (Hons), International Observatory on End of Life Care, Lancaster University, Lancaster, UK.

Objectives

- Understanding the perceptions of patients and informal caregivers in advanced COPD.
- Understanding what is lacking in PC provision in advanced COPD.

Original Research Background. Although chronic obstructive pulmonary disease (COPD) is recognized as being a life-limiting condition with palliative care needs, palliative care provision is seldom implemented in this population. The disease unpredictability, the misconceptions about palliative care being restricted to cancer and only being relevant in the last days of life prevent a timely integrated care plan for patients with advanced COPD.


Research Objectives. To explore patients and informal caregivers' experiences during the disease trajectory and to understand their perceptions on palliative care integration in COPD.

Methods. Ten individual interviews with adult patients suffering from advanced COPD (GOLD stages 3 and 4) and their informal caregivers were conducted and recorded. Data analysis was performed through thematic analysis.

Results. Six different themes were identified. Patients reported a feeling of personal guilt and a sense of discrimination by healthcare professionals with regard

to their smoking habit. Informal caregivers mentioned their caring experience of loved-ones with a "self-inflicted disease" and their distress over acute exacerbations with a sense of helplessness in the case of dyspnoea. Both groups underlined their knowledge about the disease trajectory and the importance of having a palliative care support, which is currently lacking, addressing all multidimensional aspects of advanced COPD.

Conclusion. These findings informed the second phase of the study, which involves healthcare professionals in a collaborative inquiry group as part of a participatory action research project. This group will aim to develop and try out new ways to integrate PC into outpatients' services for people with severe COPD.

Spare Ronnie from Drowning: Reducing Heart Failure Symptoms in Hospice Patients Utilizing a New Guideline-Directed Medical Therapy Algorithm (TH371C) 

Charles Newton, MD FACC FACS FCCP, Hope Health-Care Services, Fort Myers, FL.

Objectives

- Differentiate the various etiologies of congestive heart failure, and describe how this understanding impacts treatment.
- Utilizing a newly introduced, vital sign-driven, heart failure treatment algorithm, the attendee will have the capacity to devise an anti-congestive medication strategy tailored to each hospice patient, and to any point in that patient's life trajectory.
- Following the patient's response to the treatment algorithm, each attendee will have an improved capacity to prognosticate life expectancy for each heart failure patient.

Background. Guideline Directed Medical Therapy (GDMT) is the foundation of current heart failure treatment. However, in end-stage disease, upon hospice enrollment, these medications are often either abandoned, or simply cut-and-pasted into the patient's new drug regimen without scrutiny. Neither approach serves the hospice patient well.

Aim Statement. Optimal treatment entails first defining the etiology of each patient's congestive failure, (preserved or reduced ejection fraction, and the presence or absence of concomitant valvular heart disease and/or atrial fibrillation). Application then of a streamlined, tiered algorithm of GDMT, specifically adapted to the hospice setting, best achieves, and preserves, optimal symptom management.

The algorithm is vital sign qualified; each different tier of therapy requires a different level of systolic blood pressure and/or heart rate to permit medication

administration. This dynamic automatically establishes a hierarchy of importance for the different medication groups, assists with formulating a rational initial medication regimen tailored to each patient, and prevents drug administration when, because of either relative hypotension or bradycardia, the agent could be deleterious. It also aids prognostication, and the eventual transitioning of patients off GDMT to only comfort medications (opioids and benzodiazepines) at the immediate end of life.

Methods. Comparing statistics drawn from a 12-month chart review of heart failure patients admitted to our in-patient hospice facility prior to implementation of this algorithm, to an ongoing data analysis of current patients with the same primary diagnosis.

Results. Statistics reveal a 31% improvement in BORG scale, and a 28% improvement in PPS. The live discharge rate to home* has risen by 39%, with patients living (comfortably) weeks longer.

Conclusions and Implications. Improved symptom management of hospice-enrolled patients with a primary diagnosis of heart failure underpin this treatment algorithm, with ongoing patient review. *"home" may include assisted or skilled nursing facility

Associations Between Symptom Burden and Unmet Supportive Care Needs in Adults with Cystic Fibrosis (TH371D)

Elizabeth Trandel, BA, University of Pittsburgh School of Medicine, Pittsburgh, PA. Joseph Pilewski, MD, University of Pittsburgh, Pittsburgh, PA. Kwonho Jeong, MS, Center for Research on Health Care (CRHC) Data Center, Pittsburgh, PA. Laura Tycon, RN NP CRNP, University of Pittsburgh Medical Center, Pittsburgh, PA. Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA. Connie Richless, MSN RN, University of Pittsburgh School of Medicine, Pittsburgh, PA. Jonathan Yabes, PhD, University of Pittsburgh, Pittsburgh, PA. Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Identify prevalent self-reported unmet functional and psychosocial supportive care needs in adults with cystic fibrosis.
- Recognize the relationship between symptom burden and self-reported unmet supportive care needs in adults with cystic fibrosis.

Original Research Background. Although patients with cystic fibrosis (CF) experience high symptom burden and impaired quality of life, little is known about their unmet needs for supportive care, and the patient-level factors associated with these unmet supportive needs.

Research Objectives. To identify the prevalence of and relationship between symptom burden and unmet supportive care needs in adults with CF.

Methods. Adults with CF recruited from an academic CF center completed the Supportive Care Needs Survey-34, which measures the presence of and need for support with 34 common supportive care needs; this analysis focused on six functional and psychosocial needs. Multivariable logistic regression evaluated the relationship between symptom burden, measured by the Edmonton Symptom Assessment System (ESAS) total score, and care needs, adjusting for clinical and demographic variables. ESAS total score was rescaled at six-point intervals, the minimally important difference.

Results. N=165 (median: 29 years; 56% male). Eleven percent of patients reported no symptom burden, 61% mild burden, and 28% moderate/severe burden. Of the needs analyzed, the most prevalent were fears about CF worsening (50%), functional limitations (43%), and uncertainty about the future (39%).

Patients with moderate/severe symptom burden were likelier to report needing support with all six care needs than patients with no or mild symptom burden ($p < 0.001$).

For each six-point increase in symptom burden, there was an increased odds of reporting need for support with: functional limitations (OR:1.60; 95% CI:1.34-1.92), learning to feel in control (1.51; 1.28-1.77), feelings about death and dying (1.49; 1.27-1.75), fears about their CF worsening (1.47; 1.24-1.73), uncertainty about the future (1.44; 1.24-1.68), and concerns about the worries of others (1.31; 1.14-1.50).

Conclusion. Symptom burden is associated with unmet functional and psychosocial supportive care needs among adults with CF.

Implications for Research, Policy, or Practice. Patient-reported outcomes, such as symptom burden, may reveal underlying unmet supportive needs, and therefore be a patient-centered trigger for palliative care referral.

Friday, March 16

7–8 am

Concurrent Sessions

Update on New NIH Clinical Trial Policies, Application Requirements and Resources (FR400)

Jeri L. Miller, MS MSc PhD, Office of End-of-Life and Palliative Care Research (OEPCR), NIH/NINR, Bethesda, MD.

Objectives

- Increase awareness and understanding of new NIH Policies on Clinical Trials.
- Understand new NIH Clinical Trial Funding Opportunity Announcements and application procedures.
- Learn of NIH resources and tools for new NIH Clinical Trial grant applications.

This Just in Time presentation will provide participants with updates on the recent NIH policy changes surrounding clinical trial grant applications. Attendees will learn about new definitions, policies and procedures surrounding NIH clinical trials including: the use of new FORMS-E application packages, the restructure of new NIH Funding Opportunity Announcements for clinical trials, required Certificates of Good Clinical Practice, review criteria, and changes to single-IRBs requirements by NIH. Resources will be shared for continued learning and training on these new policies.

National Consensus Project (NCP) Community-Based Practice Guidelines for Quality Palliative Care (FR401)

Gwynn Sullivan, MSN, National Coalition for Hospice and Palliative Care, Pittsburgh, PA. Betty Ferrell, PhD RN CHPN FAAN FPCN, City of Hope National Medical Center, Duarte, CA. Martha Twaddle, MD HMDC FAAHPM FACP, Northwestern Medicine, Chicago, IL. Amy Melnick, MPA, National Coalition for Hospice and Palliative Care, Pittsburgh, PA.

Objectives

- Explain how the NCP Guidelines for Community-based Palliative Care were developed
- Describe the specific domains of the NCP Guidelines for Community-based Palliative Care
- Identify strategies to apply the NCP Guidelines in community-based palliative care settings

In January 2017, the National Coalition for Hospice and Palliative Care received funding from the Gordon and Betty Moore Foundation to develop and disseminate national practice guidelines that formalize and

delineate provision of quality community-based palliative care delivery for adults, children, and families living with serious and/or chronic progressive illness to safely and reliably meet their supportive care needs where they live. This session will provide an overview of how the National Consensus Project (NCP) Guidelines for Community-Based Palliative Care were developed, the specific domains of the NCP Guidelines and how to begin to implement the draft NCP Guidelines in community-based palliative care provider settings. Even though the NCP Guidelines are still in process of final revisions and endorsements, this session is one of the first presentations to nationally showcase the NCP Guidelines.

#PallTech: Leveraging Digital Resources in Hospice & Palliative Care (FR402)

Bethany-Rose Daubman, MD, Massachusetts General Hospital, Boston, MA. Leah Rosenberg, MD, Massachusetts General Hospital, Boston, MA. Haipeng Zhang, DO, Dana-Farber Cancer Institute, Boston, MA. Sue Morris, PsyD, Dana-Farber Cancer Institute, Boston, MA. Irene Yeh, MD MPH, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Describe the current culture and climate for technological innovation within our changing healthcare system.
- Identify how digital resources can promote the work of hospice and palliative care clinicians.
- Examine gaps within hospice and palliative care that can benefit from technological innovation.

The shifting landscape of healthcare in America has fortified the call for innovations in how palliative care is delivered. We are seeing greater technological advancements in how we support and communicate with patients, share information, and engage patients and families in decision-making. Keeping up to speed with these innovations can be a daunting task. Deciding if and how we should be implementing such technological developments can be even more challenging.

In fields as rooted in empathy and humanity as hospice and palliative care, we discuss how digital resources can be leveraged without sacrificing the human connection. Drawing from websites, social media, and mobile apps, we demonstrate how specific applications can be utilized by the patient, caregiver, and different members of the interdisciplinary team within hospice and palliative care. We also explore how technology, such as interactive games, virtual reality, and augmented reality, can extend the reach of our work.

Participants are encouraged to examine the role of technology in their own practice and join the discussion on how these technological resources can be

utilized wisely and improve palliative care for under-represented and underserved populations. Each participant will have the opportunity to engage with specific technological applications during the session via a companion website (www.palltech.org).

Up to the Minute Billing, Coding, and Compliance Updates for 2018 and Beyond (FR403)



Christopher Jones, MD HMDC FAAHPM, Perelman SOM at the University of Pennsylvania, Philadelphia, PA. Jean Acevedo, CHC CPC LHRM CENTC, Acevedo Consulting Inc., Delray Beach, FL. Arif Kamal, MD MBA MHS FAAHPM, Duke Cancer Institute, Durham, NC.

Objectives

- Describe the current state of legislation that affects palliative care and hospice reimbursement, including the Patient Protection and Affordable Care Act (ACA), IMPACT Act, and CMS Hospice Benefit.
- Discuss how palliative care programs can thrive in value-based reimbursement systems, such as the Merit-based Incentive Payments (MIPS) and Alternative Payment Models (APMs) from MACRA.
- Describe tips and pearls related to new and evolving billing codes to maximize communication of clinician effort to payers.

Palliative Care (PC) programs are flourishing nationally, buoyed by a change in healthcare reimbursement models away from volume-driven fee-for-service care and toward payment for value. Lately, though, significant uncertainty has been introduced into healthcare due to changing national political winds. While understanding PC's place in the larger system remains crucial, predicting the future of Medicare, Medicaid, or health insurance more broadly has become challenging.

How can PC clinicians begin to remain current in this ever changing healthcare environment? In this concurrent session, our group of MBA-trained PC clinicians and a nationally recognized PC billing and coding expert will share with attendees up-to-the-minute changes in the healthcare environment. We will begin by outlining the current state of the Affordable Care Act or its replacement, effects of the IMPACT Act of 2014, and ongoing changes to the Medicare hospice benefit, focusing on PC clinician and program-level requirements. Current provider requirements from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will be discussed and Merit-based Incentive Payments (MIPS) and Alternative Payment Models (APMs), including AAHPM's role in shaping available APMs, will be shared as well. New

coding opportunities like Non-Face-to-Face Prolonged Service Codes and annual changes implemented by Medicare on January 1, 2018 will be outlined as well. Importantly, alterations to any of the above laws or implications of new ones passed before the Assembly will be focused upon by this group of business-minded presenters.

Prognosticating the future of health care is a big challenge. It is important for our field that we "learn nationally and operationalize locally" to continue PC's growth. This concurrent session will allow for national learning by bringing forth the most current, useful, and actionable information for our attendees by remaining flexible enough to respond to healthcare's changes.

If I Block His Dopamine and Stimulate His Serotonin Will He Feel Better? Palliative Psychopharmacology 101 (FR404)



Allison Jordan, MD HMDC, BJC Medical Group and Hospice, Saint Louis, MO. Scott Irwin, MD PhD, Cedars-Sinai, Los Angeles, CA. Jennifer Pruskowski, PharmD BCPS CGP CPE, University of Pittsburgh School of Pharmacy, Pittsburgh, PA. Jeremy Hirst, MD, UC San Diego Health, San Diego, CA. Eric Prommer, MD HMDC FAAHPM, University of California Los Angeles and VA HPM Program, Los Angeles, CA. Jason Webb, MD, Duke University School of Medicine, Durham, NC.

Objectives

- List 3 situations when psychiatry should be involved in the palliative care patient's care.
- State the most important neurotransmitters that are involved in the pathogenesis of mental illness.
- Name at least 2 new drugs for mental illness.

The palliative care practitioner is often the first point-of-contact for patients suffering from mental illness. This can be in the form of new onset mental illness or pre-existing disease that may or may not have been adequately addressed. Part of the treatment planning for caring for patients with mental illness includes consideration of pharmacotherapy. The number of safe and effective medication treatments for mental illness has expanded substantially over the past 10 to 15 years.

Since the initial days of the dopamine hypothesis and its role in schizophrenia, researchers recognize the role of neurotransmitters in the pathogenesis of mental illness. Understanding the neurobiology of symptom generation helps clinicians' select specific drugs to control symptoms. Knowing when and how to prescribe psychotropics—and knowing which medication to prescribe—can be challenging. A panel of palliative care specialists, psychiatrists, and clinical pharmacists will discuss the pharmacologic

management of mental illnesses important to palliative care. The goal of this session will be to allow attendees to gain confidence in the psychopharmacologic management of delirium, depression and anxiety.

The session will enable attendees to: 1) Quickly recognize mental illnesses in palliative care settings. 2) Review the neurotransmitters important in the generation and treatment of mental illness, as well as side-effects. 3) Get updates on current treatments for mental illnesses important to palliative care. 4) Recognize adverse effects associated with psychotropic drugs. 5) Discuss ways to optimize the psychiatrist-palliative care physician interaction.

Hitting the Sweet Spot: Practical Tips for Navigating the Opioid Crisis in Outpatient Palliative Care (FR405)

Pina Patel, MD, The Ohio State University Wexner Medical Center, Columbus, OH. Kashelle Lockman, PharmD MA, University of Iowa College of Pharmacy, Iowa City, IA. Kathleen Broglio, DNP ACHPN ANP NP CHPN FPCN, Dartmouth Hitchcock Medical Center, Lebanon, NH. Brook Calton, MD, University of California San Francisco, San Francisco, CA. Justin Kullgren, PharmD, The Ohio State University Wexner Medical Center, Columbus, OH.

Objectives

- Evaluate a Palliative Care patient's risk for opioid misuse, abuse and diversion.
- Describe 4 components of an opioid stewardship strategy in ambulatory Palliative Care.
- List 3 practical tools or tips to overcome challenges of implementing risk-assessment and management tools in an ambulatory setting.

Given the ongoing public health crisis related to the over-prescription and potential risks of opioids, clinicians face increased scrutiny when prescribing opioids in ambulatory settings. Palliative Care clinicians are squarely faced with the challenges of balancing the patient's comfort and the greater societal concerns surrounding the misuse, abuse, and diversion of opioids.

Harnessing the expertise of clinicians from diverse settings and disciplines, this concurrent session will focus on practical strategies to assess a patient's risk of opioid misuse and abuse, and foster opioid stewardship in outpatient Palliative Care settings. In brief, this session will review key risk factors associated with opioid misuse, abuse and diversion, examine commonly used risk-assessment tools, and discuss the potential roles of prescription drug monitoring programs, urine drug screens, and ambulatory naloxone availability in safe opioid prescribing. This session will focus intently on real-world, tried-and-true

methods for effectively and efficiently incorporating these tools into a busy outpatient clinical practice.

The session will close with a case study of one rural academic medical center's recent experience of implementing a safe opioid prescribing workflow into their outpatient Palliative Care clinic. The case study will include the first year of data using opioid prescribing guidelines and discuss potential challenges and opportunities for outpatient practices interested in adopting a similar strategy.

Introduction to a Novel Social Media-Based Meaning Intervention for Caregivers of Children and Adolescents Receiving Palliative Care (FR406)

Kathryn Levy, MSW, The Center for Hospice and Palliative Care, Cheektowaga, NY. Pei Grant, PhD, The Center for Hospice and Palliative Care, Cheektowaga, NY. David Byrwa, MS, The Center for Hospice and Palliative Care, Cheektowaga, NY. Rachel Depner, MS, Center for Hospice and Palliative Care, Cheektowaga, NY. Kelly Tenzek, PhD, University at Buffalo, Buffalo, NY.

Objectives

- Establish the need for a caregiver intervention.
- Introduce the intervention and its components.
- Disseminating findings from the piloting of this intervention.

Informal caregiving, or care provided by an unpaid individual to an adult or child with chronic and/or life-threatening illness, is phenomena that spans across cultures, settings, and generations. It is estimated that 16.8 million adults act as informal caregivers to children and adolescents. This subset of caregivers is generally overlooked within research and literature, as "caregiving" is seen as an act of general child-rearing. In reality, the acts of caregiving related to a child or adolescent's special healthcare needs are compounded atop basic child care. Compared to caregivers of adults, caregivers of children report poorer health outcomes and greater physical and financial burden. Interventions with these caregivers then must aim to increase quality of life and offer a form of self-care while not adding to their existing level of burden. The Photographs of Meaning Program, or POMP, is a novel social media-based intervention utilizing meaning-centered psychotherapy and photo-voice techniques. POMP itself has two main components, the first being a nine-week meaning-based intervention featuring weekly photo narrative challenges for participating caregivers. At the close of the intervention, a photo exhibition is held featuring these photographs and narratives as a way to empower caregivers and help them share their experiences with friends, family, clinicians, and

community members. For feasibility purposes, a focus group and exit interviews were also included in this pilot to guide current and future interventions. This session will review the existing research on caregivers of children and adolescents with chronic and/or life-threatening illness, introduce this new and innovative intervention and its components, disseminate findings from the piloting of this intervention, and discuss future directions for research.

“This May Be Recorded for Quality Assurance”: Approaches to Practice Fidelity in Telehealth Palliative Care (FR407)



Rebecca Yamarik, MD FAAHPM, Veterans Affairs, Long Beach, CA. James Dionne-Odom, PhD RN, University of Alabama at Birmingham, Birmingham, AL. Lisa Marr, MD, University of New Mexico, Albuquerque, NM.

Objectives

- Review variety of telehealth programs delivering palliative care.
- Develop systems to ensure and report fidelity monitoring and quality assurance in telehealth palliative care.

Telehealth has demonstrated the ability to bridge specialty palliative care services to underserved populations, particularly in rural areas. Interest in telehealth models of palliative care services has grown due to the projected labor shortage in our field, the concentration of specialists in urban areas of the country, and the slow but steady progress on telehealth payment models. While telehealth programs have grown in number, the approaches to care delivery have varied.

This raises an important question: what strategies are being used to ensure consistency, quality and value of palliative care telehealth practices? In this concurrent session, three presenters representing distinct telehealth practices, will share their strategies to ensuring that their palliative care services are being delivered consistently and with high quality to patients and families. The first presenter is working with both a health plan and a population health organization to design, implement and evaluate telephonic nurse case management for patients in the last 1-2 years of life. The second presenter is an academic researcher conducting clinical trials focused on nurse-led telehealth for patients and family caregivers affected by advanced cancer and heart failure. The third represents Project ECHO[®], which is an all teach-all learn telementoring model that leverages technology to connect multidisciplinary teams of specialists with primary care providers to share best practices and increase access to palliative care in rural areas.

Each participant will present briefly on their experiences. The focus will be on how they ensure fidelity to their model and how they measure outcomes. How do they measure success? How do they know that what is occurring in the interactions between nurse and patient, between Palliative care specialist and generalist is the same every time? Techniques such as recorded calls, data collection, and initial training of providers will be discussed.

Hot Topics over Hot Coffee (FR408)



Presented by the Hospice Medical Directors Council Leadership Team

Gail Austin Cooney, MD HMDC FAAHPM, Access Trustbridge, West Palm Beach, FL. Todd R. Cote (chair), MD HMDC FAAFP FAAHPM, Bluegrass Care Navigators, Lexington, KY. Sandra H. Garretson, MD DC HMDC FACP FAAHPM, Seasons Hospice & Palliative Care, Des Plaines, IL. Michael Knower, MD HMDC, St. Charles Hospice, Prineville, OR. Shaida Talebreza, MD HMDC FAAHPM, University of Utah School of Medicine, Salt Lake City, UT. Alen Voskanian, MD MBA FAAHPM, VITAS Healthcare, Santa Monica, CA. Patrick White, MD HMDC FACP FAAHPM, BJC Hospice and Washington University School of Medicine, St. Louis, MO.

Objectives

- Address the main issues relevant to Hospice Medical Directors
- Discuss the most challenging questions faced by hospice physicians based on expert opinion and evidence-based guidelines
- Develop skills to address the most common challenges faced by hospice medical directors

The Hospice Medical Director (HMD) Council works through the Academy governance structure to ensure that issues and programs important to hospice physicians are addressed and developed. The HMD Council fosters and builds meaningful communication, connection and collaboration among hospice professionals, expands and develops opportunities for hospice physicians to further engage within the Academy and identify and support resources for hospice physicians. The leadership of HMD Council actively monitors hospice-related discussions and questions posted both on the Open Forum and on HMD Council's community site.

During this session, the most important issues faced by HMD Council's community will be addressed. HMD Council identified the following topics:

- Opioid use in hospice as it relates to the opioid epidemic
- Hospice Regulatory Update (Attending physician, GIP, etc)
- Hospice Compare and quality reporting

- Physician Aid in Dying
- Medical Marijuana

During this session, expert opinion and evidence-based recommendations relevant to these topics will be provided.

It Takes a Village: Building a Culture of Mentorship and Sponsorship to Thrive Throughout Our Careers (FR409)



Presented by the Academic Palliative Medicine Council Leadership Team

Sangeeta Lamba, MD, Rutgers New Jersey Medical School, Newark, NJ. Rebecca Sudore, MD FAAHPM, University of California San Francisco, San Francisco, CA. Gary T. Buckholz, MD HMDC FAAHPM, University of California San Diego, San Diego, CA. Steven M. Radwany, MD FACP FAAHPM, Summa Health System, Akron, OH. Joanne Wolfe, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Identify the value of mentorship and sponsorship as an integral part of one's professional growth.
- List some of the best practices and ways to overcome challenges when engaging in formal mentor-mentee relationships.
- Learn the tips and strategies on how to find the best mentor-mentee fit and manage relationships for lasting and meaningful benefit.

Effective mentoring is recognized as a critical component in the success of faculty (and trainees) throughout their careers. Recent graduates and faculty in palliative medicine have recognized and voiced this need as they move on to increasingly challenging leadership roles such as program chiefs and fellowship directors, or as they seek professional growth as researchers or educators. To address this need AAHPM has recently launched Mentor Match as part of AAHPM Connect to link mentees and mentors. To provide guidance on best practices in mentorship, this session will feature a set of panelists at various career stages who represent the diverse facets of palliative medicine such as educators, researchers, and program administrators (both adult and pediatric). The panelists will provide their perspective on the value of mentoring and how their careers have been influenced by it and how they facilitate mentoring in their mentees and in their own institutions. Discussion will include best practices, challenges as well as dos and don'ts for both mentors and mentees. We will also outline tips on how to leverage effective ways to ensure a lasting and valuable mentor-mentee relationship while exploring the concept of peer, team, and reverse mentoring as a means to empowering an organization and bridging the generational gap. Panelists will address

and answer questions on issues such as: how to seek a mentor, how to approach an educator's portfolio and how to combine clinical practice/administrative roles with scholarly activities.

8:15–10 am

Plenary Session

Solace: The Art of Asking the Beautiful Question (102)



David Whyte Poet, Author, Speaker, Langley, WA.

Objectives

- List three criteria of a Beautiful Question.
- Describe at least two methods to help clients ask themselves a Beautiful Question.
- Describe at least three objections/blocks that people have to creating a Beautiful Question.
- Explain a least two practices that clients and ourselves can use at home to better articulate Beautiful Questions to re-imagine ourselves, our world and our part in it.

Each one of us grows into a steadily unfolding story where the horizon gets broader and more mysterious, the understanding of loss and mortality more keen, the sense of time more fleeting and the understanding of our own mistakes and omissions more apparent. In the midst of this deepening we have to make a life that makes sense: there is no other life than the one that involves this constant beckoning, this invitation to the fiercer aspects of existence.

Join poet David Whyte in exploring the discipline of finding and asking the questions that help us re-imagine ourselves, our world and our part in it, questions that work to reshape our identities, helping us to become larger, more generous and more courageous; equal to the increasingly fierce invitations extended to us as we grow and mature.

10:45–11:45 am

Concurrent Sessions

PC-FACS: Year in Review (FR410)



Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA. Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Update session participants on PC-FACS processes and "Vital Statistics"
- Highlight implications of cutting edge research of clinical value to American Academy of Hospice and Palliative Medicine members

PC-FACS (Fast Article Critical Summaries for Clinicians in Palliative Care), the highest rated member benefit of the American Academy of Hospice and Palliative Medicine, offers busy clinicians an efficient way to stay on top of pertinent literature in a field that is growing exponentially. Now in its twelfth year, *PC-FACS*, published in the *Journal of Pain and Symptom Management* and delivered in a convenient format to the email box of Academy members, provides topical summaries of just published research from more than 100 journals that are not specifically dedicated to hospice and palliative medicine and might not otherwise come to the attention of our readership. Editorial Board members, peer experts selected from Academy membership through a competitive process, author succinct, thought provoking commentaries that have practical implications for practice and for the field as a whole. Published reviews and commentaries span the gamut from Basic Science through Bioethics, Humanities, and Spirituality; Geriatrics and Care Transitions; Hospice, Hospice and Palliative Medicine Interface, and Regulatory Issues; Pediatrics; Psychosocial; to Symptom Assessment and Management. This past year, we have piloted a new process for retrieving literature that has yielded articles from an expanded repertoire of journals and have broadened our editorial board to a greater number of disciplines. In this session, Editor-in-Chief Mellar Davis and Associate Editor-in-Chief Robert Arnold will take you on a lighting rod tour of some of the most important literature reviewed the past year, connecting each paper to a case scenario to highlight its clinical relevance. Session participants will have an opportunity to contribute their own perspectives of the literature for an enriched discussion of the clinical implications of this research.

Staying Inside the Lines While Thinking Outside the Box: Challenges in Providing Pediatric End-of-Life Care on General Inpatient Units at Quaternary Children's Hospitals (FR411)



Victoria Johnson, DO, Children's Hospital of Philadelphia, Philadelphia, PA. Amy Trowbridge, MD, Seattle Children's Hospital, Seattle, WA. Megan Thorvilson, MD MDIV, Mayo Clinic, Rochester, MN. Trevor McLay Seattle Children's Hospital, Seattle, WA. Dana Dombrowski, MSW LSW, Children's Hospital of Philadelphia, Philadelphia, PA.

Objectives

- Appraise current data illustrating where pediatric patients die within the inpatient setting, and what the exposure of clinical teams has to these deaths.
- Describe four common challenges in providing pediatric end-of-life care in a children's hospital outside of the ICU setting.

- Identify collaborative interdisciplinary partnerships within the hospital to assist in overcoming these four challenges.

The current data surrounding location of pediatric deaths indicates that most children in a hospital setting, with the majority of those deaths occurring in an ICU type setting. But based on the clinical condition or goals of care, patients may prefer a general floor to an intensive care unit for location of death. How can palliative care teams best support the primary teams in the end-of-life care for these children, particularly when general inpatient floors may have limited experiences in these end-of-life care scenarios?

Utilizing a case based approach, we will discuss common obstacles which can surface when children receive end-of-life care outside of an ICU setting, including staff comfort, pharmaceutical limitations, psychosocial challenges, and administrative concerns. 1) The primary medical team, often comprised of trainees, hospitalists, or subspecialists, may have little to no experience providing high quality end-of-life care. This lack of experience can leave the front line care team feeling unprepared, anxious, and inefficient, often creating a sense of "reinventing the wheel" each time a death occurs. We consider the challenges and benefits of implementing practice standards surrounding end-of-life. 2) Hospital formularies and protocols can create challenges in accessing comfort focused medications that tend to be easily accessible for children home with hospice services. We focus on challenges around administration of these medications, including concentration availability, formulations, and administration routes. 3) End-of-life care in the hospital carries many psychosocial challenges as well, including exposure to multiple different providers, financial issues with long-term hospitalization, and spiritual distress. 4) And, finally we will address several obstacles to inpatient deaths as seen through an administrative lens.

With these challenges in mind, we propose opportunities for collaboration amongst palliative care teams, nursing, primary medical teams, pharmacy and medical educators to improve competency as we aim to improve care for children at the end of life.

"Is NPO the Only Option?" An Innovative Research-Based Framework for Oral Intake Recommendations in the Seriously Ill (FR412)



Sumathi Misra, MD MPH, Vanderbilt University Medical Center, Nashville, TN. Meredith Ashford, MS CCC-SLP, Vanderbilt University Medical Center, Nashville,

TN. Blair Leyhew, MSN BSN, Gentiva Hospice, Nashville, TN.

Objectives

- Describe the four main domains by which swallowing therapy can benefit a patient or family, whose goals of care are comfort, based on framework of the World Health Organization's components of palliative care.
- List three benefits of providing nuanced swallowing recommendations for patients with advanced diseases and those receiving palliative care through the management of communication and swallowing difficulties (dysphagia).
- Discuss a framework and multiple strategies to enhance the timely collaboration between instrumental/procedural swallow evaluations and palliative care consultation across the continuum of care, including the palliative care unit (PCU), hospital, home, and nursing home and hospice care.

Speech and language Pathologists (SLPs) can improve the quality of life of people receiving palliative and/or Hospice care through the management of communication and swallowing difficulties (dysphagia). Swallowing difficulties may result in discomfort for patients and concern from caregivers; however, their role in this domain is evolving and little is understood about the current professional practice in this field. While palliative care (PC) aims to affirm life and minimize the complications of life limiting disease, speech-language pathologists (SLPs) typically work with people with progressive and life limiting disease as rehabilitation experts but often work independent of specialist palliative care teams and Hospice providers. Rehabilitation may seem incongruent with palliation; however, SLPs have a vital role in the empowerment of patients with communication difficulties and symptom reduction through specialist dysphagia management and communication therapy. Patient care provided by the speech-language pathologist can align with the framework of the World Health Organization's components of palliative care and can be delineated into four main domains of expertise. PC multidisciplinary teams do not typically integrate SLP and may be a lack of understanding between professionals regarding the SLP role. The presentation will explore the evolving interface of SLPs and palliative care. We will highlight current practices and contrast it with innovative methods of approaching patient care based on our ongoing research that will be presented. The panel will include discussion by an SLP, PC and Hospice Providers, Geriatrician and nurse practitioners providing care in the Palliative care Units (PCU, Hospitals, nursing home and home based PC and Hospice). The session will further

explore the development of the speech-language pathologist as a participating member of the PC and hospice interdisciplinary team, across the continuum of care and how that would support the overall goal of providing quality care for patients and families served by hospice.

When Daddy Is Dying: Facilitating Family Centered Adult Goals of Care Discussions (FR413)



Katie Stowers, DO, University of Texas Health Science Center at San Antonio, San Antonio, TX. Rebecca Charlton, MS CCLS, University Hospital, San Antonio, TX. Rachel Vandermeer, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX.

Objectives

- Review child developmental stages of grief and understanding of death
- Describe policies and language that foster both family centered and age-appropriate care
- Model and practice a goals of care conversation utilizing age-appropriate language for when the presence of children cannot be avoided

Goals of care discussions can become acutely necessary during a life-threatening illness. These discussions are overwhelming and emotionally taxing as they hallmark a status change with often urgent need to address preferences for specific treatments, intensity of care and future care goals. One key step in facilitating goals of care discussions is to ensure that everyone the patient desires to be present is in attendance. When the patient is an adult, the patient's request may extend to the invitation of children.

There are conflicting views regarding the appropriateness of allowing children to participate in goals of care conversations. In adult practice, a common assumption is a family is the expert on their own children's development and needs and the family's preferences should be respected. Conversely, in pediatric palliative care, children siblings are often excluded from participation in goals of care meetings; grief anticipatory guidance is provided after such a discussion to both parent and child.

Adult providers receive a lack of education in child developmental stages of grief. Children have a different understanding of the finality of death at various developmental levels and the discussion of death should reflect a child's age, development and prior experience with death. Ideally, children should be addressed separately regarding a loved one's death but this can be difficult to navigate from the level of an institution, provider or family. Attention to children's developmental stage, family's specific needs and

medical circumstances can promote family centered care discussions that both protect and support children during an adult, loved-one's dying process.

This session will 1) review child developmental stages of grief and understanding of death; 2) describe policies and language that foster both family-centered and age-appropriate care; and 3) model a goals of care conversation utilizing age-appropriate language for when the presence of children cannot be avoided.

Insuring Alignment of Our Practices and Personal Health Behaviors: An Employee Incentive Plan to Encourage Advance Care Planning (FR414)



Ira Byock, MD FAAHPM, Providence Institute for Human Caring, Redondo Beach, CA. Matthew Gonzales, MD, Providence St. Joseph Health, Torrance, CA.

Objectives

- Demonstrate ways that advance care planning promotes a healthcare organization's mission, vision, and core values.
- Recognize traditional purposes of employee health incentive plans and how a healthcare company can engage employees in advance care planning as a means of promoting healthy behaviors for the company's staff as well as the patient population it serves.
- Identify key operational components of the Providence advance care planning health incentive option and how this option was received by employees and their insured family members.

America's employer-based approach to health insurance strengthens companies' stake in their employees' wellbeing. Corporate health incentive plans have traditionally focused on reducing risks associated with physical illness, through activities related to smoking cessation, dietary modification, increasing exercise, and monitoring BMI. For healthcare companies, such incentive plans carry an additional advantage of encouraging employees to model the healthy behaviors that the corporation seeks to promote.

Providence St. Joseph Health is a large (50 hospitals, seven state) healthcare system that seeks to provide goal-aligned care and is committed to the well-being of its over 110,000 employees. The Institute for Human Caring proposed and senior leadership approved an advance care planning (ACP) activity for the 2016 corporate health incentive option. This is one part of a multifaceted plan to establish goal-aligned care as a quality standard across Providence, and make goals of care conversations a common expectation of clinicians, patients and families alike.

The Providence 2016 health incentive plan offered insured employees and covered family members the

opportunity to view a brief video, complete 8 reflective questions about their own beliefs about ACP, and decide an action to take. A traditional risk reduction activity was also available. Over 51,000 individuals (91% of participating employees and spouses) chose the ACP incentive option and over 80% rated the experience as helpful or very helpful. The organization is extending a focus on advance care planning in the 2018 health incentive.

We examine how this health incentive plan fits within a multicomponent, non-incremental change strategy aimed at making goal-aligned, whole person care the new normal care. We present the components of this "health journey" including marketing materials and videos, and the key results, including participant feedback.

Early experience suggests that this health incentive plan is contributing to cultural change consistent with organizational values and strategic priorities.

"Neither Gone nor Here": Coping with Personality Change and Loss of Identity in Neurologic Disease (FR415)



Farrah Daly, MD MBA, Goodwin House Palliative Care and Hospice, Falls Church, VA. Neha Kramer, MD, Rush University Medical Center, Chicago, IL. Matthew Mendlik, MD PhD, University of Pennsylvania Health System, Philadelphia, PA. Elizabeth Pomerleau, MDiv BCC, Goodwin House Palliative Care and Hospice, Falls Church, VA. Elizabeth Ariemma, RN BSN, Compassus Hospice and Palliative Care, Reston, VA.

Objectives

- Describe neuroanatomical localization of at least three personality or behavioral symptoms that occur in selected neurological diseases.
- List neurotransmitter involvement in behavioral symptoms and match with potential pharmacotherapies.
- Describe three characteristics of bedside nursing assessment that differentiate apathy from depression.

Loss of identity is one of the most feared consequences of neurologic disorders. While all illnesses can alter physical abilities and change relationships, neurologic disorders such as Alzheimer's disease, Parkinson's disease, and glioblastoma can uniquely alter fundamental personality traits that contribute to identity. Degeneration or destruction of particular areas of the brain can lead to behavioral changes, such as apathy, impulsivity, and perseveration. In addition to confounding symptom management, advance care planning, and complex medical decision making, these changes can cause profound distress by permanently altering relationships with caregivers and care providers. They must be distinguished from common

symptoms of anxiety and depression to help clinicians approach treatment and to allow Palliative Care and hospice staff to provide counseling and support to caregivers.

An understanding of the neurophysiology of personality and identity changes can help care providers and staff understand and anticipate the uniquely devastating nature of certain neurologic diseases. Three neurologists who practice Palliative Care, a nurse, and a chaplain will lead a case-driven discussion to explore the unique effects of these changes including refusal of care, loss of language ability, inappropriate behavior, and emotional lability. In addition we will explore the challenges these changes present to caregivers particularly surrounding existential distress, loss, and the desire to remain connected to their loved ones.

What's Lost in Translation: A Structured Series of Dialogues Exploring Challenges Experienced by Medical Interpreters Providing End-of-Life Care and Offering Strategies to Overcome Them (FR416)



Janet Abraham, MD FAAHPM, Dana-Farber Cancer Institute & Brigham and Women's Hospital, Boston, MA. Marta Solis, MBA BSHCA, Brigham and Women's Hospital, Boston, MA. Yilu Ma, MS MA CMI, Brigham and Women's Hospital, Boston, MA. Jessica Goldhirsch, LCSW MSW MPH, Brigham and Women's Hospital, Boston, MA.

Objectives

- Gain the ability to describe the impact of including professional interpreters in family meetings to overcome cultural and linguistic barriers to palliative care.
- Identify linguistic and cultural challenges faced by interpreters during palliative care encounters and describe methods the palliative care clinician can use to support and enhance the role of the interpreter in these encounters.
- List at least three reasons why pre-encounter huddles with interpreters are needed for optimal communication across language and cultural barriers, and three strategies interpreters can use to optimize their chances of being included in the huddle.

The United States is becoming increasingly diverse with over 300 languages spoken in homes across the country. When this diversity of language and culture is encountered in healthcare settings, our Western healthcare culture may bump up against that of a patient and family. Language barriers may result in healthcare disparities when professional medical interpreters are not available or not accessed. The need for effective navigation of language and cultural barriers

is no more urgent than in the field of palliative care, health care that emphasizes effective communication and attention to psychosocial needs of patients and families. Effective communication across cultural and linguistic barriers requires the skills of professional medical interpreters. It also requires good teamwork between providers and medical interpreters. Yet this teamwork can present challenges as interpreters are not always members of a palliative care team, and may not even be known to the palliative care team. Providers may have a limited view of interpreters as language conduits doing little more than providing a translation of what they say. The presenters created a series of facilitated dialogues with professional medical interpreters to learn from them about their needs, their challenges and how to better work with them to improve patient care and to mediate their experience of vicarious trauma. These dialogues included interpreters, physicians, social workers and a chaplain all from the palliative care team at a large tertiary care inpatient facility. Interpreters shared their unique stressors. These included difficulties interpreting end of life vocabulary, violating cultural norms of their patients and families, experiencing emotional, cognitive and mental stress when not included in pre-encounter huddles. This presentation will provide participants with a description of how the dialogues were developed, lessons learned from having the conversations and the value of this modality for improving interpreter/provider communication.

Substance Use Disorders 101 for the Palliative Care Specialist (FR417)



Amy Davis, DO MS FACP FAAHPM, Drexel University School of Medicine, Philadelphia, PA. Eric Prommer, MD HMDC FAAHPM, University of California, Los Angeles and VA HPM Program, Los Angeles, CA. Scott Irwin, MD PhD, Cedars-Sinai, Los Angeles, CA. Jeremy Hirst, MD, UC San Diego Health, San Diego, CA.

Objectives

- Learn how to identify behaviors affiliated with substance use disorders in the patient with advanced illness.
- Understand the tools used to screen for substance use disorders.
- Learn symptom management in patients facing serious illness who have a concurrent or historical substance use disorder.

Experts in neuroscience and medicine recognize substance use disorders as a brain disease. Current definitions describe substance use disorders as “a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations.” Manifestations include behaviors such as: impaired control over drug use,

compulsive use, continued use despite harm, and craving. Unaddressed substance use disorders perpetuate patient suffering and can devastate caregivers and families. Concurrence with serious illness complicates symptom and disease management and can interfere with care plan adherence. Uncontrolled substance use disorders can considerably reduce quality of life and often contribute to isolation, dysphoria, and anger. Serious illness itself serves as a stressor, and those in this population tend to have aberrant coping skills. Medications commonly used to control symptoms may be close to or a source of the patient's addictive triggers, creating further medical treatment complexity. Enlisting friends and family in critical decision making may be impossible due to the distance substance use disorders create among the patient and loved ones. A panel of palliative care experts on substance use disorders will use case presentation, didactics, and audience participation to enable attendees to: 1) Develop skill at differentiating pseudoaddictive from substance use disorder behaviors. 2) Understand the neurobiologic and physiologic changes that are characteristic of substance use disorders. 3) Learn how to screen for substance use disorders. 4) Develop skill at managing pain and mood symptoms in this patient population. 5) Recognize when and if one should get an addiction specialist involved. 6) Identify recovery tools that can help the patient and loved ones.

Being in Two Places at Once: Utilizing Clinical Video Telemedicine Technology to Provide Remote Hospice/Palliative Care Services (FR418)



John Franklin, MD HMDC FAAHPM, Ralph H. Johnson VA Medical Center, Charleston, SC. Lisa Vuococo, MD, Louisville VA Hospital, Louisville, KY. Laura Blakley, PhD, VA Connecticut HCS, West Haven, CT. Susan Bray-Hall, MD, VA Oklahoma City Health Care System, Oklahoma City, OK. Lynn Bushor, DNP APRN ACHPN, Department of Veterans Affairs, Mayfield, KY.

Objectives

- Understand the process of providing hospice/palliative medicine services remotely using clinical video telemedicine technology.
- The learner will be able to discuss the benefits and limitations of providing hospice/palliative medicine services using clinical video telemedicine in both the clinic and home setting.
- Utilizing the experience of a few palliative care clinical video telemedicine services throughout the country, the learner will understand the

process of developing a successful clinical video telemedicine hospice/palliative care program.

An important trend in palliative medicine is integration early in the course of chronic, serious, life limiting or life-threatening illnesses. There are, however, several barriers to accessing palliative care including: Workforce shortage, distance to travel to medical centers where these services are available (especially for rural or physician underserved areas), progressive disease processes, frailty and functional decline, mobility challenges, symptom burden, and even psychiatric symptoms (agoraphobia). New technologies are now being utilized to address some of these issues. Clinical video telemedicine (CVT) is one such technology whose utilization is rapidly expanding in all types of medical care settings. CVT offers significant benefits in the hospice/palliative medicine arena. Services can be provided at great distances from large urban medical centers. This can be particularly helpful in the rural setting where driving hundreds of miles to provide a patient with palliative care services is not feasible, practical or cost effective. Even where distances are very short, CVT services can markedly reduce the burden of patients traveling to local medical centers when illness progression limits the ability to even leave the home without great burden.

This concurrent session will provide a brief description of CVT technology including security and HIPPA concerns. The benefits and limitations of this technology will be discussed. Using this technology in various treatment sites (remote clinics, home visits) and with various diseases (cancer, COPD, CHF, ALS, dementia) will be reviewed. The experience of palliative care teams at a few VA Medical Centers throughout the country will be presented as examples of how this technology can be used to provide palliative care and hospice care. How to set up a CVT practice including marketing and administrative issues will be presented. Finally, video clips of actual visits will be shown.

Paper Sessions (FR419–FR420)

Assessing Health Literacy in Outpatient Palliative Care: A Pilot Study Comparing Two Health Literacy Measures (FR419A)



Catherine McCarty, MPH, University of Alabama at Birmingham, Birmingham, AL. Elizabeth Kvale, MD, University of Alabama Center for Palliative and Supportive Care, Birmingham, AL. Steven Allon, MD, University of Alabama at Birmingham, Birmingham, AL. Chao-Hui Huang, PhD MA MED, University of Alabama at Birmingham, Birmingham, AL. Gabrielle Rocque, MD, University of Alabama at Birmingham, Birmingham, AL.

Kathryn Burgio, PhD, Birmingham VA Medical Center (GRECC), Birmingham, AL.

Objectives

- Describe essential components of assessing health literacy in the outpatient palliative care population.
- Identify characteristics of patients who are more likely to struggle with health literacy.

Original Research Background. Despite growing interest in addressing the health literacy needs in the palliative care population, to date there is scant research using validated measures to assess health literacy levels within the palliative care population.

Research Objectives. Our pilot study aims to 1) assess health literacy among patients receiving outpatient palliative care, and 2) Examine health literacy data from the Short Test of Functional Health Literacy in Adults (S-TOFHLA) and the Health Literacy Questionnaire (HLQ).

Methods. Patients > 19 years old with an estimated life expectancy < 2 years were recruited (n=30). Health literacy was assessed using the S-TOFHLA and the HLQ. Analysis of variance using the Welch method was employed to examine the association between demographic characteristics and health literacy scores.

Results. 30 ambulatory palliative care patients (mean [SD] age, 56.2 [15.3], range 23-82) were predominantly female (80%) and 93.1% completing high school or above, with a mean score of 35.27 [SD, 0.91] and “adequate literacy” on the S-TOFHLA. However, HLQ scores varied across all nine domains. Those with > 4 chronic conditions had lower scores across all HLQ scales including ‘Ability to find good health information’ (ES 1.03) and ‘understand health information’ (ES 1.28). Participants < 65 years old scored higher in the scales ‘Ability to actively engage with health care professionals’ (ES 0.41), ‘Ability to find good health information’ (ES 0.20), and ‘Understand health information’ (ES 0.46). In comparison, participants > 65 years old demonstrated a significant difference in the scale ‘Actively managing my health information’ (ES 0.81).

Conclusion. Health literacy in the palliative care population is influenced by a variety of complex factors which can be explained in greater detail when using the HLQ rather than the S-TOFHLA.

Implications for Research, Policy, or Practice. Findings from this study assist in identifying appropriate health literacy assessment tools for the

palliative care population to improve health literacy support in clinical practice.

Goals of Care Conversations in Advanced Cancer: Patient Perceptions Versus Reality (FR419B)



Cardinale Smith, MD PhD, Icahn School of Medicine at Mount Sinai, New York, NY. Vasantham Annadurai Medical Student, University of Cincinnati College of Medicine, Cincinnati, OH. Kerin Adelson, MD, Yale Cancer Center, New Haven, CT. Sofya Pintova, MD, Mount Sinai Medical Center, New York, NY. Jason Gonsky, MD PhD, Kings County Hospital Center, Brooklyn, NY. Natalia Egorova, PhD, Icahn School of Medicine at Mount Sinai, New York, NY. Nina Bickell, MD MPH, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Describe important components of goals of care conversations
- Recognize the importance of time on recall of goals of care conversations

Original Research Background. Goals of Care discussions (GoC) should include information about cancer treatment, prognosis and elicit patients’ value. To determine the impact of communication skills training, it is imperative to assess concordance of patient report and physician conduct of GoC.

Research Objectives. Evaluate whether patients perceptions of GoC are an accurate measure of oncologist performance.

Methods. We randomized solid tumor oncologists and their cancer patients with <2 year prognosis to receive a communication skills and coaching model at 4 hospitals. We audio-recorded the 3 month post-imaging visit following 1st line chemotherapy and surveyed patients. GoC were considered to have occurred if the oncologist elicited values and discussed prognosis or treatment. We define patient perception of a GoC conversation as patient report that their oncologist talked about the likely outcome of cancer and clarified things most important to them. To assess the impact of recall, we assessed the number of days from recording to survey.

Results. We enrolled 22 oncologists and recorded 135 visits. On average, oncologists were 44 years old (32-66) and in practice 14.5 years (5-40). Patients’ mean age was 65 years (25-89); 46% female, 44% White, 9% Latino & 32% black. Overall, GoC were reported by 47% of patients compared with 15% assessed on audio recordings. Sixty-seven percent of patients were surveyed within one day of the recorded

visit (0-49). For patients surveyed within 1 day, 54% reported having GoC compared with 33% for those with later survey completion ($p=0.02$). Kappa between perceived GoC and practice was 0.02.

Conclusion. Overall rates of GoC are low. There is little agreement between patient perception and actual practice. Patients overestimate conduct of GoC and this association diminishes over time.

Implications for Research, Policy, or Practice. Rapidly diminishing recall highlights the need to perform GoC repeatedly over time. Further research evaluating approaches to GoC to ensure patients have an adequate understanding is critical.

Improving the Validity of MOLST (MA Medical Orders for Life-Sustaining Treatment) Documentation for Patients Discharged from Solid Oncology and Palliative Care Teams with Physician Assistants (FR419C)



Irene Yeh, MD MPH, Dana-Farber Cancer Institute, Boston, MA. Sarah Fairbrook, MSN NP, MedStar Washington Hospital Center, Washington, DC. David Cheng, MD, Beth Israel Deaconess Medical Center, Boston, MA. James Tulsy, MD FACP FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Describe a quality improvement intervention that emphasizes discussion of workflow barriers and how to identify valid advance care planning (ACP) forms.
- Understand the challenges inherent with ACP form design and the need for consensus on validity of advance care planning (ACP) forms across care settings.

Background. Patient records that are accurate and transferable between different care environments are an essential part of quality patient care. Inaccurate and incomplete advance care planning documentation breaks down communication during care transitions.

Aim Statement. The aim of this quality improvement project, conducted from May 2016 – Feb 2017, was to increase the percentage of valid MOLST (Massachusetts Medical Orders for Life Sustaining Treatment) forms scanned into the electronic medical record for patients discharged from solid oncology and palliative care teams with physician assistants from 50% to 65%.

Methods. Two tests of changes occurred- 1) PA Grand Rounds and 2) focus group discussions with PAs with active learning and discussion of workflow barriers. The percentage of valid MOLSTs forms scanned into Epic was the outcome measure. A total of 57 MOLST forms were analyzed from two 6-week periods. The percentage of elements (e.g. signatures, health care

provider's credentials, and designation of patient or health care proxy) completed correctly on the MOLST form was the process measure. Baseline and change data for both measures were graphed and analyzed as SPC (statistical process control) charts.

Results. The baseline rate of valid MOLST completion (outcome measure) was 50% and increased to 62% after the 2nd PDSA (Plan-Do-Study-Act) cycle. There was wide variability, appearing as common cause variation. The baseline rate of percentage of elements included on the MOLST forms (process measure) was 40% and increased to 76% after the 2nd PDSA cycle. Analysis showed evidence of special cause variation.

Conclusions and Implications. Results suggest that providing education together with workflow changes is effective in increasing the number of elements correctly completed on MOLST forms. Next steps include discussion with MA Department of Public Health regarding recommendations to redesign the MOLST form and create consensus regarding the validity criteria of advance care planning forms.

What Works Best For Whom? Exploring the Efficacy of Two Psychosocial Interventions in Palliative Care (FR419D)



Karen Steinhauser, PhD, Duke & VA Medical Center, Durham, NC. Karen Stechuchak, MS, Durham VA Medical Center, Durham, NC. Katherine Ramos, PhD, Durham VA Medical Center/Duke University, Durham, NC. James Tulsy, MD FACP FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Understand two approaches to addressing emotional well-being and preparation for end of life in patients living with serious illness.
- Understand sub-population differences in which approach works best for whom, among two interventions.

Original Research Background. Attention to psychosocial aspects of care are central to comprehensive palliative care. Yet, our understanding of which interventions are best applied to which patient populations is in its infancy requiring increased evidence.

Research Objectives. Identify the optimal treatment to address psychosocial well-being by comparing the efficacy of two psychosocial interventions among palliative care patients.

Methods. This secondary analysis of a trial ($n=135$) included patients with advanced cancer, CHF, or ESRD; one arm received the Outlook intervention, designed to address issues of life completion and preparation, and a second arm received relaxation meditation (RM). Primary outcomes: completion and preparation (QUAL-E); secondary outcomes:

anxiety (POMS) quality of life (FACT-G) and spiritual well-being (FACITsp) sub-scales of faith, meaning, and peace. This study employed QUINT analyses to examine these RCT data to determine how best to address preparation for end-of-life and emotional well-being. This recently developed methodology explores and identifies which patient subgroup(s) shows greater improvements with which intervention.

Results. Sample: 56% male; 70% cancer; 54% married; and 51% White. Different sub-groups of patients responded variably to the different treatments. For example, those with low spiritual well-being at baseline showed greater improvements in emotional well-being and decreases in anxiety with RM compared to Outlook. In contrast, for those with high spiritual well-being at baseline, Outlook resulted in greater improvements in emotional well-being and decreases in anxiety. Outlook showed greater improvements in preparation for the end of life for those with low preparation at baseline; RM showed greater improvement in preparation for patients with high preparation at baseline but poor ADL function.

Conclusion. Identifying the optimal treatment for a given patient is a primary goal of palliative care. We demonstrated that different interventions work variably for unique patient sub-populations.

Implications for Research, Policy, or Practice. This methodology (QUINT analysis) offers potential to help improve tailored approaches to care for patients living with advanced serious illness.

Integration of Advanced Care Planning into Primary Care: Use of an Electronic Health Record to Prompt Advance Directive Completion (FR420A)



Matthew McGraw, DNP APN NP-C ACHPN, Western Colorado Physicians Group, Grand Junction, CO.

Objectives

- Identify common barriers to Advance Care Planning in Primary Care.
- Identify the two criteria for classification as Advance Directives within the QI Project.

Background. Primary care is well positioned for iterative discussions that identify patient values, establish goals, and document preferences through advance care planning (ACP). Primary care clinicians (PCCs) underutilize ACP due to perceived barriers and lack of standardization. An intervention was tested with intent to increase the rate of advance directive (AD) completion.

Aim Statement. Explore ACP within a primary care agency to understand barriers and begin developing interventions tailored to the local context.

Methods. A review of literature explored ACP implications, current practice and challenges, and

potential interventions. A sample chart review established the baseline rate of AD completion of 14% in the agency. Primary care physicians were surveyed to explore perceived barriers and potential facilitators for ACP. Over a six-week period, an intervention utilized the electronic health record (EHR) to flag patients appropriate for AD. The rate of AD completion was compared to a parallel period one-year prior. A chi-squared test was done to determine statistical significance.

Results. The survey found consensus in timing of ACP and discrepancies in understanding of AD components, documentation and billing. During the baseline period only 2 AD were added. During the intervention period, 33 AD were added. The intervention was statistically significant at achieving AD completion. The AD rate increased from 0.18% to 2.72%.

Conclusions and Implications. An EHR trigger was effective at prompting PCCs to discuss AD, but proved to be labor intensive. The project prompted further innovation in the practice using specific ICD-10 codes with annotation to document status of ACP and AD. As structure at the local level is established, the approach can be disseminated more broadly for integration as a standard in primary care. ACP in primary care can align treatment with patient preferences but needs standardization, education, and innovation.

Outpatient Advance Care Planning (ACP) in an Accountable Care Organization: Impact on Documentation, Utilization, and Costs (FR420B)



William Bond, MD MS, OSF Healthcare, University of Illinois College of Medicine at Peoria, Peoria, IL. Minchul Kim, PhD, University of Illinois College of Medicine at Peoria, Peoria, IL. Chris Franciskovich, MS, OSF Healthcare System, Peoria, IL. Jason Weinberg, MS, OSF Healthcare, Peoria, IL. Jessica Svendsen, BA CCRC, OSF Healthcare, Peoria, IL. Linda Fehr, BSN CPHQ, OSF Healthcare System, Peoria, IL. Robert Sawicki, MD HMDC FAAFP FAAHPM, OSF Healthcare, Peoria, IL. Carl Asche, PhD, University of Illinois College of Medicine at Peoria, Peoria, IL. Amy Funk, PhD RN, Illinois Wesleyan University College of Nursing, Bloomington, IL.

Objectives

- Describe a case-control study design, including cost analysis methods, for Advance Care Planning research.
- Share the associations found between Advance Care Planning, documentation completion and healthcare utilization and costs.

Original Research Background. Advance Care Planning (ACP) increases the chances that patients'

wishes will be known and followed. Previous studies of ACP's effects have typically focused on specific diseases, inpatient settings, and short intervals prior to death.

Research Objectives. To study the association of ACP with documentation, utilization, and costs of care within a cohort of Medicare beneficiaries in an Accountable Care Organization (ACO).

Methods. This was a case control study of patients who died with ACP compared to matched controls without ACP from January 2013 to April 2016. Matching 1:1 was conducted via an algorithm that included demographic and utilization factors. We required 12 months data pre-ACP/pre-match and 12 months data pre-death. Data included inpatient, outpatient, and multi-system utilization and costs for ACO assigned patients. All charts were reviewed to verify Health Care Power of Attorney (HCPOA), and Practitioner Orders for Life Sustaining Treatment (POLST) documents. We used a logit model to compare documentation, and generalized linear models for utilization and cost analysis with difference-in-difference method.

Results. We matched 325 cases and 325 controls (51.1% female, 48.9% male, mean age 81). 320/325 ACP vs. 243/325 had HCPOA ($p < 0.05$), and 172/325 ACP vs. 145/325 had POLST post-ACP/post-match ($p < 0.05$). Adjusted results showed ACP cases had fewer inpatient admissions (-0.37 admissions, 95% CI -0.66, -0.08), and fewer inpatient days (-3.66 days, 95% CI -6.23 to -1.09), with no differences in hospice use, hospice length of stay (LOS), skilled nursing facility use, home health use, 30-day readmissions, or emergency department visits. Costs were \$9,500 lower in the ACP group (95% CI -\$16,207, -\$2,793).

Conclusion. ACP increases formal documentation, which along with the ACP discussion record, make wishes more clearly known. ACP was associated with a reduction in overall costs, driven by less inpatient utilization.

Implications for Research, Policy, or Practice. This study supports ACP as a best practice that should be recommended for all Medicare beneficiaries.

Advance Care Planning Documentation Practices and Accessibility in the Electronic Health Record: Implications for Patient Safety (FR420C)



Evan Walker, MD, University of California, San Francisco, San Francisco, CA. Ryan McMahan, BS, University of California, San Francisco, San Francisco, CA. Deborah Barnes, PhD MPH, University of California, San Francisco, San Francisco, CA. Mary

Katen, BA, University of California, San Francisco, San Francisco, CA. Daniela Lamas, MD, Brigham and Women's Hospital, Boston, MA. Rebecca Sudore, MD FAAHPM, University of California, San Francisco and San Francisco VA Medical Center, San Francisco, CA

Objectives

- Describe three ways in which inaccessible or non-standardized ACP documentation poses direct risks to patient safety.
- List three differences between documentation of patients' preferences in ACP discussions versus legal ACP forms/orders. The learner will be able to describe the necessity for both types of documentation in the electronic health record.
- List rates of overall and accessible ACP discussion documentation at the San Francisco VA Medical Center. By extrapolating these findings to a population level, the learner will understand the importance of ACP documentation accessibility as a quality improvement target.

Original Research Background. Documenting patients' advance care planning (ACP) wishes is essential to providing value-aligned care, as is having this documentation readily accessible. Little is known about ACP documentation practices in the electronic health record (EHR).

Research Objectives. Describe ACP documentation practices and the accessibility of documented ACP discussions in the EHR.

Methods. Participants were recruited from primary care clinics at the San Francisco VA. They were ≥ 60 years old and had ≥ 2 chronic/serious medical conditions. ACP documentation was abstracted from the EHR from 2013-2015 and included any prior legal forms/orders and ACP discussions documented within the prior five years. We calculated the frequency, type and timing of ACP documentation using percentages and means. We also determined the location of documented ACP discussions. ACP discussions were categorized as "easily accessible" if recorded in a designated ACP posting location or "not easily accessible" if found as free-text in progress notes.

Results. The mean age of 414 participants was 71 years (SD ± 8), 9% were women, 43% were non-white, and 51% had documented ACP including 149 (36%) with forms/orders and 138 (33%) with discussions. Seventy-four participants (50%) with forms/orders did not have accompanying documented discussions. Most (55%) discussions were not easily accessible. Twenty-seven participants had a subsequent discussion documenting changes in treatment preferences from a prior form/order; however, 70% of these discussions were not easily accessible.

Conclusion. Half of chronically ill, older patients had documented ACP wishes, including one third with documented discussions. However, half of patients with completed legal forms/orders had no accompanying explanatory discussions. The majority of documented discussions were not easily accessible in the EHR, including 70% of those documenting a change in treatment preferences.

Implications for Research, Policy, or Practice. Ensuring that patients' preferences are documented and easily accessible is an important patient safety and quality improvement target to ensure patients' wishes are honored.

The Associations Between Parental Status, Treatment Preferences, and Advance Care Planning Among Adults with Metastatic Cancer (FR420D)



Eliza Park, MD, University of North Carolina, Chapel Hill, NC. Laura Hanson, MD MPH FAAHPM, University of North Carolina, Chapel Hill, NC. Donald Rosenstein, MD, University of North Carolina, Chapel Hill, NC. Claire Hailey, MD, University of Chicago, Chicago, IL. Caitlin Schille, MPH, University of North Carolina at Chapel Hill, Chapel Hill, NC. Stephanie Chien, BS, University of North Carolina at Chapel Hill, Chapel Hill, NC. Chang Xu, MS, Lineberger Comprehensive Cancer Center, University of North Carolina at Chapel Hill. Mi-Kyung Song, PhD RN FAAN, Emory University, Atlanta, GA.

Objectives

- Examine the relationships between parental status and treatment preferences among adults with advanced cancer.
- Examine the relationships between parental status and completion of advance care planning activities.
- Describe differences in health-related quality of life and family functioning among adults with advanced cancer who have and do not have dependent children.

Original Research Background. In the United States, cancer is the leading cause of non-accidental death for parents of dependent children. Parents with advanced cancer face unique challenges when coping with their life-limiting illness. Studies of cancer patients demonstrate high rates of anxiety and depression related to the parental role. Additionally, parental status may influence anti-neoplastic treatment decision-making and advance care planning.

Research Objectives. The goal of this study was to examine the relationships of parental status to

treatment preferences and advance care planning in advanced cancer.

Methods. A cohort of 120 adult patients with metastatic cancer (60 parents age-matched with 60 non-parents) participated in structured interviews assessing treatment preferences and advance care planning with complementary medical record review. Participants also completed validated measures of psychosocial functioning. Differences between groups were assessed using t-tests and Fisher's Exact tests.

Results. Mean age, mean performance status scores, and median duration of metastatic illness did not significantly differ between groups. Upon study entry, parents and non-parents were equally likely to report life-extension as their primary goal of anti-neoplastic treatment. Eighty-three percent (n=50) of parents reported their parental status had a strong or moderate influence on their treatment decision-making. Compared to non-parents, parents reported greater willingness to live in pain (87% vs 62%, p=0.03) and receive a feeding tube (45% vs 22%, p=0.01) for life-extension. There were no significant differences between groups for completion of a health care power of attorney or living will. Emotional well-being scores were lower among parents (p=0.04), though overall health-related quality of life and family functioning scores were not significantly different between groups.

Conclusion. Among adults with metastatic cancer, parental status may be associated with treatment preferences for aggressive medical care near the end-of-life.

Implications for Research, Policy, or Practice. To meet the psychosocial needs of parents with life-limiting illness, greater understanding of the impact of parental status on advanced cancer outcomes is needed.

1:30–2:30 pm

Concurrent Sessions

The Practice of Palliative Medicine in Developing Countries—Part Two (FR430)



Linda Marisol Bustamante Tuche, MD, Guatemala, Guatemala. Shiv Pratap Singh Rana, MD MBBS, Noida, India. Innocent Ugwu, MBBS, Snugu, Nigeria, Africa.

Objectives

- Learn how physicians in specific countries provide palliative care to their patient populations often with limited resources

- Recognize specific cultural and political challenges to developing palliative care clinical, educational and research programs
- Describe roles of different health care providers practicing palliative care and how they meet the needs of their local populations

Please join AAHPM's International Scholars for a panel discussion. Each scholar will present for 10-15 minutes on the state of the practice of palliative care in their home country, with an emphasis on the roles of physicians, nurses, and other healthcare providers; the status of education and research in the field; and the unique challenges facing patients and providers. There will be time allotted after each presentation to field questions and dialogue from the audience. Prepare to be educated and inspired by these accomplished individuals who are leading and advancing the field of hospice and palliative medicine in their countries of origin.

Half a Shade Braver: Making a Friend of the Unknown (FR431)

David Whyte Poet, Author, Speaker, Langley, WA.

Objectives

- Identify two current situations that would benefit from a more heartfelt participation and attention.
- Describe a situation where they experience feeling unmoored and uncertain.
- Articulate two techniques to respond to unknown or unfamiliar situations.

Courage is the measure of our heartfelt participation with life, with another, with a community, a work; a future. To be courageous is not necessarily to go anywhere or do anything, except to make conscious those things we already feel deeply and then to live through the unending vulnerabilities of those consequences. To be courageous is to seat our feelings deeply in the body and in the world, and to live up to and into the necessities of relationships that often already exist, with things we find we already care deeply about: a person, a professional future, a possibility in society, or an unknown that begs us on and always has begged us on. There is a unique quality that arises for human beings when we do not know where we are, a depth of experience that goes beyond our normal way of inhabiting the world. To make a friend of the unknown is to step outside the barrage of information and into your own silence, and engage in a courageous dialog with what's emerging within you.

Through the revelations of poetry and the poetic tradition, David will illuminate the bold, courageous,

vulnerable steps to bring our hidden, interior states out into the world.

Palliative Care: Bringing It Home (FR432)

Nancy Guinn, MD, Presbyterian Healthcare, Albuquerque, NM. Abigail Gilbert-Savi, NP, Presbyterian, Albuquerque, NM. Regina Dickens, MSW, Presbyterian Palliative Care, Albuquerque, NM.

Objectives

- List two measures that keep Palliative Care program leaders up at night. Demonstrate how they link to key concerns of patients and families, hospitals, health systems.
- Demonstrate how a focus on the patient and family goals and needs and the collaboration of an interdisciplinary team in the home can affect patient care and outcomes in a very positive way.

Come visit New Mexico, a state that has piloted effective new models of care based on the healthcare funding limitations we will face in the future. Presbyterian Healthcare at Home's innovative team-based community palliative program includes a clinic- and home-based program housed in a home agency and a house calls program, as well as an advanced illness management program. Together, they have demonstrated significant impact on patient lives and on the total cost of care. The key is developing and fully utilizing primary palliative care skills, as much as tertiary palliative skills, and building a team where all team members work to the full scope of practice, including a robust social work practice and a local group of community paramedics that offer urgent as well as follow-up care in the home. Presenters will describe the evolution and timeline for the program, taking a look at the many needs assessed and addressed, the local environment and how the program fits into a non-profit health system in one of the most resource-limited states in the country. The team will discuss the tools and methods that they have developed to assist them in collaborating in care and in expressing the needs and goals of patients and families.

Evolving from Individual Wellness to Departmental Wellbeing: How to Achieve Resilience and Longevity in Palliative Medicine (FR433)

Rita Manfredi, MD FACEP, George Washington University School of Medicine, Washington, DC. Matthew Wong, MD MPH, Beth Israel Deaconess Medical Center, Boston, MA. Carol Ramsey-Lucas, MDiv,

Washington DC VA Medical Center, Washington, DC. Jan Bull, MA, Maryland University of Integrative Health, Laurel, MD. Jennifer Cho, MSW, Washington DC Veterans Affairs Medical Center, Washington, DC.

Objectives

- Describe the 7 dimensions of personal wellbeing and cultivate a strategy to sustain these practices in the setting of palliative medicine.
- Develop a wellness toolkit for departmental wellbeing in Palliative Medicine and identify methods of implementation.
- Discuss the Professional Quality of Life Assessment, Resilience Scale, and Compassion Fatigue Tool.

With rates of burnout for palliative clinicians as high as 62% in recent studies it is imperative to the wellbeing of providers and their organizations to recognize those instances in which care given may be exceeded by patient needs. Complex, vulnerable patients increase the unmet demand for more palliative services and contribute to lack of wellness and resiliency in providers. The National Wellness Institute sees wellness as an evolving process through which a person achieves his or her full potential. To facilitate this potential, wellness may be viewed as a multi-spoked wheel containing all the dimensions necessary for professional wholeness and balance in the specialty.

How can Palliative Medicine clinicians address the issues surrounding wellbeing, resilience, burnout, and “unwellness”? In this concurrent session, clinicians from multiple disciplines will discuss the importance of a shared mental model and common framework when discussing being well in Palliative Medicine, building resilience, and preventing burnout. Didactics, discussion and review of case examples will illustrate how a palliative clinician can impact his or her individual wellness. Several validated tools which measure compassion, quality of life, and resilience will be reviewed and administered. Since departmental and institutional wellness significantly impact individual wellness, discussion will center on knowledge and skills needed for programmatic improvements in wellness and the identification of outstanding interventions a department should implement to promote longevity, increase satisfaction, and recruit and retain palliative providers.

Pediatric Palliative Care: On the Road to... (FR434)

Megan Thorvilson, MD MDIV, Mayo Clinic, Rochester, MN. Lisa Squires, BSN RN, Children’s Hospital of Philadelphia, Philadelphia, PA. Jennifer Hwang, MD MHS, Children’s Hospital of Philadelphia,

Philadelphia, PA. Lindsay Ragsdale, MD, University of Kentucky, Lexington, KY.

Objectives

- Describe the gap between historical locations of pediatric deaths and parental wishes at a child’s end-of-life.
- List three challenges related to safely transporting a child from the hospital while maintaining a palliative mindset.
- Compile a checklist for your institution that can be used by palliative care and transport teams.

Despite the majority of parents preferring home for both end-of-life care and death, the majority of pediatric patients still die in the hospital, often in the ICU. We review the current literature on location of pediatric deaths, which shows a slight uptrend in home deaths, and compare that to parental preferences. We describe the obstacles to achieving a safe home death, including increasing use of medical technology and lack of hospices comfortable with pediatric end-of-life care. Finally, we highlight the current data showing that the opportunity to plan location of death leads to an increase in number of deaths at home and an increase in the number of in-hospital deaths outside of the ICU.

Starting with a current definition of pediatric palliative transport, we propose how this underutilized resource can help narrow the gap between reality and preferences for families regarding location of death. We describe how transport teams using fixed-wing aircraft and ambulances—mobile critical care units—can create the opportunity for a home death for patients even in the ICU. Through presentation of a case example, we broaden the definition of palliative transport to include palliative-focused transport back to the hospital for patients who need more aggressive symptom management or for whom a home death would be too traumatic.

Recognizing how palliative transport runs counter to default transport services, we again use a case to outline a number of challenges in executing effective palliative transport, including provider distress, cost, limited transport resources, and lack of community hospice programs. We conclude by demonstrating the number of players and the complexity involved in palliative transport—from the providers in the hospital to the hospice nurse—and offer a checklist to ensure a safe and meaningful transport.

Sojourn’s Scholars Present in the Expert’s Studio: Communication Strategies (FR435)

Toby Campbell, MD MSCl, University of Wisconsin, Madison, WI. Abraham Brody, PhD RN ACHPN

FPCN, NYU Rory Meyers College of Nursing, New York, NY. Elizabeth Lindenberger, MD, Icahn School of Medicine at Mount Sinai, New York, NY. Caroline Hurd, MD, University of Washington, Seattle, WA. Arif Kamal, MD MBA MHS FAAHPM, Duke Cancer Institute, Durham, NC.

Objectives

- Gain insight into the approach to highly skilled communication.
- Enhanced understanding of the invisible process an expert takes when approaching a complicated clinical situation.
- Learn from the approach an expert takes to personal and professional development.

Clinician/patient communication is a central skill of the palliative care and hospice professional. While a variety of training methods and approaches are used to teach communication skills, the opportunity to learn directly from a leader in the field is rare. Even more rare is the opportunity to hear about their personal and professional development. Participants will hear the expert comment on their strategies, thought processes, and development. The program will be broken roughly into three segments. In the first segment, attendees will observe our expert in an uninterrupted simulated family meeting. In the second segment, interviewers from the planning group will walk the expert through the family meeting to gain insights into their thought process about the communication strategies used and alternatives they considered. We intend to digitally record the encounter and return and replay key portions of the interview to remind the expert and the audience. In the final segment, the interviewers will dig deeper into the expert's personal and professional development into a leader of the field. For example, we may ask about how they prepare for a consult, how they cope after a difficult day, or how they balance work and family. We will consider how to engage the audience, probably in the form of submitted questions on paper or electronically rather than at a microphone. This session could be repeated with a different expert participant at a different time to allow more people to observe and also compare different approaches to a common scenario.

View from the Other Side: What Can We Learn from Palliative Care Professionals Who Became Patients? (FR436)

Judith Redwing Keyssar, BA RN, Jewish Family and Children's Services, San Francisco, CA. Torrie Fields, MPH, Blue Shield of California, San Francisco, CA. Amy Berman, BSN RN LHD, John A. Hartford Foun-

ation, New York, NY. Helene Starks, PhD MPH, University of Washington, Seattle, WA

Objectives

- Articulate three types of communication gaps that negatively impact patient participation in decisions about care and treatment.
- Identify two ways that they might improve their communication/listening skills with patients.
- Create a plan of care that includes appropriate patient education and referrals to helpful resources.

As clinicians and thought-leaders in palliative care, we place high value on communicating appropriately with patients and with colleagues. Much of our work focuses on trying to understand the patient's values and goals of care, and frame quality of life trade-offs in relation to treatment and living well, not just in terms of improving the odds of survival. When a patient tells us, "...this is the one thing that matters to me..." how do we respond? How far do we go in trying to understand what this means? And then, what happens when the tables are turned and we receive a serious cancer diagnosis and, suddenly, we are the patient?

This session will offer thoughtful perspectives and insights from palliative care clinicians/professionals who were all diagnosed with advanced cancer and struggled to receive the right care at the right time from the right provider. The dialogue will explore the gaps between what we know as professionals vs. what we experience as patients, and how we are translating our lessons learned into changing professional practice—in clinical care, healthcare financing, research, education, and philanthropy. We will highlight how our experiences have shaped our perspectives on what good care means and what kinds of support are critical.

This is a unique opportunity to understand what usual and palliative care look like from the receiving end, from four "empowered patients" who continue to work full time. We will engage the audience in discussing the nuances of communication, language, patient empowerment, the meaning of value, and how that differs from patient to provider. We will invite the audience to join in this conversation whether as patient/survivor or health professional and share how we are translating these embodied experiences into practice.

The powerful lessons and recommendations may surprise you.



Parenting with Life-Limiting Illness: Strategies to Support Families with Dependent Children (FR437)



Eliza Park, MD, University of North Carolina, Chapel Hill, NC. Cindy Moore, PhD, Massachusetts General Hospital, Boston, MA. Claire Hailey, BS, University of North Carolina, Chapel Hill, NC. Anna Muriel, MD MPH, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Understand common psychological concerns at the end-of-life for parents with life-limiting medical illness and their children and how these concerns influence parental medical decision-making and advance care planning.
- Describe methods to elicit parental concerns among adult patients from a range of cultural backgrounds, identify available resources and communication strategies to help address their parenting concerns.

Patients living with life-limiting illness who are raising dependent children face unique stressors during the period of terminal illness and end-of-life. Parents have concerns about the impact of their disease and potential death on their children and their ability to simultaneously manage treatment and caregiving responsibilities. They also have concerns about how to optimally communicate with children, particularly when treatment choices or prognosis is uncertain. Among parents with advanced cancer, the severity of parental concerns is linked to increased symptoms of anxiety and worse health-related quality of life. Thus, understanding and knowing how to address the concerns of parents with life-limiting illness is critically important to providing quality care for these individuals.

Most adult palliative medicine providers do not receive extensive training on how to promote parental communication with dependent children based upon developmental stage. Further, differences exist across families and cultures in the value placed on openness of communication. Developing skills to elicit and address parental concerns, particularly for patients and families with diverse household structures and cultural backgrounds, can substantially reduce their psychological distress.

This concurrent session aims to address a critical gap in knowledge about how to meet the supportive care needs of adult patients with dependent children. Presenters will address the unique concerns of parents with life-limiting illness and their challenges around medical decision-making and advance care planning. Presenters will also review strategies to elicit parental concerns both clinically and with a standardized measure, and discuss strategies for developmentally-appropriate parental communication with children. In this

interactive session, presenters will use their clinical experience in pediatrics, psychology, and psychiatry as well as case studies, review of literature, and evidence-based research to facilitate learning.

Am I Really Any Good At This? Exploring and Managing the Imposter Phenomenon in Palliative Care (FR438)



Andrew Lawton, MD, Dana-Farber Cancer Institute, Boston, MA. Christopher Lawton, MD, Medical College of Wisconsin, Milwaukee, WI. Erin Stevens, DO, Harvard Medical School, Boston, MA. SarahScott Dietz, MD, US Air Force, Wright-Patterson AFB, OH. Jo Weis, PhD, Medical College of Wisconsin Palliative Care Center, Milwaukee, WI.

Objectives

- Define the imposter phenomenon and describe how it manifests in medical practice.
- Describe how early career palliative care providers may be vulnerable to the imposter phenomenon.
- Identify concrete strategies to manage feelings of imposterism.

The imposter phenomenon (IP) describes the experience of questioning one's abilities and fearing exposure as an intellectual fraud, despite objective evidence of success. This phenomenon has been associated with high-achieving individuals and is common among medical providers early in their career. Despite being common, feelings of imposterism are likely under-acknowledged in the medical community. Such feelings may signal a normal part of professional development, and may even be productive, by promoting self-reflection in one's practice. For some providers, however, the IP can be associated with significant anxiety and psychological distress. Early career palliative care providers may be vulnerable to feelings of imposterism as they transition to independent practice, take on new roles as educators and investigators, and strive to emulate respected mentors. In this session, a panel of early career palliatricians and a psychologist will use case examples to explore the IP, highlight its relevance to palliative care practice, and provide targeted strategies to manage such feelings. By normalizing the IP and offering tools to navigate it, this session aims to help providers build confidence and enhance professional satisfaction.

Behavioral and Psychotic Symptoms of Dementia vs. Delirium in Hospice: Challenges in Diagnosis and Management in the Long-Term Care Setting: Part 1 (FR439)



Rebecca Yamarik, MD FAAHPM, Veterans Affairs, Long Beach, CA. Martina Meier, MD, Providence TrinityCare Hospice, Torrance, CA. Jennifer Tjia, MD MSCE, University of Massachusetts Medical School,

Worcester, MA. Barbara Messinger-Rapport, MD CMD HMDc FACP, The Cleveland Clinic, Cleveland, OH.

Objectives

- Describe characteristics distinguishing behavioral and psychological symptoms (BPSD) of dementia from terminal delirium in nursing home residents with advanced dementia at the end of life.
- Review the evidence for the pharmacologic and non-pharmacologic management of BPSD and delirium.
- Building on the Centers for Medicare and Medicaid (CMS) regulatory requirements for management of psychotropic medications in nursing home residents, develop a framework for successful hospice-nursing home team collaboration for management of BPSD and terminal delirium through engagement of palliative, medical, nursing facility and family caregiver engagement.

A majority of patients with dementia suffer from at least one behavioral and psychological symptom (BPSD) of the disease. BPSD describes a wide spectrum of non-cognitive manifestations of dementia, including apathy, dysphoria, verbal and physical aggression, agitation, psychotic symptoms, sleep disturbances, oppositional behavior, and wandering. Symptoms are highly prevalent in the moderate to severe stages of dementia, when the patient is typically admitted to hospice. It has become apparent that antipsychotic treatment for BPSD shortens life expectancy and exposes these patients to morbidities including sedation, falls, fractures, aspiration, and movement disorders, with only slight efficacy for achieving improvement in target behaviors. Long-term care (LTC) regulations require gradual dose reductions in psychotropic medication, and precise behavioral documentation to support starting or continuing psychotropic medications. Hospice providers who understand the regulations can support the facility in both caring for the patient as well as adding to the documentation that the facility needs. However, terminal agitation is also a common finding at the end of life and it is important for hospice providers to differentiate between BPSD and terminal delirium.

In this two-part session, we propose a case-based approach with audience participation to: 1) Differentiate BPSD from delirium for hospice dementia patients in order to appropriately treat BPSD and 2) Diagnose, manage and treat delirium in hospice dementia patients in the LTC setting.

In part 1, we introduce a hospice case study of moderate to severe dementia in a nursing home. Hospice providers may initially mistake the agitation in BPSD for terminal delirium. We will discuss how to

differentiate between BPSD and terminal delirium, and suggest non-pharmacological and pharmacological interventions for BPSD in this patient. We will review the literature to highlight our evidence-based approach, and allow the audience to participate in deciding management based on the literature.

Paper Sessions (FR440–FR441)

How the Medicare Shared Savings Program ACO Model Affects Hospice Utilization (FR440A)



Julia Driessen, PhD, University of Pittsburgh, Pittsburgh, PA. Turner West, MPH MTS, Bluegrass Care Navigators, Lexington, KY.

Objectives

- Describe how Medicare's MSSP ACO model changes the financial incentives around hospice delivery, relative to Medicare fee-for-service (FFS).
- Identify how Medicare's MSSP ACO model affects who elects hospice and the characteristics of their hospice utilization.

Original Research Background. The inclusion of hospice in the savings calculation for Medicare ACOs suggests that ACOs may be incentivized to utilize hospice differently than Medicare fee-for-service providers. However, little is known about how Medicare ACOs are approaching hospice care specifically, and end-of-life care more generally.

Research Objectives. Identify how Medicare's MSSP ACO model affects who elects hospice and the characteristics of their hospice utilization.

Methods. We examined 2014 Medicare data for a 50% sample of Medicare beneficiaries aligned with the Medicare Shared Savings Program (MSSP) ACO and a 5% sample of Medicare fee-for-service beneficiaries not aligned with an ACO. We compared demographics, health status, and hospice utilization of hospice utilizers based on whether they were aligned to an MSSP ACO.

Results. Decedents aligned with an MSSP ACO were statistically significantly more likely to enroll in hospice, though the actual difference was relatively small (49.3% vs. 48.0%). MSSP beneficiaries electing hospice tended to be younger and have higher rates of conditions such as COPD and heart failure, and lower rates of dementia. MSSP-aligned hospice beneficiaries were more likely than non-aligned beneficiaries to have a length of stay of less than seven days (27.3% vs. 26.1%), but were less likely to have a stay longer than 180 days (11.8% vs 13.4%). Medicare paid significantly less for MSSP-aligned beneficiaries who elected hospice, with mean payments approximately \$500 less in the MSSP cohort than in the non-aligned FFS group.

Conclusion. Hospice utilization among MSSP ACO beneficiaries does appear to be slightly different than among non-aligned Medicare beneficiaries, suggesting that the ACO model's emphasis on quality and coordination of care, along with the inclusion of hospice in the savings calculation, may affect the way ACOs view hospice.

Implications for Research, Policy, or Practice. This work highlights the opportunity for innovation in how hospice care is used under the shift towards value-based reimbursement, as embodied by the ACO model.

Can Administrative Claims Be Used To Identify People with Functional Limitation? An Exploration of Candidate Predictors in a Sample of Medicare Beneficiaries (FR440B)



Harriet Mather, MD MSc, Icahn School of Medicine at Mount Sinai, New York, NY. Amy Kelley, MD MSHS, Icahn School of Medicine at Mount Sinai, New York, NY. Evan Bollens-Lund, MA, Icahn School of Medicine At Mount Sinai, New York, NY.

Objectives

- Identify people with functional limitation.
- Understand the limitations of administrative claims in identifying people with functional limitation.

Original Research Background. Functional limitation (FL) in people with serious illness is associated with poor healthcare outcomes yet measures of function are not routinely captured in administrative records. A claims-based proxy for FL would facilitate identification of those in greatest need for palliative care services.

Research Objectives. Explore the predictive utility of candidate claims-based indicators in identifying individuals with FL.

Methods. We sampled subjects from Wave 1 of the National Health and Aging Trends Study with 12 months' prior fee-for-service Medicare. FL was defined as receiving help with ≥ 1 activities of daily living (ADLs). Candidate predictors included claims for medical assistive devices (MeAD: hospital bed, wheelchair, walker, cane, commode, urinal, bed pan, toilet/tub/shower assistive devices, lift/transfer board/safety belt), home oxygen, home health (HH), and skilled nursing facility (SNF). We evaluated sensitivity, specificity, and c-statistic of each predictor alone, and in combination. Secondary analyses defined FL more restrictively as help with ≥ 2 ADLs.

Results. Among 4,757 beneficiaries, 18.9% reported FL. Sensitivity/specificity/c-statistic of predictors of FL were: (i) MeAD claim 21.0/97.3/0.59; (ii) Home oxygen 11.3/96.7/0.54 (iii) HH/SNF claim 41.6/89.0/0.65.

Overall, the combination of any: MeAD, home oxygen, HH/SNF claim had the best predictive utility (sensitivity=55.4, specificity=85.0, c-statistic=0.70). This same combination performed similarly for the more restrictive definition of FL, 62.8/82.8/0.73.

Conclusion. Claims-based proxies lack sensitivity in identifying FL, even at higher levels of FL. The combination of any MeAD, home oxygen, or HH/SNF claim had the best predictive utility but missed 45% of those with FL.

Implications for Research, Policy, or Practice. Those using claims-based proxy measures for FL must balance sensitivity (the need to identify all with FL) with specificity (the need to identify only those with FL). However, claims-based proxies are all poorly sensitive indicators of FL and are of limited use as a screening measure for FL. Health systems and insurers should implement routine collection of self-reported function in all settings.

Association between Posttraumatic Stress Symptoms and Health Care Utilization in Geriatric Patients with Cancer: Findings from the Patient Care Connect Program (FR440C)



Chao-Hui Huang, PhD MA MED, University of Alabama at Birmingham, Birmingham, AL. Kelly Kenzik, PhD, University of Alabama at Birmingham, Birmingham, AL. Katherine Duhamel, PhD, Memorial Sloan Kettering Cancer Center, New York, NY. Courtney Williams, MPH, University of Alabama at Birmingham, Birmingham, AL. Edward Partridge, MD, University of Alabama at Birmingham, Birmingham, AL. Maria Pisu, PhD, University of Alabama at Birmingham, Birmingham, AL. Gabrielle Rocque, MD, University of Alabama at Birmingham, Birmingham, AL. Elizabeth Kvale, MD, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL.

Objectives

- Characterize posttraumatic stress-related symptoms (PTSS) in geriatric patients with cancer.
- Describe demographic and clinical characteristics associated with PTSS.
- Describe the association between PTSS and health care utilization and its research and clinical implication.

Original Research Background. Cancer patients are at greater risk for developing posttraumatic stress symptoms (PTSS) compared to the non-cancer population. However, little is known about the presentation of PTSS among geriatric oncology patients and its relationship with health care utilization.

Research Objectives. Our study aims to characterize PTSS in a cohort of geriatric cancer patients and

examine the association between PTSS and health care utilization.

Methods. Patients ≥ 65 years old enrolled in the Patient Care Connect Program implemented in 12 cancer care centers were included in the analysis ($n=5,503$). PTSS was assessed using the Distress Thermometer Problem List and was categorized into domain-specific PTSS clusters based on the DSM-5 criterion (i.e., intrusion, negative cognition and mood (NCM), and arousal). Health care utilization was measured from Medicare claims and assessed health care cost and any ER or hospitalization visits from 2012-2015. Multivariable logistic regression was conducted with outcomes being the presence of PTSS. T-tests and Chi-square tests were employed to examine the association between PTSS and health care utilization.

Results. The mean age at diagnosis was 74.7 (range: 65-102), 54.4% were female, 85.3% white, 29.8% had a high-acuity cancer. Approximately 7% were categorized as having any PTSS domain. A significantly greater proportion of patients with NCM symptoms had a hospitalization (4.1%) compared to those without (2.4%, $p=0.006$). A significantly greater proportion of patients with arousal symptoms had ER (2.3%) compared to those without (1.0%, $p=0.006$). Overall, patients with PTSS in any domain had a higher average health care cost per quarter from 2012-2015 compared to those without (\$7,021 vs. \$5,675, $p<.0001$).

Conclusion. A subset of geriatric cancer patients reported PTSS that warrants clinical attention. Presence of PTSS was associated with higher health care cost and utilization.

Implications for Research, Policy, or Practice. More research is needed to develop interventions targeting PTSS in geriatric cancer patients and evaluate strategies for cost-effective health care utilization.

Rates of Medicare Utilization During Gaps in Hospice Election (FR440D)



Thomas Christian, PhD, Abt Associates, Cambridge, MA. Joan Teno, MD MS, University of Washington, Seattle, WA. Pedro Gozalo, PhD, Brown University, Providence, RI. Michael Plotzke, PhD, Abt Associates, Cambridge, MA

Objectives

- Understand how much hospice beneficiaries utilize non-hospice services during gaps in elections.
- Understand provider characteristics associated with the highest rates of gap spending per beneficiary.

Original Research Background. Medicare Hospice beneficiaries may revoke hospice, utilize non-hospice Medicare, and afterwards re-elect the benefit. Little is known about how beneficiaries utilize services during such election gaps.

Research Objectives. Determine hospice beneficiaries' gap utilization and characterize providers with high gap spending rates.

Methods. Retrospective cohort analysis of Medicare hospice beneficiaries utilizing the benefit during Federal Fiscal Year 2016 (FY2016). Using 100% Medicare Standard Analytic Files and the Medicare Enrollment Database we examined rates of Medicare utilization during hospice election gaps.

Results. In FY2016, 1.3 million hospice episodes ended, of which 207,387 (16.9%) were live discharges, 107,336 (51.8%) of which had re-elections, and of these, 75,089 (70.0%) had Medicare spending during the gap with mean (median) total gap spending of \$9,528.21 (\$4,185.38) at a mean (median) rate of \$645.90 (\$217.07) per day and total gap spending exceeding \$715 million. We find that hospices are more likely to be categorized in the highest quintile of per-beneficiary election gap spending if they are newer (35.6% certified in the 2010s vs. 4.5% in the 1980s; AOR 3.99, 95% CI 2.39-6.65), for-profit (28.8% for-profit vs. 16.2% non-profit; AOR 3.27, 95% CI 2.23-4.79), smaller (31.0% having 50-99 beneficiaries vs. 6.3% having 800+; AOR 2.31, 95% CI 1.73-3.09), free-standing (23.8% freestanding vs. 7.2% in the 1980s; AOR 1.62, 95% CI 1.15-2.30), and located in the south (32.6% South vs. 8.2% Northeast; AOR 3.29, 95% CI 2.17-4.99).

Conclusion. Hospice beneficiaries utilized almost three-quarters of a billion dollars between election periods in FY2016. These rates were higher in newer, for-profit, smaller, free-standing, southern providers.

Implications for Research, Policy, or Practice. Beneficiaries are free to leave from hospice to regain Medicare coverage of their terminal condition at any time. One concern is if such transitions lead to fragmented care. Further research and monitoring is needed to ensure that hospice beneficiaries are receiving adequate and high quality care.

Is Fentanyl Patch End-Of-Dose Failure Associated with Body Mass Index? (FR441A)



Jason Meadows, MD MS, Memorial Sloan Kettering Cancer Center, New York, NY. Jessica Goldberg, MSN NP, Memorial Sloan Kettering Cancer Center, New York, NY. David Collett, APRN, Memorial Sloan Kettering Cancer Center, New York, NY. Kenneth Seier, MS,

Memorial Sloan Kettering Cancer Center, New York, NY.

Objectives

- Explain to all patients the nature and possibility of end-of-dose failure to patients when initiating therapy with fentanyl transdermal preparations.
- Increase screening of patients on using transdermal fentanyl preparations for end-of-dose failure, with particular attention to patients with cancer cachexia.

Original Research Background. Transdermal fentanyl is widely used for patients with cancer pain requiring a long-acting opioid analgesic. The delivery of fentanyl in this form relies on a drug reservoir forming in subcutaneous fat. The manufacturer-recommended initial dosing frequency is every 72 hours. However, some patients experience “end-of-dose failure” (EDF) with worsening pain after a shorter interval. No studies have examined whether EDF correlates with body mass index (BMI).

Research Objectives. To assess whether low BMI is associated with prescription of transdermal fentanyl at q48h dosing frequency.

Methods. All outpatient fentanyl patch prescriptions dispensed between January 1, 2014 and December 31, 2015 at our academic cancer center were extracted using an institutional database. For each prescription patient age, sex, race, patch dose, dosing frequency, and cancer type, as well as height and weight (used to calculate BMI) were collected. A generalized estimating equations (GEE) model was fit to account for correlation within patient and determine association between BMI and patch frequency.

Results. A total of 2,750 patients filled 6,569 fentanyl patch prescriptions over the study period. Patients were a median of 60 years old, 56.1% female, and 73.3% white (11.2% African American, 7.2% Asian). The median number of prescriptions per patient was 1 at a median dose of 37. Among 287 underweight patients (BMI<18.5), 34 (11.8%) received at least one q48h fentanyl patch prescription compared with 62 (10.2%) of obese (BMI>30) patients. Patients who received q48h patch had lower BMI (.58 unit decrease; $p<0.01$) than patients who received the q72h patch.

Conclusion. Lower BMI is associated with q48h fentanyl patch dosing, suggesting that it may also be associated with end-of-dose failure in cancer patients. These patients should be closely monitored and alerted to this possibility.

Implications for Research, Policy, or Practice. Prospective studies assessing end-of-dose failure and BMI are needed to guide prescribing practices and determine if initial dosing frequency of q48h is appropriate in some patients.

The Relationship Between Socioeconomic Status and Patient-Reported Symptoms and Quality of Life: A Report from The PEDIQUEST Study (FR441B)



Maya Ilowite, MD, Dana-Farber Cancer Institute, Boston, MA. Clement Ma, PhD, Dana-Farber Cancer Institute, Boston Children’s Hospital, Boston, MA. Hasan Al-Sayegh, MBChB MPH, Boston Children’s Hospital, Boston, MA. Joanne Wolfe, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Kira Bona, MD, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Understand the association between household income and symptom distress in children with advanced cancer.
- Understand the association between household income and health-related quality of life in children with advanced cancer.

Original Research Background. Children with advanced cancer experience high symptom distress, which negatively impacts a child’s quality of life. Socio-demographic factors are known to impact disease outcomes in pediatric cancer, but the relationship between socioeconomic status and symptom distress and quality of life is unknown.

Research Objectives. To evaluate the relationship between socioeconomic status and patient-reported symptom distress and health-related quality of life among children with advanced cancer.

Methods. We performed a secondary data analysis of a subgroup of children enrolled on the multicenter Pediatric Quality of Life and Symptoms Technology (PEDIQUEST) study. Parent-reported household income was categorized as low (<\$50,000) or high (\geq \$50,000). Multiple surveys per patient were used in analyses. The association of household income with symptom frequency and distress, and health-related quality of life was evaluated using generalized estimating equations models adjusting for sex, age, diagnosis, time since disease progression, cancer treatment intensity, and intervention arm.

Results. Seventy-eight children were included in this analysis. Fifty-six (72%) high-income and 22 (28%) low-income patients returned a median number of 7 (range=2-20) and 10 (range=1-33) surveys, respectively. In multivariate models, children from low-income families reported higher physical ($p=0.09$) and total ($p=0.06$) symptom distress, which approached significance. Low-income children were significantly more likely to report pain than high-income children (64% vs. 42%, $p=0.02$), and a majority characterized their pain as highly distressing. Children from low-income families also reported significantly lower physical, school, and total quality of life scores ($p<0.04$).

Conclusion. Children with advanced cancer from low-income families experience higher symptom distress and worse quality of life. This disparity may be partially related to uncontrolled pain, which may respond to more intensive management.

Implications for Research, Policy, or Practice. Further research is needed to evaluate reasons for poverty-related disparities in symptom distress and quality of life and explore avenues to improve equity.

Disconnecting Pain: Neurosurgical Interventions for the Treatment of Intractable Cancer Pain (FR441C)



Rotem Tellem, MD, Tel Aviv Medical Center, Tel Aviv, Israel. Ido Strauss, MD, PhD, Tel Aviv Medical Center/Tel Aviv University, Tel Aviv, Israel. Uri Hochberg, MD, Tel Aviv Sourasky Medical Center, Tel Aviv, Israel. Michal Arad Sobol, BA RN, Tel Aviv Medical Center, Tel Aviv, Israel.

Objectives

- Describe three neurosurgical interventions for intractable cancer pain.
- Examine the appropriateness of each of the previously described neurosurgical interventions for several clinical scenarios in light of this innovative research.

Original Research Background. There is a great importance to deliver good pain management to cancer patients suffering from advanced metastatic disease. There are selected patients for whom pharmacotherapy does not achieve acceptable pain relief or is limited by marked side effects. These patients, may benefit from neurosurgical procedures that selectively intervene along the pain processing pathways. Careful patient selection is critical for the success of these procedures. In the last year we have established a specialized service consisting of palliative care specialists, pain specialists and a neurosurgeon specifically for this task.

Research Objectives. To present our experience in interdisciplinary evaluation of cancer patients undergoing neurosurgical interventions for intractable pain. Reviewing clinical considerations guiding the choice of the therapeutic approach through representative clinical cases.

Methods. Retrospective review of all patients who were evaluated and operated for intractable oncological pain.

Results. Eighty-nine patients were evaluated. Forty-one patients were selected for neurosurgical interventions. 48 patients were excluded. Patients' refusal was the reason for exclusion in 22 case and 26 patients were found to be clinically unsuited for these interventions. Twenty-three patients with localized pain

underwent selective cordotomy. Good pain palliation was achieved in 21 patients immediately post op (91%), at 30 days post op 17 patients were still pain free (74%), and at 3-months 6/6 patients available for follow-up were still free of their original pain. Sixteen patients with diffuse pain underwent bilateral stereotactic cingulotomy. Good pain palliation was achieved in all patients in the immediate post op period. During the 1-month and 3-months follow-up visits, 12/13 patients (92%) and 7/9 patients (77%) available for follow-up, reported significant pain relief. Two patients with abdominal pain underwent midline myelotomy.

Conclusion. In carefully selected patients, evaluated by an interdisciplinary palliative care team, neurosurgical procedures can produce significant pain relief.

Implications for Research, Policy, or Practice. Interdisciplinary cooperation may improve patients care and provide additional palliation modalities.

Universal Precautions for Opioid Prescribing in Ambulatory Palliative Care (FR441D)



Kathleen Broglio, DNP NP ACHPN ANP CHPN FPCN, Dartmouth-Hitchcock Medical Center, Lebanon, NH. Alex Doering, BA, Geisel School of Medicine at Dartmouth, Hanover, NH. Ellen Bassett, MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH. Amelia Cullinan, MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH. Lisa Stephens, MSN APRN ACHPN, Dartmouth-Hitchcock Medical Center, Lebanon, NH. Matthew Wilson, MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH. Donna Soltura, MSW, Dartmouth-Hitchcock Medical Center, Lebanon, NH. Janice Chapman, RN, Dartmouth-Hitchcock Medical Center, Lebanon, NH

Objectives

- Discuss implementation of universal precautions in opioid prescribing within a population of people with serious illness.
- Discuss the outcomes of the first year implementation of universal precautions in opioid prescribing in the palliative care clinic.

Background. Opioid overdose deaths have dramatically increased throughout the United States. Palliative care has been excluded from many practice guideline changes in opioid risk assessment and prescribing. Yet, emerging evidence suggests that the risks for abuse, misuse and diversion may be the same in this population. With the trend toward earlier palliative care consultation and the development of ambulatory palliative care clinics, adapting universal precautions for opioid prescribing may improve both the safety and effectiveness of opioid management in the seriously ill population.

Aim Statement. To assess the feasibility of implementing universal precautions for opioid prescribing for seriously ill patients in the palliative care clinic.

Methods. Internal interdisciplinary guidelines and processes for opioid risk assessment and monitoring were developed and implemented in October 2016. Charts were reviewed from the first weeks of October 2016, January 2017, and April 2017 for key items of the opioid prescribing guidelines. Information was de-identified, aggregated, and evaluated using descriptive statistics.

Results. Sixty-eight patients were seen in the palliative care clinic and 32 (47%) were prescribed opioids by the palliative care clinician. Of these 32 patients, 90% had an opioid management plan, 78% had a urine drug screen completed at the current or prior visit, and 75% had an opioid treatment agreement on file. The mean morphine equivalent daily dose was 316 mg. Opioid risk stratification was assessed and documented in 25 patients (78%), and of these eight (33%) were high risk. All high risk patients were referred to social work.

Conclusions and Implications. Implementation of universal opioid precautions is feasible and may identify at-risk patients and enable clinicians to provide safer opioid management without an increase in clinic staff. Further work is necessary to improve clinician utilization of the guidelines. In-depth analysis may provide valuable information to inform risk assessment and prescribing practices.

3–4 pm

Concurrent Sessions

The “R” Word (Retirement): Planning for Career Transitions and Life After Hospice and Palliative Care (FR450)



Sharon Teitelbaum Master Certified Coach (MCC) BA MA, Boston, MA.

Objectives

- Discuss the 3 stages of retirement: Leaving, Transitioning, Living in Retirement.
- Get an experiential taste of the Leaving process and the Transitioning process.

Over the years, you’ve helped countless patients and families have the hard conversations about what’s next for the patient. This session is an opportunity for you to learn some skills for having the hard conversations with yourself about retiring from this career: figuring out what you want and how to get there.

This hand-on workshop is designed to help you understand the dynamics of personally transitioning out of

your current career and into retirement, and how you can start preparing now for that transition. It offers you some tools for working with yourself at various stages along the way. You’ll come away with experience doing some of the thinking and idea-collecting you’ll need to do as you move toward retirement, and you’ll hear some of your colleagues’ thoughts and ideas as well. (Please note, this is not a financial planning session.)

This session includes a conceptual introduction to the process of retiring from a professional career, including its three main stages: Leaving, Transitioning, and Living in Retirement. It uses hands-on, experiential processes designed to give participants direct experience with the first two stages.

“I Don’t Qualify for a Liver Transplant—Now What?” What is the Role of Palliative Care in End-Stage Liver Disease? (FR451)



Sandhya Mudumbi, MD, University of Alabama at Birmingham, Birmingham, AL. Nicholas Hoppmann, MD, University of Alabama Birmingham, Birmingham, AL. Marie Bakitas, DNSc, NP-C, FAAN, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Describe the current evidence for palliative care interventions in the end-stage liver disease population.
- Describe challenges in caring for a patient with end-stage liver disease from patients, caregivers, and healthcare providers’ perspectives.
- Describe study designs and intervention components necessary to advance research in improving the quality of care in end-stage liver disease.

Of the 400,000 patients with end-stage liver disease (ESLD) in the United States, only about 2% are transplanted; the remainder will die from the disease. However, despite high symptom burden and advanced care planning needs, only 10% of ESLD patients deactivated from the transplant list are referred to palliative care. There is a paucity of high quality data and standardization in use of palliative care in ESLD compared to other forms of end-stage organ dysfunction (e.g., heart failure, chronic obstructive pulmonary disease). In preparation for developing an ESLD clinical and research program, we conducted an extensive rapid review of ESLD literature from six databases (PubMed, EMBASE, CINAHL, PsychInfo, clinicaltrials.gov, Cochrane) for adults with end-stage liver disease who received palliative care interventions. In the first part of the session, we will present the results of this literature review and highlight important studies. Based on

these results, we have designed a pilot qualitative study to understand perspectives from patients, caregivers, and healthcare providers with regards to challenges and opportunities in identifying and managing patients with end-stage liver disease. In the second part of the session, we will review the results of this pilot study and review the specific challenges and opportunities identified. Lastly, we will explore key elements of research design and intervention development for this population necessary to further research in this area of critical need.

Incorporating Bereaved Parents as Facilitators and Educators in Teaching Principles of Palliative and End-of-Life Care (FR452)



Jennifer Snaman, MD, St. Jude Children's Research Hospital, Memphis, TN. Erica Kaye, MD, St. Jude Children's Research Hospital, Memphis, TN. Deena Levine, MD, St. Jude Children's Research Hospital, Memphis, TN. Lisa Clark, PhD, St. Jude Children's Research Hospital, Memphis, TN. Robin Wilcox, BSN, St. Jude Children's Research Hospital, Memphis, TN. Melody Cunningham, MD FAAHPM, Le Bonheur Children's Hospital, Memphis, TN. Justin Baker, MD FAAP FAAHPM, St. Jude Children's Research Hospital, Memphis, TN.

Objectives

- Identify innovative ways to incorporate highly trained bereaved parent volunteers into educational opportunities in palliative care for health care providers and staff.
- Describe the process of implementation and content of palliative care educational forums facilitated by bereaved parent educators.
- Conduct training, support, and debriefing that is provided to bereaved parent volunteer educators and facilitators involved in staff education on palliative and end-of-life care.

High quality medical education for all members of the clinical and supportive care team requires training in principles of palliative and end-of-life care, including symptom management, empathic communication, ethical considerations, and provision of support around the time of death and throughout bereavement. We have demonstrated that experiences of bereaved parents can augment and inform palliative care educational curricula in uniquely powerful and valuable ways. We present a novel and innovative palliative care training program facilitated by bereaved parents of children cared for at our institution, who now serve as volunteer

educators in palliative care didactic forums for clinical staff. Current and ongoing educational events include quarterly offerings of the End of Life Nursing Education Consortium (ELNEC), and Quality of Life Seminars, two independent one-day training programs for nurses, support staff, advanced practice nurses, and physicians. These educational sessions utilize small groups, facilitated by a bereaved parent volunteer and a palliative care team member, to augment didactic teaching, encourage interactive discussion and questions, and allow practice in palliative care skills.

Bereaved parents also function as facilitators and educators in intensive and interactive communication workshops for medical trainees and collaborate with palliative care physicians to teach communication skills in national forums in which they provide communication training and discuss fundamentals of bereavement support. Unquestionably, appropriate selection and training of bereaved parent educators is essential to programmatic success. Parents receive support through scheduled debriefings following each event, with additional one-on-one support provided as needed. Feedback from bereaved parent participants demonstrate unanimous perception of teaching opportunities as meaningful avenues to continue longitudinal relationships with the institution and create lasting legacies to honor their children. Our uniquely innovative integration of bereaved parents in education around palliative and end-of-life care is a model which we have observed to be an effective and beneficial intervention for both staff and parents.

Documentation Design: Palliative Care Notes in the EHR Era (FR453)



Christian Sinclair, MD FAAHPM, University of Kansas Medical Center, Kansas City, KS. April Krutka, DO, Intermountain Healthcare, Ogden, UT.

Objectives

- Implement a structured, evidence-based approach to update and design note templates.
- Increase note efficiency and efficacy across palliative care settings.

Electronic health records (EHRs) have proliferated throughout health care, only to be matched by the howls of clinicians who are frustrated by the increasing time sink of documentation. The promise of data and efficiency with EHRs is yet to be realized for many clinicians, but there are ways to improve the documentation experience while improving efficiency and increasing effectiveness of digital communication.

Using eye-tracking and mouse-tracking technology, we can understand what sections of notes are read first and which are completely ignored by referring clinicians. Classic medical teaching emphasized the SOAP note as representative of the workflow of gathering information and turning it into a plan, but with bloated EHR notes, the plan is now buried at the end of endless scrolling. APSO may be a more effective way of communicating the plan.

Based on research and the experience at two health systems, we will share how an iterative design process in developing note templates allows for a universal but customizable approach that is flexible across settings and disciplines. This session will assess how to properly balance the many needs of a note (clinical communication, legal, billing, quality improvement, and others) with a busy clinician workflow. The opportunity to use documentation as written communication with patients and families through Open Notes will also be explored. Consultation/Admission notes, progress notes, and advance care planning notes will be highlighted, but other note types can be addressed using these universal design principles.

EPIC and Cerner systems will be featured, but many of the approaches to documentation design are EHR-agnostic. This session will not cover billing or coding issues.

Speed Dating: Now for Kids! (FR454)

Emma Jones, MD, Dana-Farber Cancer Institute and Boston Children's Hospital, Boston, MA. Mary Lynn McPherson, PharmD MA MDE BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Jill Morgan University of Maryland School of Pharmacy, Baltimore, MD.

Objectives

- List "cutting edge" therapies in the fields of pediatric oncology, immunology, pulmonology, and neurology.
- Describe the use of "avant-garde" symptom management medications in pediatric palliative care.
- Recognize pediatric indications in which the use of "old dogs" may be appropriate and effective.

This session will utilize the popular "Speed Dating with the Pharmacy Ladies" format to provide content most relevant to pediatric palliative care. Pediatric Palliative Care is a diverse specialty with a wide range of care settings and nearly infinite number of unique diagnoses and care plans. Using the rapid fire, high yield approach, we aim to cover a range of topics which will include something for everyone. Three major domains will be addressed:

- Cutting edge medications for treatment of disease.

- Avant-Garde symptom medications.
- Old dogs, new tricks.

Seizure Bootcamp: Everything You Ever Needed to Know to Manage Seizures in End Stage Disease (FR455)



Mara Lugassy, MD, MJHS Hospice and Palliative Care, New York, NY. Neha Kramer, MD, Rush University Medical Center, Chicago, IL. Ebtesam Ahmed, PharmD MS, St John's University College of Pharmacy, Queens, NY. Joel Phillips, DO, Michigan State and Mercy Health Physician Partners, Grand Rapids, MI. Colleen Fleming-Damon, PhD ARNP-BC ACHPN FT, MJHS Institute for Innovation in Palliative Care, New York, NY.

Objectives

- Describe common clinical presentations of seizures in advanced illness.
- Implement strategies for appropriate use of anti-epileptics in end stage illness.
- Develop a framework for management of acute seizure activity in home and inpatient hospice settings.

Seizures are a common occurrence in end stage disease, occurring in a wide range of conditions, including dementia, stroke, AIDS, end stage renal disease, and both primary brain tumors and metastatic disease. Not only are uncontrolled seizures a significant source of distress to both patient and families, but they present a significant management challenge to the hospice team, who are often faced with controlling seizures in the face of advancing disease, increasing seizure risk factors, and declining ability of the patient to take oral medications.

Through use of current evidence, case studies, and interactive discussion, this session will present participants with the opportunity to establish a framework to effectively assess and manage seizures in the end stages of illness, with particular attention to management of seizures in the hospice setting. Participants will develop the bedside clinical skills necessary to detect subtle presentations of seizures and to distinguish them from common seizure mimics. Participants will also develop increased comfort with use of antiepileptics in end stage disease, including facility with non-oral routes of administration, and with treatment of acute seizures in both the home and inpatient settings. In addition, participants will develop techniques to effectively educate families and other caregivers about the safe management of acute seizures at home.

When Helping Hurts: Iatrogenic Effects on the Patient-Caregiver Dyad (FR456)

Katie Jones, APN, VA Medical Center, West Roxbury, MA. Kysa Christie, PhD, VA Boston Healthcare, West Roxbury, MA. Lara Skarf, MD, VA Boston Healthcare System, West Roxbury, MA.

Objectives

- Identify domains and screening tools to elicit self-perceived burden.
- Describe correlations between medical treatment decisions, syndromes (e.g., ICU admission, feeding tube placement, delirium) and caregivers' mental health.
- Develop language for identifying and intervening in: 1) patients with self-perceived burden, 2) caregiver distress, and 3) the changing dyadic relationship.

For many people with a serious illness, family members assume a caregiving role. While the caregiver role can strengthen relationships, it also poses challenges. This manifests as self-perceived burden for patients and caregiver burden. This talk will review both perspectives including the patient as a self-perceived burden and the toll of caregiving by examining the emotional impact of medical conditions and treatment decisions that have direct impact on caregiver coping and mental health.

Patients' self-perceived burden can result in guilt, depression, suicidality, and requests for hastening death. This talk will explore ways to elicit the patients' experience including the use of burden scales. Use of these tools will foster language for providers to screen for self-perceived burden, caregiver burden and intervene with couples to meet the needs of both care receiver and caregiver.

Furthermore, mental health of the caregivers can be complicated by additional iatrogenic factors including treatment decisions (e.g., ICU admission, LVAD) which have been shown to result in PTSD, complicated bereavement, and anxiety. Symptomatic states including anorexia, delirium, and behavior disturbances are also associated with greater caregiver distress. Our aim is to help palliative care teams have the foresight to consider the emotional burden of common treatment decisions and symptomatic states. While palliative care involvement has been shown to benefit patients' mental health and coping, given the complex nature of the caregiving dyadic relationship, patient focused interventions are likely not enough. Using case examples, we will illustrate burden in patients, caregivers and couples. We will use Sli.do to engage audience and teach strategies and language to intervene effectively (including interventions that

bolster "uplifting" effects of caregiving which has been shown to improve the coping of caregivers). Lastly we will increase awareness of the iatrogenic effects of conditions and decisions that affect couples coping with serious illness.


Is There Accountable Care for Community Based Programs for the Seriously Ill? (FR457)

Joan Teno, MD MS, University of Washington, Seattle, WA. Amy Kelley, MD MSHS, Icahn School of Medicine at Mount Sinai, New York, NY. R. Sean Morrison, MD FAAHPM, Icahn School of Medicine at Mount Sinai, New York, New York. Justin Sanders, MD MSC, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Identify key challenges to measuring the quality of care for the purpose of accountability of community-based programs for persons with a serious illness.
- Identify quality measures that examine whether care is consistent with a person's goals of care and will be able to list the potential limitations of those measures, given the description of existing measures of goal-concordant care.
- List research priorities for future measurement development of accountability measures of community-based programs for seriously ill.

The Center for Medicare & Medicaid Services is transitioning from volume-based incentives in traditional fee-for-service to value-based incentives. Value is defined by measures of quality and constraining costs. This change in financial incentives and MA-CRA has prompted a rapid growth of community-based palliative care programs with many targeting seriously ill persons, who are often high-need and high-cost. Accountability measures are key to earning public trust in these programs by ensuring that seriously ill persons are receiving high quality care rather than care focused solely on cost-reduction. We convened 45 experts in palliative care, health policy, health economics, and quality measures to ask: 1) what is denominator of who should be offered these programs? 2) What are the guiding principles for quality measurement? 3) What can we do now in measuring the quality of care of these programs? 4) What research is needed? and 5) What should we be able to do in the future in measuring the quality of care of these programs? This session will present the findings of this 2017 Conference and engage the audience in a dialogue on future efforts for accountability of community base programs for the seriously ill.

“Don’t Limit Me”: Discussing Serious News with Intellectually Disabled Adults (FR458) 

Colleen Vega, CNS, Stanford Hospital, Stanford, CA. Felicia Hui, MD, Stanford University, Stanford, CA. Stephanie Harman, MD, Stanford Palliative Care, Stanford, CA. Laurel Mildred, MSW, Mildred Consulting and Advocacy, Sacramento, CA. Karla Schroeder, DNP MHA ANP NP, Stanford Health Care, Stanford, CA.

Objectives


- Identify different ways the palliative care team can support patients with intellectual disabilities (ID) and their families when discussing serious news.
- Distinguish the difference between guardianship, conservatorship and supported decision making.
- Use guidelines to disclose information to ID patients in an easily understandable way.

Palliative care (PC) services provide expert communication skills when discussing serious news, and yet intellectual disability (ID) patients and their families often underuse these services. As individuals with ID live longer, dedicated ID services are underprepared to deal with chronic and/or serious illnesses. Collaboration and partnership among ID and PC services are key in providing high-quality care to ID patients. Specifically, PC has a unique opportunity to enhance decision making and quality of life within this population.

ID patients are typically not included in decision making for their own health. ID is a significant limitation in adaptive behavior seen in the conceptual, social, and practical skills of an individual. It presents before age 18 and currently affects 1-3% of the general population. There are many unique challenges to discussing serious illnesses with patients who have ID: 1) Assessment of their cognitive and conceptual ability, 2) evaluation of their capacity to make decisions, and 3) delivery of complex information to them. Supportive decision making, a process in which a third party assists ID patients with legal choices, is an alternative option to conservatorship. An interdisciplinary approach with PC and supportive decision making can help ID patients and their families understand and cope with serious illnesses.

This session will help PC clinicians identify different ways they can support ID patients and their families. Importantly, as the population of ID grows and outlives its support systems, so will its overall PC needs. The difference between guardianship, conservatorship and supportive decision making will be discussed, along with the legal and ethical considerations in assessing capacity. Finally, presenters will provide a framework to disclose information to patients with

ID so that they understand what is being said and facilitate skills practice amongst the session participants.

Not Quite There Yet: Striving to Create a Diverse and Inclusive Palliative Care Workforce (FR459) 

Catherine Deamant, MD FAAHPM, Cook County Health and Hospitals System, Chicago, IL. Solomon Liao, MD FAAHPM, University of California Irvine Medical Center, Irvine, CA. Heather Harris, MD, Zuckerberg San Francisco General and the University of California, San Francisco, San Francisco, CA. Karolina Soriano, MSW LCSW, UC San Diego Health, San Diego, CA. Lisa Marr, MD, University of New Mexico, Albuquerque, NM. Tartania Brown, MD, Metropolitan Jewish Health System, New York, NY. Andrea Ferguson, MDiv MA, University of New Mexico, Albuquerque, NM.

Objectives

- Describe demographics of current palliative care workforce and fellowship training programs.
- Appreciate perspectives and raise awareness on aspects of diversity and inclusion to improve recruitment of underrepresented professionals.
- Identify challenges and develop strategies to create and better support a diverse workforce in palliative care.

The U.S. Census Bureau projects that by 2050, 54% of the population will be ethnic and racial minorities. A report from the Sullivan Commission on Diversity in the Healthcare Workforce from 2004 stated: “The fact that the nation’s health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans. Today’s physicians, nurses, and dentists have too little resemblance to the diverse populations they serve, leaving many Americans feeling excluded by a system that seems distant and uncaring.” With the changes in U.S. demographics, achieving greater diversity in the healthcare workforce can lead to a more culturally competent workforce, increase access to high quality care for medically underserved, strengthen the research agenda and prepare a more diverse pool of future leaders. AAHPM has recently developed a Diversity Strategic Plan and identified themes tied to the academy’s strategic goals, including membership diversity, cultural competency in patient care and programming and quality of patient care, with attention on disparities. The National Association of Social Workers Standards and Indicators for Cultural Competence also supports cross cultural knowl-

dge, skills, service delivery, workforce diversity, education and leadership. The Standards of Practice for Professional Chaplains in Hospice and Palliative Care reflect inclusivity and respect for diversity as foundational values. This concurrent session will provide a brief overview of what is known about workforce demographics in palliative care and through narrative stories provide various perspectives from diverse applicants, team members, fellowship directors and institutional policies and processes that foster a diverse and inclusive work environment. Through small group discussion, we will seek to address challenges and barriers and identify strategies for creating a diverse and inclusive work environment.

Immunotherapy 101 (FR460)

Eric Prommer, MD HMDC FAAHPM, University of California, Los Angeles and VA HPM Program, Los Angeles, CA. Arif Kamal, MD MBA MHS FAAHPM, Duke Cancer Institute, Durham, NC. Mary Buss, MD MPH, Beth Israel Deaconess Medical Center, Boston, MA. David Hui, MD MS MSC, MD Anderson Cancer Center, Houston, TX.



Objectives

- Learn when immunotherapies are used in cancer care.
- Understand how immunotherapies affect quality of life.
- Learn about common toxicities associated with immunotherapy use.

Immune checkpoint inhibitors have changed the landscape of advanced cancer treatment during the last few years. They represent appealing treatment alternatives for patients and clinicians for several reasons. By targeting specific cell receptors researchers have produced drugs unleashing the immune system against tumor cells. In harnessing the immune system, this therapy has found application in several cancer types with response rates ranging from 15% to 90%. Additionally, select difficult to control cancers with conventional therapies are now able to be controlled with durable responses. Unfortunately, while eliciting the immune system against tumor cells, autoimmune toxicities may manifest. These toxicities are wide ranging and can be life threatening. Additional concerns are the use of these drugs in cancer patients not represented in clinical trials. Such trial-ineligible patients may now desire immunotherapy, leading to concerns about clinical benefit, necessitating input from the palliative care specialist. Thus, a major gap in knowledge regarding the safety and efficacy of these agents persists, even after regulatory approval. This

session will be led by both palliative care specialists and oncologists. The panel will, by way of didactics and case presentations, enable the palliative care clinician to understand the basics of immunotherapy. The attendee will leave the session with a practical understanding the role of these therapies in cancer including: 1) indications, 2) mechanisms of action, 3) impact of these new therapies on quality of life, 4) common toxicities associated with immune therapies, 5) management of toxicities, and 6) use of immune checkpoint inhibitors in challenging clinical scenarios.

Paper Sessions (FR461)

Palliative Care from Cancer Diagnosis for All: Memorial Sloan Kettering's "One-Two-Three" Program (FR461A)



Andrew Epstein, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Virginia Klimek, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Kimberly Chow, ACHPN ANP NP CHPN, Memorial Sloan Kettering Cancer Center, New York, NY. Anjali Desai, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Kelley Anderson, RN, Memorial Sloan Kettering Cancer Center, New York, NY. Robin Rawlins-Duell, NP, Memorial Sloan Kettering Cancer Center, New York, NY. Jessica Goldberg, MSN NP, Memorial Sloan Kettering Cancer Center, New York, NY. Judith Nelson, MD JD, Memorial Sloan Kettering Cancer Center, New York, NY.

Objectives

- Describe the purpose and design of a novel program ("One-Two-Three") integrating primary and specialist palliative care with outpatient oncology care for all patients from diagnosis at Memorial Sloan Kettering Cancer Center.
- Describe the results and implications of pilot implementation of the "One-Two-Three" program in blood cancer and solid tumor clinics at Memorial Sloan Kettering Cancer Center.
- Appreciate the role of the "One-Two-Three" program in eliciting core patient values as part of high quality advance care and oncology treatment planning.

Background. Early palliative care is an unmet need for cancer patients.

Aim Statement. To evaluate in high-volume outpatient oncology clinics the feasibility, acceptability and preliminary impact of a novel program providing palliative care by the primary teams, with support from palliative care specialists, from diagnosis as an institutional standard.

Methods. One-Two-Three is a structured program of assessment and response addressing palliative care needs regardless of cancer stage or prognosis starting with the first three clinic visits after diagnosis. Assessments include patient physical/emotional/spiritual symptoms (10 symptoms, self-reported, 0-10), communication (information preferences, illness understanding), and proactive care planning through exploration of core values. As first responders, oncology nurses are guided by “ready responses” in an empathic framework and coaching or direct patient consultation by palliative care specialists. Feasibility, acceptability and impact on patient, caregiver, and utilization outcomes are evaluated, quantitatively and qualitatively.

Results. Assessments were piloted with 27 consecutive newly-diagnosed patients in blood cancer and solid tumor clinics. Symptom and communication assessments each took < 5 minutes and showed high prevalence of moderate/severe distress (30% of patients for 8/10 symptoms, 160 assessments), variation in information preferences (73% wanting detail, 27% broad overview only), and unmet communication needs. Oncology nurses engaged patients in structured discussions (<15 minutes) of core values. Clinic workflow was maintained. Patients, families, and oncology clinicians endorsed the initiative. As palliative care by oncology teams improved, specialists focused on more complex issues.

Conclusions and Implications. Routine inter-professional primary palliative care with specialist support from diagnosis is feasible and acceptable in our center’s high-volume outpatient oncology clinics. Systematic assessment in key palliative care domains confirms important needs and informs response approaches. Ongoing evaluations focus on other outcomes (e.g., quality of life); impact on clinicians/processes; and utilization (e.g., ED/hospital visits, hospice use). This program normalizes palliative care, enhances primary palliative care by oncology teams, and can serve as a model for other centers.

Using a Best Practices Advisory (BPA) Alert Tool to Identify and Enhance Outpatient Palliative Care (OPC) Referrals for Stage 4 Cancer Patients (FR461B)

Mark Swidler, MD, Yale University School of Medicine, New Haven, CT. Jennifer Kapo, MD, Yale University, New Haven, CT. Kerin Adelson, MD, Yale Cancer Center, New Haven, CT. Nitu Kashyap, MD, Yale New Haven Health System, New Haven, CT. Amelia Trant, BS, Yale University School of Medicine, New Haven, CT.

Objectives

- Understand the present state of oncology referrals to outpatient palliative care
- Understand a way to enhance integration of palliative care in the outpatient oncology clinic setting

by using active prompting system to help oncologist assess need for OPC

Original Research Background. OPC referrals from oncology clinics using the current electronic health record (EHR) are significantly under-utilized and do not meet national cancer guidelines.

Research Objectives. To develop a BPA Alert tool in the Epic® HER to identify appropriate patients for OPC referral.

To use that tool to increase Oncology-OPC integration.

Methods. In a first phase silent pilot study without health care provider knowledge, BPA Alert criteria were used to trigger an OPC referral that included:

- stage IV or metastatic disease and
- no palliative visit in last six months and
- not on hospice

In a second phase live study, the BPA Alert tool was activated in the Thoracic Oncology Clinic.

Results. In two oncology clinics over a six-week period using the silent BPA alert, the following results were:

- Number of patients seen: 1,654.
- Number of total patients meeting criteria 17% (284/1654).
- Number of patients meeting criteria who were referred to OPC: 5% (14/284).
- At five weeks using the active BPA Alert, the following results were available:
- One-hundred-fifty-nine patients met criteria for OPC referral.
- Sixteen/159 or 10% were referred to OPC, a doubling compared with the silent pilot.
- Twenty-two/159 or 13.8 % provided acknowledgment of palliative care plans already in place (by clicking the appropriate button within the BPA Alert drop-down menu).

Conclusion. Using this electronic BPA Alert, 38/159 or 23.9% of patients had documentation that palliative needs were addressed. In the next step phase, it will be introduced in the GI Oncology clinic. Data collection is ongoing.

Implications for Practice and Policy. This electronic tool has the potential to improve OPC referral rates and increase adherence with national guidelines which call for concurrent palliative care for all patients with advanced malignancies.

Palliative Care Interventions in End-Stage Liver Disease: A Rapid Review of Literature (FR461C)

Sandhya Mudumbi, MD, University of Alabama at Birmingham, Birmingham, AL. Alayne D. Markland, DO

MSc, Birmingham/Atlanta Geriatric Research Education and Clinical Center/ University of Alabama at Birmingham, Birmingham, AL. Cynthia Brown, MD MSPH, University of Alabama at Birmingham, Birmingham, AL. Nicholas Hoppman, MD, University of Alabama at Birmingham, Birmingham, AL. Catherine H. Smith, MLS MPH, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Summarize the 16 final included studies and describe the types of study design, interventions, measured outcomes, quality assessment, and future research needs.
- Describe features of a rapid review compared to a systematic review that make this methodology more accessible to trainees, practicing clinicians, and policy-makers.

Background and Objective. Of the 400,000 patients with end-stage liver disease (ESLD) in the United States, approximately 2% of patients are transplanted, with the remainder dying from liver disease. These patients have high symptom burden and may benefit from palliative care (PC) intervention. Our objective was to review the evidence for PC interventions in patients with end-stage liver disease with an effective and time-efficient methodology, the rapid review.

Study Identification. We reviewed six databases (PubMed, EMBASE, CINAHL, Psych Info, ClinicalTrials.gov, Cochrane) for adults with ESLD and hepatocellular carcinoma (HCC) who received PC. We included patients with HCC since most have liver cirrhosis and similar symptoms with disease progression. We excluded pharmacological and procedural interventions and included PC provider interventions focusing on communication regarding patient prognosis, goals of care, symptom management, and focused end-of-life care.

Data Extraction and Synthesis. Data were extracted for study design, participant and intervention characteristics, and three main groups of outcomes: patient-centered outcomes (symptoms, quality-of-life, etc.), quality-of-death outcomes (receiving focused end-of-life care, advanced directives, concordance of actual care with wishes, etc.), and healthcare resource utilization (ER visits, hospitalizations, lengths of stay, costs of treatment, etc.).

Results. Our search resulted in 2,460 studies. After de-duplication and exclusion criteria applied, 16 studies were included. There was one RCT and 15 non-randomized studies. A majority (10) were focused on HCC and the others (6) on non-malignant ESLD. Interventions included inpatient PC consultation (5), inpatient hospice (3), outpatient hospice (3), outpatient PC (3), and a combination (2). A majority of the outcomes were healthcare resource utilization

(12), with others being quality-of-death (7) and patient-centered outcomes (5).

Conclusions and Implications for Practice, Policy, and Research. There is a lack of high quality research in PC interventions for ESLD and HCC. Future research should focus on development of a PC intervention specific to ESLD, higher quality methods including RCTs, with a greater emphasis on patient-centered outcomes.

Life Program: Pilot of a Palliative Psychology Group Intervention (FR461D)



Katherine Ramos Durham VA Medical Center /Duke University, Durham, NC. Jessica Fulton, PhD, Durham VA Healthcare System, Durham, NC. Hayden Bosworth, PhD, Duke University Medical Center, Durham, NC. Nicki Hastings, MD, Duke and Durham VA Health Care System, Durham, NC. Karen Steinhauser, PhD, Duke & VA Medical Center, Durham, NC.

Objectives

- Describe at least two evidence-based mental health interventions to improve anxiety, depression and distress that can be integrated into clinical care.
- Describe three psychosocial outcomes of delivery a palliative mental health group intervention. Identify three to four facilitators and three to four barriers to implementing quality improvement projects into an integrated health care system.

Background. Living with serious illness can exacerbate depression and anxiety. Mental health palliative interventions improve distress symptoms in the general population; however, interventions for veterans receiving palliative care are poorly understood. To enhance mental health care for seriously ill veterans, we evaluated and expanded clinical services (via a group intervention).

Aim Statement. Our objectives were to assess the effectiveness of a palliative psychology quality improvement intervention (“Life Program”) to reduce stress, depression and anxiety.

Methods. Eligible Veterans were receiving palliative care for a life-limiting illness at the Durham VA Health Care System and referred to the Life Program (LP) by a treating provider in palliative care and/or oncology. The LP targeted three primary areas: personal values, mindfulness, and psychological flexibility. Group size ranged between 4-8 participants, over 6-8 weekly sessions. Using a pre-posttest design primary outcomes were depression, anxiety, and stress, including satisfaction with the intervention.

Results. Of the five groups delivered, 17 out of 39 recruited Veterans completed all sessions. Non-completers dropped from the program due to travel burden, competing medical appointments, sickness

and fatigue. The mean age of the completers ($n=17$) was 63.06 ($SD = 8.47$). Most were male (93%), Caucasian (57%), and had a cancer diagnosis (57%). Pre-post mean scores suggest clinically meaningful reductions in severity levels of depression (18.82 pre. vs. 13.20 post), anxiety (16.59 pre. vs. 14.59 post.), and stress (19.18 pre. vs. 13.88 post.). Veteran scores of psychological flexibility, self-compassion and mindfulness also improved. Participants, on average (4.44 out of 5), reported feeling satisfied with the quality of the intervention. Veterans also endorsed feeling 'more likely' to seek psychology services after having completed the intervention (4.38 out of 5).

Conclusions and Implications. The LP for veterans with serious illness was effective, although program adherence may benefit from flexible delivery formats.

4:30–5:30 pm

Concurrent Sessions

The State of HPM Policy: Opportunities to Expand and Protect Access to Palliative Care and Hospice at the State and Local Levels (FR470)



Stacie Sinclair, MPP LBSW, Center to Advance Palliative Care, New York, NY. Phillip Peterson, MD, Hospice Compassus and Medical Services of America, Princeton, WV. Rhonda Oakes, RN CHPN, Change Healthcare, Springfield, MO. Jordan Endicott, JD, American Academy of Hospice and Palliative Medicine, Chicago, IL.

Objectives

- Describe the importance of state-level activity in expanding and protecting hospice and palliative care.
- List 3-4 state policy levers available to improving the availability and quality of hospice and palliative care services.
- Discuss high-impact activities conducted by state and local collaborations.

It is difficult to understate the impact of the 2016 election on the care of seriously ill patients in the coming years. After 8 years of unprecedented federal involvement and investment in health care, the new administration and a Republican-controlled Congress have proclaimed their intention to return this responsibility to the states. Early policies have included proposals to loosen federal health care regulations, increase flexibility in implementing certain provisions of the Affordable Care Act, and transition Medicaid to a block grant program. These proposals suggest that there will be an increase in states' authority to set policy for the care of vulnerable populations, accompanied by a significant reduction in federal funds over

time. As the primary insurer of long-term care through Medicaid, states already bear the responsibility for a portion of costs for their aging citizens; they also cover a significant percentage of care for seriously ill children through Medicaid and the Children's Health Insurance Program. Therefore, it behooves states to identify proven strategies for improving care for these populations while reducing overall costs—strategies like palliative care and hospice.

Over the past decade, more states have engaged in activities to create awareness of and expand and protect access to palliative care and hospice. In 2013, this trend was accelerated by the American Cancer Society Cancer Action Network's grassroots efforts to introduce Palliative Care Advisory Council legislation in every state (as of submission, this legislation had been passed in 17 states, with several more states "in play"). As states have prioritized improving care for seriously ill patients, we have learned about the activities in which they are engaging, promising strategies, and early lessons learned. In this session, attendees will learn about these initiatives and identify potential opportunities to engage in palliative care and hospice advocacy in their own states.

Cancer Immunotherapy: The Changing Landscape for Palliative Care and Hospice (FR471)



Julie Waldfogel, PharmD CPE, The Johns Hopkins Hospital, Baltimore, MD. Mary Buss, MD MPH, Beth Israel Deaconess Medical Center, Boston, MA. Suzanne Nesbit, PharmD BCPS CPE FCCP, The Johns Hopkins Hospital, Baltimore, MD. Lynn Billing, BSN CHPN, Kimmel Cancer Center at The Johns Hopkins Hospital, Baltimore, MD.

Objectives

- Explain the mechanism of action of immunotherapy in cancer treatment.
- Describe the effect of immunotherapy on cancer response patterns and its impact on expectations of patients and providers.
- Discuss effective management of immune-mediated side effects.

Recent advances in immunotherapy, such as immune checkpoint inhibitors, have drastically changed the oncology landscape, including occasional dramatic responses. They have also created new challenges for hospice and palliative care providers. Through interactive lectures, case-based examples, role play and "pop quiz"-style questions, this concurrent session will review the available evidence for immunotherapy in cancer care focusing on the key issues palliative care and hospice providers should know when caring

for patients currently or previously treated with immunotherapy.

Two pharmacists with extensive experience in oncology palliative care will list commonly used immunotherapy agents, explain mechanisms of action and clarify the complex nomenclature of immunotherapy agents. Common side effects as well as less common, but potentially life-threatening side effects with specific strategies for how to manage side effects will be described. The panel will explain important considerations in the pharmacologic approach to managing symptoms in patients receiving immunotherapy, such as caution in the use of steroids. A palliative oncologist with four years of experience providing palliative care to patients treated almost exclusively with targeted and immunotherapy will review available data on immunotherapy's impact on clinical outcomes, including alteration in measuring response to treatment, impact on life expectancy and the growing list of cancers successfully treated with these regimens. The success of these agents raises important questions for exactly how and when to integrate palliative care into the care of patients on immunotherapy. Through an illustrative case, a clinical oncology palliative care nurse with expertise in caring for patients on immunotherapy, will describe how immunotherapy can dramatically alter patient prognostic perceptions and their approach to decision-making about cancer-directed therapy. The success of these new agents heightens the role of palliative care specialists in helping patients and oncologists navigate decisions about continuing cancer-directed therapy versus enrolling on hospice while living with incurable cancer.

Your Prayers Are Answered: A Simulation-Based Interdisciplinary Curriculum (FR472)



Maxwell Vergo, MD FAAHPM, Dartmouth Hitchcock Medical Center, Lebanon, NH. Nancy Wood Dartmouth Hitchcock Medical Center, Lebanon, NH. Meredith MacMartin, MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH. Charles Whang, MD, Dartmouth Hitchcock Medical Center, Lebanon, NH.

Objectives

- Describe the essential knowledge and skills a learner will need in order to competently respond to a patient wishing for a healing miracle.
- Be familiar with using Simulation to engage learners in practicing their response to a patient wishing for a healing miracle.
- Identify barriers to implementation of this interdisciplinary healing miracle curriculum.

Responding to patients who express a belief in healing miracles is an important competency for practitioners in hospice and palliative medicine. In addition, support for these patients is best accomplished jointly by an interdisciplinary team, particularly by chaplains and medical providers. These interactions can be complex and require practice to competently respond in a real-time encounter. Therefore, utilization of simulated based communication coaching is an ideal approach to prepare interdisciplinary learners for this scenario. Communication training that incorporates two or more disciplines offers the additional benefit of practicing 'sharing an encounter' with a provider from a different discipline and maximize both individuals' unique skill sets.

At Dartmouth-Hitchcock, we have both an established hospice and palliative medicine fellowship and a Clinical Pastoral Education (CPE) program. The program director for the fellowship and the CPE Supervisory Candidate have experience with interdisciplinary education, and will share their curriculum around this topic. Specifically, attendees will refresh their knowledge and skills around responding to a patient with a belief in healing miracles, obtain teaching materials to help meet their own teaching needs, observe a simulated interdisciplinary encounter, and identify barriers to bringing this material home.

Partnering with Payers to Meet the Needs of Pediatric Palliative Care Patients (FR473)



Melody Cunningham, MD FAAHPM, Le Bonheur Children's Hospital, Memphis, TN. Shayla Williamson, MSN RN NE-BC, Methodist Le Bonheur Healthcare - Affiliated Services, Germantown, TN. Justin Baker, MD FAAP FAAHPM, St. Jude Children's Research Hospital, Memphis, TN. Katrina Pennington, BSN RN CHPPN, Methodist LeBonheur Healthcare, Memphis, TN. Ashleigh Young, BA, Methodist Alliance, Memphis, TN. Rachel Bolick, LCSW, Methodist LeBonhuer Healthcare, Memphis, TN. Carla Norton, MDiv, Methodist Le Bonheur Healthcare System, Memphis, TN.

Objectives

- Describe the building blocks of a financially self-sustaining community-based palliative program.
- Develop tools and strategies to utilize in an effort to enable insurers to understand the cost benefit of providing coverage for home-based palliative visits for non-hospice patients.
- Recognize the impact of palliative visits and relationship development for patients who are ultimately cured and 'graduate' from palliative

program and for those who transition to hospice and end-of-life care.

Advances that benefit children with chronic, complex illnesses has increased the need for Pediatric Palliative Care. From a payer perspective, Home Care and Hospice services are defined, regulated and have a structured reimbursement process. When a patient needs palliative care, regulations and guidelines are opaque and obtaining reimbursement is extremely challenging.

The QoLA Kids Program averages 25 Palliative patients. Inability to get reimbursed for the care of such a significant portion of our census was not an option. Since beginning this journey last fall, we have been able to accomplish the following:

- Reimbursement for 100% of our Palliative patients
- Receive payment for patients that already have Private Duty Nursing (PDN) in the home
- Receive payment for patients that have exceeded their lifetime maximums with the payer
- Financially run in the black with ability to invest in expansion.

It has been a one patient at a time approach. We have reviewed each patient's clinical story and partnered with the payer to ensure they understand that it is impossible to place a lifetime maximum on children who were born as they are. Additionally, we have been able to prove that continuing to pay our program to care for the patients in the community has the following benefits:

- Increased quality of life (QOL) for the patient
- Increased QOL for the family
- Decreased need for readmission to the hospital
- Cost savings for home visit vs a Clinic/Urgent Care visit

Using this approach, we have successfully attained reimbursement for 100% of our Palliative patients. Our journey has proven that the most influential factors in convincing a payer to provide authorization are:

- Ability to effectively communicate the patient's past medical history
- Ability to communicate the positive impact services have on the patient/family unit
- Clear communication of the cost-savings that result from the community-based care provided.

Behavioral and Psychotic Symptoms of Dementia vs Delirium in Hospice: Challenges in Diagnosis and Management in the Long Term Care Setting: Part 2 (FR474)

Rebecca Yamarik, MD FAAHPM, Veterans Affairs, Long Beach, CA. Martina Meier, MD, Providence TrinityCare Hospice, Torrance, CA. Jennifer Tjia, MD

MSCE, University of Massachusetts Medical School, Worcester, MA. Barbara Messinger-Rapport, MD CMD HMDC FACP, The Cleveland Clinic, Cleveland, OH.

Objectives

- Describe characteristics distinguishing behavioral and psychological symptoms (BPSD) of dementia from terminal delirium in nursing home residents with advanced dementia at the end of life.
- Review the evidence for the pharmacologic and nonpharmacologic management of BPSD and delirium.
- Building on the Centers for Medicare and Medicaid (CMS) regulatory requirements for management of psychotropic medications in nursing home residents, develop a framework for successful hospice-nursing home team collaboration for management of BPSD and terminal delirium through engagement of palliative, medical, nursing facility and family caregiver engagement.

A majority of patients with dementia suffer from at least one behavioral and psychological symptom (BPSD) of the disease. BPSD describes a wide spectrum of noncognitive manifestations of dementia, including apathy, dysphoria, verbal and physical aggression, agitation, psychotic symptoms, sleep disturbances, oppositional behavior, and wandering. Symptoms are highly prevalent in the moderate to severe stages of dementia, when the patient is typically admitted to hospice. It has become apparent that anti-psychotic treatment for BPSD shortens life expectancy and exposes these patients to morbidities including sedation, falls, fractures, aspiration, and movement disorders, with only slight efficacy for achieving improvement in target behaviors. Long-term care (LTC) regulations require gradual dose reductions in psychotropic medication, and precise behavioral documentation to support starting or continuing psychotropic medications. Hospice providers who understand the regulations can support the facility in both caring for the patient as well as adding to the documentation that the facility needs. However, terminal agitation is also a common finding at the end of life and it is important for hospice providers to differentiate between BPSD and terminal delirium.

In this two-part session, we propose a case-based approach with audience participation to: 1. Differentiate BPSD from delirium for hospice dementia patients in order to appropriately treat BPSD and 2. Diagnose, manage and treat delirium in hospice dementia patients in the LTC setting.

In part two, we will focus on the diagnosis and management of delirium. When is delirium reversible? What basic workup should be done on a hospice



patient with delirium in the LTC setting? What are the different types of delirium (hyperactive, hypoactive, mixed) and why does that matter? How does terminal delirium differ from non-terminal delirium? We'll incorporate a review of the new research regarding the efficacy of antipsychotics, as well as antibiotic stewardship in diagnosing "urinary tract infections" for behavior problems.

Speed Dating with the Pharmacy Ladies: "PharmaOnly.com" (FR475)



Kathryn Walker, PharmD CPE, Medstar Health and University of Maryland School of Pharmacy, Baltimore, MD. Mary Lynn McPherson, PharmD MA MDE BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD.

Objectives

- Discuss 3 pearls related to pharmacology of palliative medications.
- Discuss 3 pearls related to appropriateness of maintenance medications in EOL care.
- Discuss 3 pearls related to using palliative medications in a safe and effective manner.

After "meeting" in 2012, a bond has formed and new tips are on the way for Round Five of Speed Dating! Complex medication decisions are an integral part of treating palliative care patients. Pharmacists have a unique perspective on using these medications creatively and effectively. This one-hour session will flirt with tips and tricks on using medications appropriately for patients facing advanced diseases. Whether debriding a medication profile, aggressively treating symptoms or strategizing a dosage formulation, it can be hard to commit to medication decisions. Two pharmacists will speed-date their way through medication tips designed to highlight important and little known medication facts that are important in palliative medicine. Find a tip that you are compatible with that may just change your life.

Tears in the Cloud: Facing Serious Illness and Grief in the Digital Age (FR476)



Gregg VandeKieft, MD MA FAAHPM, Providence Health & Services, Olympia, WA. Denise Hess, MDIV, Providence Health & Services, Hillsboro, OR. Christian Sinclair, MD FAAHPM, University of Kansas Medical Center, Kansas City, KS.

Objectives

- Compare and contrast traditional models of communicating about the personal experience of serious illness and grief.
- Describe the emergence of autopathography as a therapeutic tool for patients and clinicians.

- Identify unique aspects of technology-based grieving and "processing" serious illness.

As social media becomes increasingly pervasive, persons with serious illness or who have experienced loss increasingly utilize various social media platforms to share information and to "process" the experience. This session will contextualize this use of social media as the natural evolution of expressing one's experience of serious illness and/or grief as new communication technologies have emerged. Specific examples will be included from YouTube, Facebook, and CaringBridge. Various literary approaches to exploring and sharing the experience of serious illness and grief will be explored, including academic work, general review, and first-person narrative ("pathography"). Web-based resources will be provided for individuals facing serious illness, persons wishing to support them, and clinicians.

Coding and Billing Jeopardy—Play with the Experts (FR477)




Constance Dahlin, MSN ANP-BC ACHPN® FAAN FPCN, Hospice and Palliative Nurses Association, Pittsburgh, PA. Nancy Guinn, MD, Presbyterian Healthcare at Home, Albuquerque, NM. Anne Monroe, MHA, Bluegrass Care Navigators, Lexington, KY.

Objectives

- Identify the importance and rules for capturing reimbursement from three sites of community-based palliative care eligible for reimbursement.
- Delineate Evaluation and Management and Time-Based service codes, including the benefits and consequences of each, including the appropriate use of Advance Care Planning codes.
- State billing and coding resources.

Payment for services with precise billing and coding systems is essential for revenue for palliative care programs in the community. An organization's billing and coding system sets the foundation for reimbursement from Medicare, Medicaid, and private insurance—and ultimately the budget. Accuracy and quality of billing documentation and submission is essential, as well as monitoring code changes. Through an interactive and engaging process, this session will provide a review of the potential patient encounters eligible for billing as well as accurately capturing the delivery of services. An interdisciplinary palliative care panel—a coding expert, a palliative physician, and a palliative nurse practitioner—will provide discuss billing and coding essentials from across the spectrum. Using a game format, the session will move through a face paced look at common quandaries, pitfalls, and myths about billing and coding. Participants will learn the importance of documentation supporting codes, the benefits and consequences of Evaluation and Management and Time-

Based codes, and the appropriate use of Advance Care Planning codes. Resources from the Center for Medicare and Medicaid Services (CMS), Medicare Learning Network (MLN), Center to Advance Palliative Care (CAPC), Hospice and Palliative Nurses Association (HPNA), American Academy of Hospice and Palliative Medicine (AAHPM) and National Hospice and Palliative Care Organization (NHPCO) will be highlighted. The hour will conclude with an interactive Q & A session, and useful "take home" materials.

Integrating Palliative Care for Patients with Hematologic Malignancies: Lessons Learned and Strategies to Ease Integration (FR478) 

Areej El-Jawahri, MD, Massachusetts General Hospital, Boston, MA. Alison Rhodes, ACNP-BC ACHPN, Massachusetts General Hospital, Boston, MA. Thomas LeBlanc, MD MA MHS FAAHPM, Duke Cancer Institute, Durham, NC. Jason Telles, NP, Massachusetts General Hospital, Boston, MA. Jennifer Temel, MD, Massachusetts General Hospital, Boston, MA. Vicki Jackson, MD MPH FAAHPM, Massachusetts General Hospital, Boston, MA.

Objectives

- Understand the challenges and barriers to integration of palliative care in the care of patients with hematologic malignancies and those undergoing hematopoietic stem cell transplantation (HCT).
- Explore palliative care and oncology clinicians' perspectives on the early integration of palliative care for patients with hematologic malignancies and those undergoing HCT.
- Review several strategies to facilitate palliative care integration in the care of patients with hematologic malignancies and those undergoing HCT.

Early palliative care integrated with oncology care is becoming the standard of care for patients with advanced solid tumors. However, patients with hematologic malignancies rarely utilize palliative care due to multiple factors including the unpredictable illness trajectory, prognostic uncertainty, and misperceptions equating palliative care with 'end-of-life care'. We successfully conducted a randomized clinical trial of early palliative care integrated with transplant care for patients with hematologic malignancies and demonstrated that these barriers are surmountable. Additionally, the palliative care intervention led to improvement in patient-reported quality of life and psychological distress both acutely during HCT and at 6 months posttransplant. By examining the role palliative care played in caring for patients undergoing HCT, we will 1) understand how to successfully overcome barriers for such integration; and 2) assess how this integrated care model led to improved outcomes.

During this trial, both transplant and palliative care clinicians gained important insights regarding how to best promote collaboration. By examining their perspectives on addressing the needs of patients with hematologic malignancies, we will formulate successful strategies to promote integration and enhance the quality of life and care for this population.

During the session, learners will begin in dyads to identify barriers to integrating palliative care for patients with hematologic malignancies at their institutions. We will then review the literature regarding the known barriers to palliative care integration in this population. Second, an oncologist and palliative care clinician who were part of the trial will describe approaches that facilitate successful integration utilizing interactive case-based examples. Finally, using illustrative cases, we will describe practical approaches to improve integration, including building trust between palliative care and oncology, discussing the unpredictable illness course and prognosis, clear role definition for each group, and ways to navigate the three-way relationship between patient, palliative care clinician, and oncology provider.

Scrappy and Resourceful: Multisetting Palliative Care in Rural America (FR479) 

Dillon Stein, DO, Butler Health System, Butler, PA. Michael Fratkin, MD, ResolutionCare, Eureka, CA. Kori Novak, PhD, Karuk Tribe, Yreka, CA. John Reefer, MD FACP, Butler Memorial Hospital, Butler, PA. Kathy Selvaggi, MD MS FAAHPM, Butler Health System, Butler, PA.

Objectives

- Compare the growth of palliative care in larger populated areas vs smaller hospitals and rural communities.
- Identify common challenges amongst palliative care programs developing in rural areas.
- Examine individualized approaches to providing palliative care in settings with limited financial and supportive resources.

Palliative care is high quality patient care that matters for every patient with serious illness. Rapid growth of palliative care programs thus far has occurred at larger hospitals and academic health systems. The case for hospital based palliative care programs has been effectively made and strong evidence for community based palliative care is accumulating. Importantly, workforce shortages persist and will worsen as the demand for high quality palliative care delivery models rise while the number of training programs remains limited. These shortages are felt more acutely by the 25–30% of Americans that live in rural settings.

Providing high quality team-based palliative care in rural settings, in small hospitals, outpatient clinics, and homes presents economic and workforce challenges. Simply following an algorithm or copying blueprints from larger, academic centers may not be feasible in smaller communities with unique histories, smaller stakeholder groups, and thinner economic margins. The solutions are as complex as the individuals we are trying to care for: resources are scarce, education is essential, and sustainability is paramount.

In this session, we share examples of palliative care program development in rural America, citing data and the unique narratives that describe common challenges and successes. This session will compare and contrast the palliative care programs arising from rural and under-resourced communities. A panel of palliative care physicians, administrative champions, and program developers will share their perspectives on the challenges and rewards of building more with less. We will highlight programs that include two California-based efforts to leverage technology to bring palliative care support to small hospitals and to the Karuk Tribe, as well as a single-hospital health system in southwestern Pennsylvania utilizing administrative and community supports to overcome the barriers for palliative care program development.

Anticipating Death in Children and Adults with Childhood Onset Severe Central Nervous System Impairment: A Case Series Review (FR480)



Julie Hauer, MD, Boston Children's Hospital, Boston, MA. Catherine Clark, MSW LICSW, Seven Hills Pediatric Center, Groton, MA. Holly Jarek, DSc, Seven Hills Pediatric Center, Groton, MA.

Objectives

- Discuss problems due to severe central nervous system impairment that can remain intractable to treatment options.
- Define tipping points that can prompt anticipatory discussions, including suggested recommendations that best meet goals.
- Utilize language strategies that prepare families when prognosis is not possible.

Little is written about trajectories and features that precede death in those with childhood onset severe central nervous system (CNS) impairment. This session will cover this topic through a review of deaths at a long-term care facility for children and young adults with severe neurological impairment and associated complex medical care needs.

Of the more than 30 deaths, the majority (70%) were anticipated and guided by goals of care.

Circumstances that prompted discussions included: problems that can be attributed to the CNS and remained intractable to various interventions, including seizures, recurrent intestinal pseudo-obstruction (hypothalamus and medulla), pain (thalamus), agitation (loss of CNS inhibition), and edema (medulla); increasing symptom burden; and gradual changes in alertness and ability to participate in activities. Details that preceded unexpected deaths will also be reviewed, including several with acute ileus who died following transfer to a hospital.

Details will include: the length of time from the redirection of care plans until death, symptom management at the end-of-life, results of tests, prolonged survival following discontinuation of mechanical ventilation, changes in medical nutrition and hydration, and differences in planned vs unexpected deaths. Outcomes in those who survived using the same noninvasive management strategies will be included given the lack of prognostic ability, a time when parents were prepared for their child's potential death, and how parents responded before and after this experience.

This is an important session given the lack of prognostic information, placing such individuals at significant risk for invasive testing and interventions, including surgery, at the end of life. Consideration of testable and "fixable" problems versus problems that can be due to the CNS without confirmatory tests will be discussed. This information will be used to outline "tipping points" that can prompt anticipatory discussions with parents and guardians, with suggested language offered.

Paper Session (FR481)

A Retrospective Review of the Management of Malignant Bowel Obstruction at a Large, Tertiary Cancer Care Center (FR481A)



Rebecca Calabrese, MD, State University of New York at Buffalo, Roswell Park, Buffalo, NY. Moeena Mian, DO, University at Buffalo, Buffalo, NY. Chong Wang, MA, Roswell Park Cancer Institute, Buffalo, NY. Michelle Walter, DO, Roswell Park Cancer Institute, Buffalo, NY. Amy Case, MD FAAHPM, Roswell Park Cancer Institute, Buffalo, NY.

Objectives

- Define what a malignant bowel obstruction.
- Explain why treatment and symptomatic management of malignant bowel obstruction is important in palliative oncology.
- List three medical and surgical therapeutic modalities to conservatively treat malignant bowel obstruction.

Original Research Background. MBO (malignant bowel obstruction) is a frequent and challenging

complication of advanced malignancy. For inoperable patients, symptoms can often be controlled using analgesics, anticholinergics, and anti-emetics. A recent study demonstrated that octreotide, dexamethasone, and metoclopramide in combination may provide rapid symptom improvement. There are no published guidelines or algorithms for the medical management of MBO.

Research Objectives. We examined palliative medical therapy in patients with inoperable MBO using combinations of octreotide, dexamethasone and/or metoclopramide.

Methods. We retrospectively identified and screened patients with inoperable MBO at a large, tertiary cancer center from January 1, 2012 to December 31, 2012, and January 1, 2016 to May 31, 2017, analyzing the use of octreotide, dexamethasone, and metoclopramide as primary treatment.

Results. We identified 133 patients, 36 in 2012 and 97 in 2016/2017. Of these patients, 51 had no medications, 50 had octreotide alone or with dexamethasone and/or metoclopramide, 32 had dexamethasone or metoclopramide and no octreotide, and 20 had all three medications (triple therapy). Of those who received triple therapy, 90% deobstructed vs. patients who received no medications (70.6%) ($p=0.085$). Of the patients who received octreotide, 70.0% deobstructed, vs. 68.8% receiving dexamethasone and/or metoclopramide ($P=0.905$). The mean days to deobstruction for patients receiving octreotide vs. patients on dexamethasone and/or metoclopramide was 21.2 and 7.5 ($p=0.018$). The mean days to deobstruction for patients receiving triple therapy vs. no meds was 12.2 and 5.6 ($p=0.001$).

Conclusion. Treating MBO with triple therapy yielded a higher percentage of deobstruction than using no medication, and those treated with octreotide yielded a higher percentage of deobstruction than no octreotide. The days to deobstruction using triple therapy or other combinations with octreotide were significantly higher than no therapy or therapy without octreotide.

Implications for Research, Policy, or Practice. More prospective research is needed to formulate standard practice guidelines and algorithms for treatment of MBO in palliative oncology.

Factors Predicting Platelet Transfusions at the End-of-Life in Cancer Inpatients (FR481B)



Jason Meadows, MD MS, Memorial Sloan-Kettering Cancer Center, New York, NY. Raymond Baser, MS, Memorial Sloan Kettering Cancer Center, New York, NY.

Objectives

- Identify three factors associated with increased platelet transfusion at the end of life.

- Describe the relationship between number of visits by a palliative care consultant and the number of platelet transfusions received at end of life.

Original Research Background. For cancer patients near the end of life, transfusions decisions may be challenging because risks may sometimes outweigh benefits.

Research Objectives. To understand non-laboratory factors that are associated with platelet transfusions near time of death.

Methods. Medical oncology inpatients dying at our cancer hospital between October 1, 2013 and September 30, 2015 were identified through an institutional database. Our primary outcome variable was the number of platelet units transfused within seven days before death. Gender, age, race, religion, state/country of origin, cancer diagnosis, oncologic treatment (surgery/chemotherapy/radiotherapy), intensive care unit (ICU) admission, resuscitation status, and Palliative Care consultation were collected as potential predictors. Associations between the predictors and number of platelet units received were evaluated using zero-hurdle negative binomial models.

Results. Of 1,248 decedents, 52% were male and most were Caucasian (73%), Christian (58%), local residents (92% from NY/NJ/CT). Palliative Care saw 49% of patients within seven days before death. Twenty-one percent received 1-6 platelet units and 9% received seven or more units (range 7-35) within seven days before death. In the multivariable model, leukemia, lymphoma, and myeloma diagnoses predicted both receipt of platelet transfusion and higher number of units received. Female gender ($OR=1.7$) and chemotherapy receipt ($OR=1.9$) increased odds of receiving platelet transfusion as did younger age ($OR=0.8$ per 10-year increase in age). ICU admission predicted both receipt of platelet transfusion ($OR=3.6$) and higher number of units received ($OR=1.3$). Compared to patients not seen by a Palliative Care consultant, patients with 3-7 visits ($OR=0.5$) and eight or more visits ($OR=0.4$) were significantly less likely to receive a transfusion.

Conclusion. Demographic (e.g. gender, age) and health-related (hematologic malignancy, ICU admission) factors are associated with increased platelet transfusions for cancer inpatients approaching death. Palliative Care consultation may lower likelihood of platelet transfusion though prospective research is needed to demonstrate causality.

Implications for Research, Policy, or Practice. Research assessing burdens of benefits of transfusions at EOL is needed, particularly in patient

populations receiving the highest volumes of transfusions.

Illness Understanding, Prognostic Awareness and End of Life Care after Drainage Percutaneous Endoscopic Gastrostomy for Malignant Bowel Obstruction in Metastatic Gastrointestinal Cancer (FR481C)



Jessica Goldberg, MSN NP, Memorial Sloan Kettering Cancer Center, New York, NY. Debra Goldman, MS, Memorial Sloan Kettering, New York, NY. Sarah McCaskey, BSN NP, Memorial Sloan Kettering, New York, NY. Douglas Koo, MD MPH, Memorial Sloan Kettering Cancer Center, New York, NY. Andrew Epstein, MD, Memorial Sloan Kettering Cancer Center, New York, NY

Objectives

- Describe the importance of illness understanding and prognostic awareness in patients with metastatic GI cancers receiving dPEG for MBO.
- Describe elements of end of life care in patients with metastatic GI cancers receiving dPEG for MBO.

Original Research Background. Malignant bowel obstruction (MBO) is a common complication in patients with metastatic gastrointestinal (GI) cancer. This condition portends a poor prognosis and few patients receive additional tumor-directed therapy before enrolling in hospice. The management of MBO may include drainage percutaneous endoscopic gastrostomy (dPEG) which offers the possibility of short-term palliative benefit. In these patients with limited life expectancies, illness understanding and prognostic awareness is important for informed decision making. However, such understanding in this population has not been documented.

Research Objectives. The goals of this project were to assess illness understanding, prognostic awareness, and elements of end of life care in patients receiving palliative dPEG for MBO.

Methods. From 1/2015-6/2017, 125 patients with metastatic GI cancers underwent dPEG for the management of MBO. Demographic information, clinical variables, and patient outcomes were abstracted from the medical record and an observational retrospective analysis was conducted.

Results. The most common cancers were colon, pancreatic, and gastric. Of the 94% (118) of patients who were discharged alive, 14% (17/118) received additional chemotherapy, 53% (63/118) had a do not resuscitate order, and 81% (95/118) enrolled in hospice. The median time to death for all patients after dPEG was 31 days (range 1-578 days). Thirty-four percent (43/126) of the population was seen by the Palliative Care Consultation Service during the

admission for MBO. Of this group, 65% were asked about their illness understanding and expectations for the future. All reported understanding the advanced nature of their disease. However, only 39% (15/28) were realistic about their poor prognosis and inability to receive additional tumor-directed therapy.

Conclusion. Our findings suggest ongoing needs in palliative care delivery for patients with metastatic GI cancers, at both the primary and specialist level.

Implications for Research, Policy, or Practice. Further research is needed to address the underpinnings of illness understanding in these patient, and how best to support them in their subsequent care.

Understanding “Access” and “Excess”: A Secondary Data Analysis to Describe Prescription Opioid Medication Use and Potential Harms for Patients with Cancer in Rural Southwest Virginia (FR481D)



Virginia Lebaron, PhD APRN ACHPN, University of Virginia School of Nursing Charlottesville, VA. Fabian Camacho, MS MA, University of Virginia, Charlottesville, VA. Marianne Beare, MSN RN ANP-BC, University of Virginia, Charlottesville, VA. Jessica Keim-Malpass, PhD RN, University of Virginia, Charlottesville, VA. Rajesh Balkrishnan, PhD, University of Virginia School of Medicine, Charlottesville, VA. Leslie Blackhall, MD MTS, University of Virginia, Charlottesville, VA. Nengliang Yao, PhD, University of Virginia School of Medicine, Charlottesville, VA. Patricia J. Hollen, PhD RN FAAN, University of Virginia School of Nursing, Charlottesville, VA. Aaron Gilson University of Wisconsin Carbone Cancer Center, Madison, WI.

Objectives

- Describe measures of ‘access’ and ‘excess’ related to the opioid crisis in rural Southwest Virginia.
- Understand need for improved data sources to answer important research questions related to the opioid epidemic.

Original Research Background. Southwest (SW) Virginia of Central Appalachia is a rural area with disproportionately high cancer mortality rates and high rates of opioid fatalities. Little is known about how to most effectively and safely manage pain in a region where there exists both a high cancer burden and significant opioid misuse.

Research Objectives. Describe and map both prescription opioid medication (POM) use and potential harms for patients with cancer in Southwest Virginia.

Methods. This is a secondary data analysis to characterize both ‘access’ and ‘excess’ related to POMs in the two most rural health districts of SW Virginia from

2011 – 2015. Prescription and medical claims data were analyzed to identify predictors of POM use and opioid-related substance use disorder (ORSUD) admissions. Relevant data were also extracted from healthcare workforce, opioid retail distribution (ARCOS), and forensic reports. Data were integrated using geospatial analysis to identify and map geographical patterns.

Results. Multi-level logistic regressions from claims data ($n = 4330$) suggest age, payer source, cancer type, gender, prescriber type and specialty are significant ($p < .001$) predictors of being prescribed POMs. Of 463 patients who received a POM during same year or years prior to hospitalization, only 2.38% ($n=11$) were admitted for an ORSUD. Geospatial maps identified ‘hot spots’ of probability of being prescribed POMs. Healthcare workforce data suggest extremely limited access to cancer and pain specialists while forensic data indicate POM overdose deaths are significantly higher than the state average. ARCOS data reveal declining POM consumption, except for oxycodone.

Conclusion. Integrating data from multiple sources provides a clearer view of geographic patterns and predictors of both POM use and potential harms.

Implications for Research, Policy, or Practice. Results can inform targeted clinical interventions and policy initiatives that achieve a balanced approach to POMs – ensuring access for patients in need, while reducing risk.

4:30–6 pm

Interactive Educational Exchange (FR482)

Deliberate Practice for Entrustable Professional Activities: A Point-of Care Procedural Curriculum for Delivering Serious News and Facilitating Family Conferences in Residency Training (FR482A)

Caroline Hurd, MD, University of Washington, Seattle, WA. Anthony Back, MD, University of Washington, Seattle, WA. Lindsay Gibbon, MD, University of Washington, Seattle, WA. Amy Trowbridge, MD, University of Washington, Seattle, WA.

Objectives

- Name the steps in the framework for serious illness conversations.
- Utilize this framework to discuss serious news or facilitate a family conference.
- Prepare for these conversations using multimedia tools.

- Identify and respond to emotion.
- Lead a serious illness conversation independently by the end of residency.

Background. Empathic communication is a core competency identified by the Accreditation Council for Graduate Medical Education (ACGME). Many specialties identify effectively delivering serious news and facilitating family conferences as key entrustable professional activities (EPAs). However, few programs have systematically incorporated these skills into residency training. Our monthly curriculum for delivering serious news and facilitating family conferences is based on the successful VitalTalk method, and integrates communication frameworks, simulated practice, multi-media just-in-time learning tools, real-time observation and procedural logs for our Internal Medicine and Pediatrics residency programs.

Methods. The curriculum has six components 1) pre-rotation self-directed modules, 2) a smart phone application, 3) a half-day simulation workshop, 4) observed encounters with structured real-time feedback, 5) a MedHub procedure log with an observer assessment, 6) attending physician end-of-rotation EPA assessment. Evaluation of the curriculum was done using pre-workshop, post-workshop and post-rotation questionnaires as well as qualitative interviews of residents and faculty.

Results. The study period is from January 2017–December 2017. Preliminary data shows 37 residents (17 pediatric, 20 internal medicine) completed the intervention. 94% agreed the curriculum taught them new skills. 76% reported >1 observed encounter. Pre-rotation self-assessed EPA independence was 47% partial supervision, 41% minimal supervision and 6% independent, which improved to 0%, 65% and 35% respectively, post-rotation. Although only one third reported using the multi-media tools during the rotation, over half said they would use them in the future to teach others. Eight qualitative interviews have been completed and are being analyzed.

Discussion. While many programs have redesigned their residency assessment process to align with the Next Accreditation System using EPAs, few have taken the next step to integrate curriculum to teach individual EPAs. This is one of the first studies to show that self-assessed levels of independence in serious illness communication EPAs improves with a procedural, point-of-care, curriculum using multi-media tools and simulation. Additionally, our study indicates that learners may use multi-media resources as a guide to teach other learners, rather than self-practice.

Conclusion. Integration of a multi-modal serious illness communication curriculum into pediatric and internal medicine residency rotations improves self-assessed levels of independence in key EPAs.



Case-Based Curriculum for Teaching Prognostication and Serious Illness Communication in Heart Failure: A Module for Medical Trainees and Practicing Clinicians (FR482B)



April Zehm, MD, Massachusetts General Hospital and Harvard Medical School, Boston, MA. Charlotta Lindvall, MD PhD, Dana-Farber Cancer Institute, Brigham and Women's Hospital, and Harvard Medical School, Boston, MA. Kimberly Parks, DO, Boston VA Healthcare System and Harvard Medical School, Boston, MA. Kristen G. Schaefer, MD, Dana-Farber Cancer Institute, Brigham and Women's Hospital, and Harvard Medical School, Boston, MA. Eva Chittenden, MD, Massachusetts General Hospital and Harvard Medical School, Boston, MA.

Objectives

- Describe that prognosis in advanced heart failure is highly variable and uncertain, but illness trajectory is more predictable and clinically useful.
- Illustrate the trajectory of illness in heart failure and use this model to promote disease understanding amongst patients and families.
- Review a communication framework for discussing goals of care tailored to the patient's stage of illness.
- Discuss preparedness planning for heart failure patients undergoing mechanical circulatory support or cardiac transplantation.

Background. The increasing prevalence, associated co-morbidities, and medical advances that often prolong the advanced phase of heart failure (HF) mandate an organized and thoughtful approach to medical decision-making in this population. However, many clinicians have difficulty discussing prognosis and goals of care (GOC) with patients. Barriers include disease- and therapy-specific prognostication challenges and a paucity of evidence-based primary palliative care education initiatives. To have effective discussions about serious illness, providers need advanced training.

Methods. A 45-minute training module was developed, which consisted of a case-based small group session and a take-home HF communication guide. The curriculum highlights prognostication challenges in HF and introduces an illness trajectory-based framework to cue iterative GOC conversations. Specific skills taught include assessing patients' illness understanding and information-sharing preferences, exploring goals and values, making prognostic disclosures, and making medical recommendations for goal-concordant care. We piloted this learning module with 46 internal medicine residents and interdisciplinary palliative care fellows in groups of 2-15, and

obtained anonymous quantitative and qualitative post-session learner survey data to examine initial feasibility and acceptability.

Results. Clinicians rated the session highly. All learners either strongly agreed or agreed the session was clinically useful. Learners unanimously found the teaching methods effective and most felt they could easily apply these skills to their clinical work: 96% felt this session would change or improve their practice. In open-ended feedback, learners said the session gave them a better understanding of the HF illness trajectory, an improved framework for discussing GOC with HF patients, and specific language to use when having these discussions.

Discussion. This short communication skills teaching session was highly valued by both general and specialty-level clinicians in training, and was practically feasible.

Conclusion. This represents a new paradigm for teaching and learning prognostication and serious illness communication skills in HF, where illness trajectory guides timing and content of GOC conversations. Importantly, this tool can be used to help non-palliative care clinicians elicit the goals and values of patients with heart failure.

LIVE.DIE.REPEAT: Palliative Care Module (FR482D)



Kharmene Sunga, MD, Mayo Clinic, Rochester, MN. Caitlin Loprinzi Brauer, MD, Mayo Clinic, Rochester, MN. Jessica Stanich, MD, Mayo Clinic, Rochester, MN. Jennifer Derrick, MD, Mayo Clinic Health System, Mankato, MN.

Objectives

- Identify patient characteristics that should trigger discussion of goals of care and code status.
- Discuss characteristics of and differences between POLST and Advanced Directives.
- Demonstrate how to have a patient-centered code status discussion.
- Implement end-of-life care management (including AICD/pacemakers) in the dying emergency department patient.

Background. Simulation is a useful tool for engaging learners in the care of complex patient presentations due to the ability to provide direct observation of care with immediate debriefing and feedback. In this project we aimed to create a deliberate practice simulation module for teaching palliative care assessment, patient communication skills, and end-of-life care in a critically ill emergency department patient.

Methods. Emergency medicine residents underwent a four-hour high-fidelity educational simulation session involving the care of a patient with stage 4 pancreatic cancer presenting with respiratory distress and

sepsis in the setting of pneumonia. The patient has a POLST form indicating comfort focused treatment, as well as an advanced directive naming her surrogate decision makers. Using the LIVE.DIE.REPEAT method originally described by Sunga et al, participants progressed through several simulation levels with predefined critical actions and increasing levels of complexity. Between each level the scenario was paused to discuss knowledge, skills and attitudes demonstrated during the simulation compared against ideal behaviors and actions, as well as teaching points regarding palliative care management. Following each debriefing, participants repeated the previous level for benefit of deliberate practice. Emergency medicine residents were asked to provide assessment of the LDR Palliative Care module using a Modified Simulation Effectiveness Tool (MSET) survey, originally described by Elfrink et al, and which gauges participant learning and confidence.

Results. 15 of 18 residents completed the survey. In all 13 domains of the MSET, residents on average chose to "somewhat agree" or "strongly agree" that the LDR Palliative Care module was successful in enhancing their learning and confidence with the material.

Discussion. Our pilot work suggests the LDR simulation format is an acceptable method for training emergency medicine residents in the diagnosis and management of patients presenting with the need for palliative care in the setting of a terminal illness. Further work is needed to determine whether the LDR Palliative Care module can be adapted for other healthcare settings, and whether it can affect future performance and contribute to positive patient-based outcomes.

Conclusion. The LDR Palliative Care simulation module may be a suitable method for training healthcare providers on end-of-life management of patients with critical illness.

An Innovative, Interactive Online ELNEC- Undergraduate Curriculum for Nursing Students (FR482E)



Polly Mazanec, PhD ACNP FPCN ACHPN, Case Western Reserve University, Cleveland, OH. Betty Ferrell, PhD RN CHPN FAAN FPCN, City of Hope National Medical Center, Duarte, CA. Pam Malloy, MN RN FPCN FAAN, American Association of Colleges of Nursing, Washington, DC. Andra Davis, PhD MN RN, Washington State University, Vancouver, WA. Megan Lippe, PhD MSN RN, University of Alabama, Tuscaloosa, AL. Casey Shillam, PhD RN-BC, University of Portland, Portland, OR.

Objectives

- To design an ELNEC curriculum that prepares undergraduate nursing students to provide

primary palliative care to patients facing serious illness and their families.

- To develop an interactive online curriculum which meets the new 2016 competencies of the American Association of Colleges of Nursing (AACN) CARES document.
- To create a curriculum that eliminates barriers to teaching palliative care content, such as lack of program space, or lack of faculty expertise.

Background. The increasing demand for all nurses to be competent in primary palliative care and a known gap in palliative care undergraduate nursing education drove the ELNEC team to develop an innovative, online curriculum for nursing students. ELNEC- Undergraduate prepares students to provide primary palliative care in any clinical setting, across the lifespan, and to meet the undergraduate palliative nursing 17 competencies outlined in the AACN CARES document.

Methods. The six one-hour modules contain evidence-based text, brief videos demonstrating palliative nursing skills and testimonials from nursing leaders in palliative care. The student interactively engages in critical-thinking questions and case studies. At the end of each module, the student must successfully master (80%) ten NCLEX-style nursing board questions. A certificate of training is awarded after completion of the curriculum.

Results. Since Jan., 2017, 95 nursing programs have enrolled in the curriculum. During the first six months, over 11,000 modules and 1700 curricula have been successfully completed, with mastery at 90.3%. Nine questions at the end of each module evaluate applicability to clinical practice, quality of the content and ease of technology. Responses are scored on a 4-point Likert scale from "strongly agree" to "strongly disagree". Ninety-eight percent of responses to the 11,000 modules viewed were rated "strongly agree" and "agree". An additional result of the curriculum implementation has been the collaboration and development of a six-school research consortium to assess pre and post curriculum knowledge and attitude data.

Discussion. ELNEC- Undergraduate has been positively received by hundreds of students and faculty. Partnering with Relias Learning to create an online educational experience has helped to address barriers to teaching palliative care in nursing programs. In addition, preliminary implementation data from the ELNEC- Undergraduate Research Consortium is improving our understanding of student knowledge and attitude outcomes from the curriculum.

Conclusion. Evaluations have demonstrated the successful implementation of the curriculum and outcome data collection is ongoing. The curriculum provides all schools with access to primary palliative nursing education.

Saturday, March 17**7-8 am*****Cambia Leadership Lecture Breakfast******Emerging Leadership: Finding Your Voice and Highest Value Through Focused Leadership (CAMBIA)*** 

Steven Pantilat, MD FAAHPM, University of California San Francisco, San Francisco, CA. Betty Ferrell, PhD MA RN FAAN FPCN CHPN, City of Hope Medical Center, Duarte, CA. Ab Brody, PhD RN ACHPN FAAN FPCN, New York University Rory Meyers College of Nursing, New York, NY. Zara Cooper, MD MS FACS, Brigham and Women's Hospital, Boston, MA. Toby Campbell, MD MSCI, University of Wisconsin, Madison, WI. Lynn F. Reinke, PhD RN NP ARNP FAAN, VA Puget Sound Health Care System, Seattle, WA.

Objectives

- Discuss leadership opportunities, needs and challenges in the field.
- Describe The Cambia Health Foundation's Sojourns Scholar Leadership Program, an effort that invests in palliative care professional development to drive impactful, innovative health care system and policy changes at the local, regional, and national level.

Participants who register for the session will be surveyed about questions they have about leadership. The moderator will select questions from the survey and encourage questions from the participants for the panel to discuss:

1. What emerging leaders can share about leadership opportunities and challenges with their colleagues.
2. How to manage/lead people above you in the organization and people who report to you.
3. Factors that help physicians and nurses become leaders (e.g., programs, role of mentors, colleagues, coaches).
4. How to develop a shared vision and mission within a group while supporting individuality.
5. Becoming a leader while keeping a work-life balance.
6. Having an impact at the national level while becoming a leader in one's own institution.
7. The complexity of conducting research and participating in national collaborative programs and those with multiple missions.
8. The value of dreaming big (e.g. leading an institution, health system, changing health care policy or a school).


8:15–10 am***Plenary Session******State of the Science: Update in Hospice and Palliative Care (103)*** 

Heather L. Coats, PhD APRN-BC, University of Colorado, College of Nursing, Denver, CO. Laura P. Gelfman, MD MPH, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Summarize selected important recent peer-reviewed articles related to two "hot" topic areas.
- Critique the methodologies and understand the conclusions of these articles.
- Determine if the findings are relevant to the patients for whom the attendees cares.

The objective of this session is to review the recent journal articles about the 2 "hot" topics (selected by crowd sourcing from the AAHPM and HPNA communities) that were published with the highest potential for impact on the field of hospice and palliative medicine. A hand search of leading journals highly relevant to the practice of hospice and palliative care will be supplemented with a search of evidence based reviews, a targeted keyword search, and conversations with experts in the disciplines of medicine, nursing, and social work. Journal articles will be reviewed for both study quality and potential for immediate impact on the field of hospice and palliative care.

10:30–11:30 am***Concurrent Sessions******Defining the Disease in DT-LVAD: A Comprehensive Approach to a Complex Continuum of Care (SA501)*** 

Sara Wordingham, MD, Mayo Clinic Arizona, Phoenix, AZ. Jennifer Woodburn, DNP AGPC-NP, Mayo Clinic Arizona, Scottsdale, AZ. Sharene Hollenbach, MSN RN OCN, Mayo Clinic Arizona, Scottsdale, AZ. Samantha Williamson, MSW LMSW, Mayo Clinic Arizona, Phoenix, AZ.

Objectives

- Strategically define the DT-LVAD advanced illness trajectory with special emphasis on challenging aspects of care for 'transitional phase' patients and their caregivers.
- Utilize shared decision making communication methods to engage LVAD patients and their caregivers in iterative advance care planning.

- Describe the needs of DT-LVAD patients beyond their medical therapy and identify measures that support the multidisciplinary LVAD team.

Destination therapy left ventricular assist devices (DT-LVAD) offer life in the setting of ultimate death with the device in situ—a trajectory that can be complicated for patients, caregivers, and providers. Advancements in LVAD technology and the growing concept of a truly multidisciplinary team have set the stage for a comprehensive program of support. However, with this life-sustaining therapy challenges persist in our endeavors to improve clinical and non-clinical outcomes. Significant challenges may arise for DT-LVAD patients, caregivers, and teams as patients transition from chronic LVAD support to comfort oriented care, in which a device may be properly functioning but the body weakening or a device decompensating in an otherwise stable patient. Although caregivers endure substantial burdens throughout the LVAD support trajectory, the level of caregiver burnout fluctuates and requires monitoring. Our focus in caring for this population must be two-fold—on extending quality of life with this distinctive technology while simultaneously acknowledging the processes that will ultimately lead to end-of-life. Early and ongoing engagement of palliative care teams and DT-LVAD specific advance care planning (ACP) has the potential to augment patient-centered care and hone quality of life based interventions for patients and families.

In this concurrent session, clinicians from a multidisciplinary team will define a novel approach to understanding the DT-LVAD advanced illness trajectory, reveal engaging strategies to break through barriers of complex ACP, uncover how bi-directional communication and education can enhance multidisciplinary team function, highlight the needs of DT-LVAD patients and caregivers beyond medical therapies, and discuss expanding options for approaching end-of-life care. Data from quality improvement work will provide an understanding of patient and caregiver quality of life approaching end-of-life, clinician reported challenges, and system improvements in ACP processes. This session will offer clear strategies for redefining institutional best practices in collaborative and comprehensive DT-LVAD care.

2018: Targeting the Pusher: Beyond Going Beyond Senna and Colace for the Management of Constipation in Hospice (SA502)



Jamie Fertal, DO, University of California at Irvine, Orange, CA. Martina Meier, MD, Providence TrinityCare Hospice, Torrance, CA. Mary Lynn McPherson, PharmD MA MDE BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Eric

Prommer, MD HMDCA FAAHPM, University of California, Los Angeles and VA HPM Program, Los Angeles, CA.

Objectives

- Understand the pathophysiology of functional bowel disorders vs opioid induced bowel dysfunction.
- Learn how to classify bowel disorders and tailor therapies according to disorder.
- Learn mechanisms of action of new drugs for constipation.

Constipation occurs in the majority of patients who are in hospice and palliative care patients. Frequencies range from 70% to 87% according to studies. Surprisingly research suggests that opioid are responsible for constipation in only 25% of cases and that there is a significant large populations of patients, who we are likely to encounter in hospice with functional disorders that may not respond to the mantra of “Senna and Colace.” Add the growing number of elderly in the population who have a high prevalence of functional bowel disorders one has to consider better approaches to evaluating constipation. Complicating the management of constipation are the ever growing list of medications which may work for functional bowel disorders but not for opioid induced bowel dysfunction. Sorting out proper evaluation and proper application of therapies enhances therapeutic success and avoids inappropriate use of laxatives and lowers the risk for polypharmacy. This session will be presented by a panel of hospice/ palliative care specialists, and experts in palliative pharmacotherapeutics. Attendees will walk away with a new perspective on constipation. They will understand the proper applications of the new therapies for constipation. The session will by way of didactics, case presentation and audience participation help attendees: 1.) Recognize and classify types of constipation likely to occur in the hospice setting. 2.) Refine and improve methods of constipation evaluation. 3.) Understand differences in the pathophysiology of functional disorders versus opioid bowel dysfunction. 4.) Get a detailed overview of new drugs and where they fit therapeutically in the spectrum of constipation disorders. 5.) Get a perspective on the cost of new and old medications for constipation.

Alternative Payment for Palliative Care: Getting from Here to There (SA503)



Allison Silvers, MBA, Center to Advance Palliative Care, New York, NY. Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI. Torrie Fields, MPH, Blue Shield of California, San Francisco, CA.

Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Describe at least four available billing codes covering palliative care services.
- Describe four or more payment arrangements that can be used by any palliative care team, along with their pros and cons.
- Describe at least three primary interests of payers in provider contracting for their seriously ill members.

Despite political uncertainties, the drive towards payment reform continues unabated, and palliative care providers have strong opportunities for sustainable payment. This session will help attendees to understand the opportunities better, as well as destroy some prevailing myths about alternative payment. First, this session will review the scope of successful payment arrangements that now exist for palliative care programs, both under Medicare and with private payers. This payment arrangement review will cover both important fee-for-service changes and alternative payments, drawing on interviews and market research conducted under the CAPC Payment Accelerator. Next, the session turns to a frank discussion with a health plan on their goals as a payer and the practical considerations they face in negotiating provider payments. It also covers how a health plan can compensate a palliative care team both directly and indirectly, turning a medical group or ACO into the palliative care team's payer. Finally, presenters will review why the palliative care field must think broadly about payment opportunities and suggest next steps.

Opening the Black Box: How Interventional Radiology Can Help Our Patients in Hospice and Palliative Care (SA504)

Christopher Jones, MD HMDC FAAHPM, Perelman SOM at the University of Pennsylvania, Philadelphia, PA. Jeffrey Weinstein, MD, Beth Israel Deaconess Medical Center, Boston, MA.

Objectives

- Describe indications for four commonly used interventional procedures for patients with serious illness.
- Explain the clinical experience of patients undergoing a tunneled catheter placement, kyphoplasty, celiac plexus block, and other common procedures.
- Identify the most and least cost-effective procedures that VIR clinicians can perform for four common palliative care conditions.

Thanks to rapidly advancing technology, the number of clinical interventions to treat serious illnesses grows

each year. Vascular Interventional Radiology (VIR) is at the center of medicine's procedural growth and has become a vital part of clinicians' symptom management toolbox. Unfortunately, most clinicians practicing Palliative Care (PC) have had little interaction with VIR providers and, while often understanding the purpose of available procedures, have not seen and cannot explain to patients the experience of undergoing common VIR procedures.

How can PC and hospice clinicians understand the complex and ever changing landscape of VIR? In this explanation and demonstration-heavy concurrent session, an academic palliative care and hospice physician with training in business and the Interventional Radiology residency/fellowship program director at a large academic hospital will join together to expose attendees to the 'how and why' of VIR. Evidence-based indications for common procedures like gastrostomy and jejunostomy feeding tube placement, thoracic and abdominal drainage catheter placement, kyphoplasty, celiac plexus block, and others will be provided and these procedures will be explained using a combination of hands-on demonstration, video, and illustration. In addition to the clinical aspects of each procedure, the patient experience of undergoing these interventions will be described and samples of the tools and devices being discussed will be circulated through the audience to encourage high-level understanding. Under the Medicare Hospice benefit, hospices must bear the cost of these interventions. We will discuss the relative costs of typical interventions for ascites, pleural effusion, and compression fractures and share strategies to ensure interventions are cost-effective both initially and over time.

Remaining current with technological advances is difficult, especially for clinicians who practice outside the acute hospital setting. This concurrent session will shine light in the black box of VIR to improve care for many of our patients.

Trauma-informed Palliative Care: Interdisciplinary Perspectives on Assessing and Treating Patients and Families with Trauma- and Stress-Related Symptoms (SA505)

Chao-Hui Huang, PhD MA MED, University of Alabama at Birmingham, Birmingham, AL. James Dionne-Odom, PhD RN, University of Alabama at Birmingham, Birmingham, AL. Kathleen Bickel, MD MPHIL MS, University of Colorado School of Medicine and Eastern Colorado VA Health Care System, Denver, CO. Efrat Lelkes, MD, University of California San Francisco, San Francisco, CA. Elizabeth Kvale, MD, University of Alabama at Birmingham, Birmingham, AL. Edward MacPhee, MD, University of

Colorado and Eastern Colorado Health Care System, Denver, CO.

Objectives

- Recognize the widespread impact of trauma and prevalence rate of trauma- and stress-related symptoms in patients and families receiving palliative care.
- Describe validated assessment tools and evidence-based treatments to address trauma- and stress-related symptoms in palliative care settings.
- Develop actionable strategies to integrate trauma-informed care into clinical practice across various palliative care settings from children to adults and in military veterans.

Research indicates that life-threatening medical diagnoses and their associated treatments can be traumatic stressors, impacting coping and quality of life in patients and caregivers. Trauma- and stress-related symptoms from post-traumatic stress disorder (PTSD) or related illnesses may occur at any point, from the time of diagnosis to the end-of-life. The prevalence rate of PTSD in patients facing a serious illness (16-18%) is estimated to be at least double that of the general population (8%). Subsyndromal PTSD may be as high as 80% in patients facing recurrent cancer, while approximately 20–30% of family caregivers experience PTSD symptoms. The effects of PTSD and other trauma-related disorders can be wide-ranging. Patients with PTSD may isolate themselves, be reluctant to engage with clinical staff or caregivers, and may have more difficulty to control physical and emotional symptoms. Meanwhile, caregivers with PTSD may develop complicated grief after the patient dies.

Despite the prevalence, there is a lack of routine screening for trauma- and stress-related symptoms in the palliative care population, delaying treatment until symptoms become pronounced. How can palliative care clinicians address trauma- and stress-related symptoms in patients and family caregivers facing serious illness? What can we learn from past clinical experiences to transform the way we conceptualize, assess, and treat these symptoms? In this concurrent session, our interdisciplinary panel will review recent advances in trauma-informed care across various palliative care settings from children to adults and in military veterans. We will introduce a conceptual framework for understanding the impact of trauma- and stress-related disorders in palliative care, offer recommendations for assessing and risk-stratifying patients and caregivers using validated measures, and discuss evidence-based treatments that can be adapted to palliative care settings to ameliorate the distress and emotional suffering of patients and family caregivers facing the double burden of serious illness and trauma symptoms.

Making the Case for the C Suite: Using Leadership Insights and Strategic Resources to Put Your Pediatric Palliative Care Program in Prime Time (SA506)




Rebecca Kirch, JD, National Patient Advocate Foundation, Washington, DC. Joanne Wolfe, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA. James Block, MD, Center to Advance Palliative Care, New York, NY.

Objectives

- Improve proficiency in explaining the value proposition for pediatric palliative care and its benefits for all audiences.
- Describe how to develop and deploy a strategic action plan to promote institutional leadership support for pediatric palliative care.
- Identify at least three available strategic resources the field can use to make the case for pediatric palliative care institutional support.

Pediatric palliative care programs are often highly dependent on hospital funding, and studies show that these programs deliver value that warrants focused investment. Growth in the field has been notable, yet it has not kept pace with the rising numbers of infants and children who are living longer with serious illness and could potentially benefit from palliative care services. Momentum building in the broader palliative care field presents an unprecedented opportunity to bridge the gap for pediatric palliative care. Palliative care has become the fastest-growing healthcare specialty in the United States, largely spurred by increased understanding of its potential to improve care quality and clinical outcomes while reducing costs. Many hospital administrators, policymakers, payers, and providers recognize these high value benefits, but the advantages are not yet equally well understood and appreciated in pediatric care. Successfully embedding pediatric palliative care services into hospital culture and building sustainable programs requires effective advocacy, backed by evidence, to support staffing and other resource requests necessary to meet current program needs and foster future growth potential. This interactive concurrent session will feature new data captured in qualitative interviews conducted in 2017 among hospital leadership executives about the key factors of pediatric palliative care they considered as most compelling in their decision-making about funding. In addition, session faculty will share their insights on making the case effectively for executive leadership and other influential stakeholders, drawing on decades of extensive experience in advocacy, hospital and health system business practices, and pediatric program development. Finally, the session will provide practical tips

and introduce new evidence-based strategic resources developed by the Center to Advance Palliative Care (CAPC) to help the field expand and mature their programs and accelerate advancement into prime time.

The “SAFEST” Way to Navigate Substance Abuse—A Talking Map for Difficult Situations (SA507) 

Julie Childers, MD MS FAAHPM, University of Pittsburgh, Pittsburgh, PA. Jennifer Pruskowski, PharmD BCPS CGP CPE, University of Pittsburgh School of Pharmacy, Pittsburgh, PA. Pina Patel, MD, The Ohio State University Wexner Medical Center, Columbus, OH.


Objectives

- Screen patients for substance abuse in the outpatient palliative care setting.
- Set limits on the use of opioids and other controlled substance while maintaining the commitment to care for the patient.

Current literature suggests that up to 40% of patients with palliative care needs have risk factors for substance abuse. As controlled substances, such as opioids and benzodiazepines, are often prescribed for the management of symptoms, these risk factors can directly influence a patient’s adherence to these classes of medication. Palliative care clinicians seeing patients in the outpatient setting must balance the goal of pain control with vigilance for overuse of prescribed medications, often in combination with alcohol or benzodiazepines, and sometimes even addiction. These difficult situations require effective communication with the patient and their caregivers in order to balance the patient’s rational access to these medications, while maximizing safety. One talking map, “SAFEST” (Screen for misuse or addiction; Ask the patient; Frame concern about misuse or addiction; Express empathy; Set firm limits; and Treat pain (and addiction if present)) helps to navigate these difficult situations. SAFEST guides clinicians to set boundaries around the use of opioids as necessary while continuing to provide whole-person care, which may include some use of opioids, non-opioid treatments only, treatment of depression or anxiety, and/or treatment of addiction.

In this session, after a brief didactic, faculty will show the roadmap in action, stopping and restarting a sample case involving excessive alcohol use in a patient prescribed opioids for cancer pain, involving the audience in problem-solving effective communication strategies.

Paper Session (SA508)

An Electronic Clinical Decision Support Tool to Assist Hospital Physicians with Prognosis: Development and Mixed Methods Evaluation (SA508A) 

Deborah Morris, MD MHS, Eastern Virginia Medical School, Norfolk, VA. Parag Bharadwaj, MD, Virginia Beach, VA.

Objectives

- Identify process improvement strategies to develop clinical decision support (CDS) tools in the clinical setting.
- Identify potential CDS tools for prognosis and mortality that may impact access and utilization of supportive services in your community.

Background. Many electronic medical records (EMRs) have been created for hospital medicine, but few are tailored to the specific needs of palliative care medicine. No tool exists to assist medical providers with prognosis at time of hospital admission within EMRs. As part of clinical initiatives focusing on appropriate utilization of hospice, we have designed and implemented the first automated version of a mortality risk assessment tool within EPIC electronic medical record.

Aim Statement. Describe design and implementation process of an automated electronic decision support (CDS) tool for prognosis across a network of acute care hospitals. Evaluate decision support tool’s acceptability to hospitalists and other providers.

Methods. As part of system-wide clinical initiatives, our hospital system implemented a decision support tool in the EMR to address mortality risk on admission to the hospital. Process improvement committees identified a validated tool that could be adapted and automated within our EMR. Through an iterative process with IT an automated version mortality risk assessment tool within EPIC electronic medical record. Timeline and steps of EMR tool design and implementation will be presented.

Results. The tool’s risk assessment algorithm correlated with independent expert review of hospice eligibility. 161 patient charts were reviewed and there was a 100% match for automated risk category assignment vs. hand audit via chart review. 40 /54 (74%) High risk patients were Hospice appropriate based on CMS Hospice enrolment guidelines. Pilot hospital site data revealed three qualitative findings emerged: 1) all providers value the tool; 2) the tool greatly influenced communication regarding goals of care and hospice; 3) successful implementation may require

medication of alert timing. There were no substantial concerns from any participating provider or staff.

Conclusions and Implications. A fully-integrated, self-populating clinical decision support tool for mortality risk assessment can be implemented successfully in an EMR across a network of hospitals. CDS tool could contribute to improved access and utilization of supportive services including hospice.

Capturing Dignity (SA508B)

Ali Mendelson, MD, University of California, San Diego/Scripps Health, San Diego, CA. Kari Holder, BA, University of Pennsylvania, Philadelphia, PA.

Objectives

- Discuss the limitations in access to dignity therapy.
- Describe the use of photographs in place of written narrative as a novel tool to improve dignity, expanding the definition of and access to dignity conserving therapy.

Original Research Background. Relatively few patients and providers are able to participate in dignity therapy.

Research Objectives. This was the initial qualitative study investigating the feasibility of using photographs in place of written narrative as a novel tool to improve dignity, expanding the definition of and access to dignity conserving therapy.

Methods. Participants chose a single photograph representing how they want to be seen by providers. Structured interviews were conducted 24 hours after the photograph was hung above their hospital bed.

Results. All 11 patients and/or families who were approached agreed to participate. Seven patients completed the survey. 57% of photographs were chosen by family. 86% of participants thought providers noticed the photograph and asked questions about it, 57% thought it improved their hospital experience, and 43% thought it helped providers to learn more about them. The most common theme overall was family. Physical appearance was the most common reason participants chose the specific photograph. Similar themes (personal characteristics, goals/hopefulness, and family) were common among responses to questions about what patients want providers to know about them, what they are most proud of, and their goals going forward.

Conclusion. In this initial study looking at the use of photographs to expand the scope of dignity therapy, we found that patients are interested in having a photograph on their hospital wall, it stimulated conversations with providers, and most patients felt it improved their experience in the hospital. Future studies could investigate the effects on patient satisfaction, length of stay, goals of care, disposition, and staff

members as well as differences between photographs chosen by patients and their family.

Implications for Research, Policy, or Practice. Goals of both this and future studies would be to expand the definition of dignity therapy, expand the population of patients who are able to participate in dignity conserving therapy, and increase the number of providers who are able to provide dignity conserving therapy.

Quality Improvement Yields Quality of Life: A Palliative Care Tissue Donation Collaborative (SA508C)

Karen Blackstone, MD, Veterans Affairs Medical Center, Washington, DC. Anissa Rahman, MD, George Washington University, Washington, DC. Margaret Gloria, MD, Washington DC VA Medical Center, Washington, DC. Elizabeth Cobbs, MD, George Washington University, Washington, DC.

Objectives

- Describe elements of a successful tissue donation collaborative program
- Describe tissue donation eligibility, potential benefits, and process

Background. Although 25% of all US deaths occur in nursing homes, nursing home residents (including those enrolled in hospice care) are not routinely considered for tissue donation programs. Nursing home residents with non-cancer hospice diagnoses may be eligible post-mortem tissue donors and able to provide critical and life-enhancing donations of skin, corneas, heart valves, veins, and bone. This review demonstrates a successful collaborative tissue donation program within a Veterans Affairs (VA) nursing home.

Aim Statement. We will routinely (90%) identify potential tissue donors from a hospice/palliative/nursing home program and increase the number of tissue donors from one VA Medical Center in one year.

Methods. In 2015 a VA Medical Center Interdisciplinary Organ/Tissue Donation Committee (Surgery, Palliative Care, Nursing, Ethics, Quality Management, Regional Transplant Community) created and implemented policies and procedures for organ/tissue donation and procurement, including potential donors who died in the nursing home/hospice/palliative care unit. Outcome measurements included: location and number of deaths, percent of referrals completed, potential donors, characteristics of donors, satisfaction of providers/families.

Results. Collaborative Program Year 1: 200 total deaths with 128 (64%) referrals completed to Regional Transplant Community. Seven potential donors were identified and four families consented to tissue donation. Two of the four donors died in the nursing home with hospice care, all were known to

the palliative care consult team. Primary diagnoses = organ failure (organ, heart, and kidney). Nursing home/hospice/palliative care providers and families of decedents reported satisfaction with the process and opportunity to consider tissue donation. Updated measurements, quality improvement interventions, challenges, successes, and donor case studies will be presented.

Conclusions and Implications. Post-mortem donated tissues from nursing home hospice patients can be life-saving or life-improving for people with trauma, burns, cancer, blindness, and more. Hospice and nursing home leaders may collaborate with Medical Center tissue donation programs to build successful partnerships and give families the option of the gift of tissue donation.

Introduction of Triggers for Palliative Care Consultation Improve Utilization and Satisfaction within a Level IV NICU (SA508D)



Linda Nguyen, MD MPH, St. Christopher's Hospital for Children, Philadelphia, PA. David Cooperberg, MD, St. Christopher's Hospital for Children, Philadelphia, PA. Michael Spear, MD MS MSED, St Christopher's Hospital for Children, Philadelphia, PA.

Objectives

- Identify three key elements that influence successful implementation of triggers for palliative care consultation within a NICU setting.
- Recall the four major trigger domains that qualify for pediatric palliative care consultation within a NICU setting.

Background. The use of a palliative care guideline, such as a trigger list for palliative care consultation (PCC), remains controversial in the NICU. Despite knowledge that a palliative team is present at our institution, the level of utilization of their services, and the NICU providers' attitudes and beliefs regarding neonatal palliative care, are unknown.

Aim Statement. We sought to increase awareness of the palliative care team's role and the criteria in which a consultation is appropriate, with a SMART aim to increase the number of PCCs within our level four NICU by 20% by the end of December 2016.

Methods. The setting is in a Level four NICU at an academic urban pediatric hospital. The study design included observational time series with multiple planned sequential interventions, which include but not limited to surveys and education. Medical chart review screened for eligibility for PCC. Statistical process control charts show performance over time.

Results. Many providers noted a need for a guideline for PCC. Prior to implementation of the

triggers, of those who qualified for PCC, 26% received consultation, which increased to 46% after implementation. There was also an increase in the percentage of survey respondents who understand what the team's role is, know when they should be consulted, and noticed a positive difference since their utilization. Lastly, the time until initial consultation decreased from approximately 1.5 months to one week.

Conclusions and Implications. We achieved our goal of increasing the number of PCC by 20%, and decreased time to initial consultation. The triggers helped establish prompt and proactive referral. Not only can a written guideline increase awareness of a palliative care team's role within a NICU, but it also enhances the satisfaction amongst providers of the care they are giving. Early integration of palliative care within the NICU can help guide revision of treatment goals, improve communication, and provide continuity of comprehensive care to families.

1:30–2:30 pm

Concurrent Sessions

The Practice of Palliative Medicine in Developing Countries—Part Three (SA511)




Farah Khalid, MBBS, Kuala Lumpur, Malaysia. H.M. Iqbal Bahar, MD, Silchar, India. Jelena Dimitrijevic, MD, Belgrade, Serbia.

Objectives

- Learn how physicians in specific countries provide palliative care to their patient populations often with limited resources.
- Recognize specific cultural and political challenges to developing palliative care clinical, educational and research programs.
- Describe roles of different health care providers practicing palliative care and how they meet the needs of their local populations.

Please join AAHPM's International Scholars for a panel discussion. Each scholar will present for 10-15 minutes on the state of the practice of palliative care in their home country, with an emphasis on the roles of physicians, nurses, and other healthcare providers; the status of education and research in the field; and the unique challenges facing patients and providers. There will be time allotted after each presentation to field questions and dialogue from the audience. Prepare to be educated and inspired by these accomplished individuals who are leading and advancing the field of hospice and palliative medicine in their countries of origin.

"What I Really Need Right Now Is to Hear from Other Parents with a Child Like Mine"  (SA512)

Blyth Lord, EdM, Courageous Parents Network, Newton, MA. Janet Duncan, MSN CPNP, Boston Children's Hospital and Dana-Farber Cancer Institute, Boston, MA. Marsha Joselow, MSW LCSW, Boston Children's Hospital and Dana-Farber Cancer Institute, Boston, MA. Patricia O'Malley, MD, Massachusetts General Hospital for Children, Boston, MA.

Objectives


- Describe two benefits of a web-based educational tool for parents of children with serious illness and clinicians who care for them.
- List three common themes explaining what is most important to parents of seriously ill children in coping with the diagnosis.
- State two ways this educational tool could be used with parents and clinicians.

Upon learning that their child has a life-threatening illness, parents are typically overwhelmed and grief-stricken. A diagnosis usually comes from clinicians who provide written resources and verbal explanations to begin helping parents understand what lies ahead. Clinicians can offer support however cannot truly understand the anxiety and grief parents experience or the scary questions parents may have lurking in their minds but are often afraid to ask. Parents do ask how on earth they are ever going to make it through this 'nightmare,' and how it is that other parents like them have done it.

While support and empathy from their clinicians is critical, parents crave insights and wisdom of fellow parents who have walked in their shoes. Parents trust other parents and seek them out. There are significant practical and legal limitations, however, as to how clinicians can connect parents with other parents in person.

Through this interactive session, participants will learn about an innovative online resource for families, available at no cost and 24/7, devoted to the medical, emotional, and psychological issues families face while caring for children with serious illness. Courageous Parents Network offers intimate video interviews profiling the diversity of family experience and perspectives, tips for family care, the value of palliative care, and perspectives from clinicians on questions that families ask - about diagnosis through end of life and bereavement. This resource helps families learn from the experience of others and lessens feelings of isolation that parents often experience.

In this session, participants will learn how and when to introduce families to this resource, as well as how to use it to prompt and facilitate difficult conversations with patients and families, including those who are facing end-of-life.


"What Do You Mean You Are Going to Stop the Statin?!": Communication Techniques for Deprescribing  (SA513)

Jennifer Pruskowski, PharmD BCPS CGP CPE, University of Pittsburgh School of Pharmacy, Pittsburgh, PA. Mary Lynn McPherson, PharmD MA MDE BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Holly Holmes, MD MS AGSF, UTHealth McGovern Medical School, Houston, TX.

Objectives

- Review the process of and barriers to deprescribing.
- Explore the psychological connections both patients, families and caregivers, as well as providers, have with medications.
- Describe the role of motivational interviewing and share-decision making in the process of deprescribing, and apply concepts to patient cases.

There is currently a high prevalence of potentially inappropriate medications in patients with serious illness. These potentially inappropriate medications can lead to a plethora of medication related issues that directly inhibit a patient's quality of life. To address this problem, deprescribing is necessary. Deprescribing is defined as the systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient's care goals, current level of functioning, life expectancy, values, and preferences. As with any process, there are barriers to implementation. The five main barriers to deprescribing are: 1. The psychological connection to medications; 2. Risk of adverse withdrawal events; 3. Lack of evidence-based medicine; 4. Unclear patient population; and 5. Lack of a feasible model. Accordingly to literature, the number one barrier to deprescribing is the psychological connection with medications. This connection can be with patients and/or their caregivers, or other providers. As palliative care providers are communication experts, this session will aim to widen the communication toolkit both by extrapolating from previously published techniques, and with introducing new talking maps. Patient simulations will be utilized to illustrate these interactions.

"I Have a Terrible Sore Throat, I'm Itching and Haven't Slept in Days": Pharmacopalliation of Mucositis, Pruritus, and Insomnia in Hospice and Palliative Care Patients  (SA514)

James Ray, PharmD, University of Iowa College of Pharmacy, Iowa City, IA. Carla Pies, DNP GNP ANP ARNP, University of Iowa Hospitals and Clinics, Iowa

City, IA. William Clark, MD, University of Iowa Hospitals and Clinics, Iowa City, IA.

Objectives

- Describe the pathophysiology, clinical manifestations, and prevention of mucositis, pruritus, and insomnia.
- Identify pharmacologic and non-pharmacologic interventions for mucositis, pruritus, and insomnia.
- Summarize the scientific evidence underlying the successful management of mucositis, pruritus, and insomnia.

Symptom assessment tools are designed for the clinician to quickly and effectively determine the presence and severity of the most common symptoms encountered in palliative care or hospice patients. Mucositis, pruritus, and insomnia are all assessed in the Memorial Symptom Assessment Scale but could be missed by using a tool such as the Edmonton Symptom Assessment Scale (ESAS). The purpose of this session is to raise the awareness of these less common but equally distressing symptoms that can pose a challenge to successful management in many patients.

Mucositis refers to mucosal damage within the gastrointestinal tract. It occurs in 20–40% of patients receiving conventional chemotherapy and up to 80% of patients receiving high-dose chemotherapy preparation for stem cell transplantation and nearly all patients receiving chemotherapy and radiation therapy for head and neck cancer. Additionally, certain oral-targeted therapies for cancer produce a significant amount of morbidity from this adverse effect.

Pruritus is a nuisance symptom, but many patients suffer from protracted episodes of suffering as a result of poorly executed therapy by clinicians. Opioid therapy for an underlying pain condition often produces pruritus. However, it may be an adverse effect of other medications as well as experienced by patients with end-stage hepatic or renal disease.

Insomnia is often overlooked in the overall symptom burden of many patients in hospice and palliative care. Clinicians must exercise great care when using sleep aids in combination with opioids due to the enhanced risk of opioid-induced respiratory depression. Insomnia is the most common risk factor for the subsequent development of delirium, especially in the hospitalized patient. Restoration of sleep hygiene is essential to the overall care of the palliative care and hospice patient.

At the completion of this concurrent session, participants will be prepared to utilize the latest evidence-based information to palliate the symptoms discussed.

Ketamine and Depression: Is It Ready for Primetime? (SA515)



Eric Prommer, MD HMDC FAAHPM, University of California, Los Angeles and VA HPM Program, Los Angeles, CA. Scott Irwin, MD PhD, Cedars-Sinai, Los Angeles, CA. Jeremy Hirst, MD, UC San Diego Health, San Diego, CA.

Objectives

- Understand where ketamine fits in the treatment of depression.
- Understand the mechanism of action of ketamine in depression.
- Learn methods of administration of ketamine for depression.

Depression is common in the hospice and palliative care population, with prevalence estimates ranging from 17% in the palliative care population to up to 40% in hospice patients. Depressive disorders such as major depression frequently go unrecognized or undertreated, and are associated with significant disability, impaired quality of life, and increased healthcare utilization. Depression is also associated with poor symptom control and often affects pain, appetite, and motivation. Several studies now provide evidence of ketamine hydrochloride's ability to produce rapid and robust antidepressant effects in patients with mood disorders that were previously resistant to treatment. Despite the relatively small sample sizes, lack of longer-term data on efficacy, and limited data on safety provided by these studies, they have led to increased use of ketamine as an off-label treatment for mood and other psychiatric disorders. The studies performed have also shed light on methods of administration, ideal routes of administration, proper administration techniques as well as information about single and repeated dosing. Safety in the palliative care population is known. This session, given by a panel of palliative care experts in ketamine use will identify where the drug is in its route to further clinical use. The session will enable attendees to 1.) Understand the current status of ketamine for the treatment of depression. Patient identification and selection will be highlighted. 2.) Understand the mechanism of action of ketamine and how it differs from traditional antidepressants. 3.) Understand current methods of administration and how it differs from administration for pain. Preadministration screening will be highlighted. 4.) Understand proper post administration management. 5.) Identify new toxicities and risk mitigation strategies.

A Guide for Palliative Medicine Clinicians Taking Care of Lesbian, Gay, Bisexual, and Transgender Patients Using a Whole Person Care Approach (SA516)



Sean O'Mahony, MD MS FAAHPM, Rush University Medical Center, Chicago, IL. Rakiyah Jones, MSN

MBA MPH FNP-BC, Columbia University, New York, NY. Will Mellman, MSW, Columbia University Medical Center, New York, NY. Bruce Scott, MD, Wright State University, Dayton, OH. Ronit Elk, PhD, University of South Carolina, Columbia, SC. Amanda Hinrichs, DO, Park Nicollet/University of Minnesota, Minneapolis, MN. Shail Maingi, MD, St. Peter's Health Partners Cancer Care, Troy, NY. Asher Kolieboi, MDiv, United Church of Christ, Baltimore, MD.

Objectives

- Understand the impact of spiritual and existential distress in LGBT patients with chronic medical illnesses.
- Access tools and resources to support LGBT patients and families facing life threatening illnesses and uncertain legal protection state-by-state.
- Assess the unique needs of transgender patients who are receiving care from faith-based organizations.

In 2011, the Institute of Medicine report on the Health of Lesbian, Gay, Bisexual, and Transgender (LGBT) People cited lack of legal protections and lack of social support as significant barriers to the quality of palliative care. LGBT patients have achieved expanded rights and access to health care. State health policy and legislation varies widely across the country and many states offer little legal protection to LGBT patients. LGBT patients living with chronic illnesses experience higher rates of depression and anxiety and more likely to have lower rates of satisfaction with care that they receive from health care providers (Kamen C 2015). Healthcare providers receive little training on caring for LGBT patients and often are unaware of educational and patient support resources for LGBT patients. While LGBT patients and their families are reported to have higher preferences for advance care planning, palliative care, and hospice many palliative care and hospice organizations lack policies and educational resources in regard to care of LGBT patients and families.

Our transdisciplinary team of co-presenters includes representatives from medicine, advance practice nursing, social work and chaplaincy. The presenters will use case-based teaching to highlight the role of chaplaincy in assessing LGBT specific spiritual and existential distress. We will address the role of chaplaincy in promoting psychological well-being in LGBT patients by chaplain led Dignity Therapy.

We will address the role of social workers to proactively promote formalized surrogate decision makers of LGBT patients' preference, psychosocial well-being and resources to address variability in state protection for LGBT patients.

We will address the role of hospice and palliative medicine teams in caring for transgender patients with advanced illnesses who are receiving care from faith-based and long-term care organizations.

We will present resources for providers to educate their teams on caring and advocating for LGBT patients.

Resource List

- Resources to Improve The Quality Of Hospice And Palliative Care For Sexual And Gender Minority Patients And Families
- Center of Excellence For Transgender Health - <http://transhealth.ucsf.edu/>
- Hospice Foundation of America LGBT Resources- <https://hospicefoundation.org/End-of-Life-Support-and-Resources/Coping-with-Terminal-Illness/How-to-Choose/LGBT-Resources>
- Lambda Legal Tools for Life and Financial Planning- <http://www.lambdalegal.org/publications/take-the-power>
- LGBT best and promising practices for cancer care for LGBT patients and families throughout the cancer continuum- <http://www.lgbthealthlink.org/Cancer-Best-Practices>
- LGBT Hospice and Palliative Care Network – <https://lgbthpm.org/resources/>
- National Resources Center on LGBT Aging - <http://LGBTagingcenter.org/resources>
- Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders- <http://sageusa.care/>

Citations. Institute of Medicine: The Health of Lesbian, Gay, Bisexual, and Transgender People Building a Foundation for Better Understanding. Washington, DC: National Academy of Science, 2011.

Kamen C, Mustian KM, Dozier A, Bowen DJ, Li Y. Disparities in psychological distress impacting lesbian, gay, bisexual and transgender cancer survivors. *Psychooncology* 2015 24(11):1384-91.

Air Out There: Options for Non-invasive Respiratory Supports and Safe Transitions from ICU to Hospice (SA517)



Lauren Goodman, MD MSC, Ohio State University, Columbus, OH. Elaine Chen, MD, Rush University Medical Center, Chicago, IL. Brady Scott, MS RRT-ACCS AE-C FAARC, Rush University, Chicago, IL.

Objectives

- Describe and detail non-invasive oxygenation and ventilation supports.
- Operationalize the transition and weaning of these supports to the hospice setting or more compassionate environments.
- Build a training workshop/symposium to institute with local hospices; assist in transition from ICU/intensive care.

The transition from hospital to home hospice is often complicated by oxygenation and ventilation support devices. There is a growing number and variety of devices used in hospitals to sustain patients with respiratory failure. Hospice and palliative teams must understand these devices to be able to effectively communicate with patients and families about their use and discontinuation, and to work within the team to maintain patient comfort and control of symptoms during transition to hospice. This session will use cases seen by dual-trained Hospice and Palliative Medicine and Pulmonary/Critical Care physicians at multiple institutions to discuss a number of respiratory support devices, including both traditional invasive mechanical and non-invasive positive pressure ventilation, and newer supports such as heated humidified high flow oxygen and autotitrating ventilators. Through the cases presented, we will first describe the indications for and features of these respiratory support devices, including patient interfaces, considerations for programming settings, and reviewing peer-reviewed literature regarding their use. A respiratory therapist will demonstrate use of these devices and techniques for appropriate use and troubleshooting. We will discuss benefits, limitations, and costs of these respiratory support devices from a hospice and palliative perspective. Finally, we will propose methods for transitioning from each of these devices to less complex support measures such as simple nasal cannula or pure ambient air while maintaining symptom control for the purpose of promoting patient comfort.

Paper Session (SA518)

Rural African Americans Pastors' Perspectives on EoL Care for Their Congregants: Phase One of a Three-Phase Pilot Study (SA518A)



Ronit Elk, PhD, University of South Carolina, Columbia, SC. Alvin Reaves, MD, MedStar Southern Maryland Hospital, Clinton, MD. Karen Jones, PhD MSPH, University of South Carolina, College of Nursing, Columbia, SC. Ramona Rhodes, MD, University of Texas Southwestern Medical Center, Dallas, TX. Wendy Anderson, MD MS, University of California San Francisco, San Francisco, CA.

Objectives

- Understand the importance of why it is important to recognize the importance of cultural perspectives in caring for patients from different cultures.
- Gain an understanding of the methods for gaining insight from African American pastors
- Gain an understanding of some of the key ways that pastors want healthcare professionals to treat their congregants when providing care for African American rural patients.

Original Research Background. Culture shapes how people make meaning out of illness, suffering, and dying, and strongly influences their responses to diagnosis, illness and treatment preferences. Lack of sensitivity to cultural differences may significantly compromise care for rural Southern African American (AA) patients. To meet the needs of such patients, attention must be paid to developing culturally competent skills among healthcare providers.

Research Objectives. Aims of this three-phase study is to develop and test the feasibility of a training program for healthcare providers, focusing on culturally-appropriate communication skills with AA patients. The church and pastor are the spiritual, cultural and lifestyle cornerstone for rural AAs, with pastors playing a central role in patient illness, recovery and death. The aim of Phase 1 is to gain understanding of preferences for culturally-based ways of communication through focus groups with Southern AA pastors.

Methods. Using Community Based Participatory Research, a Community Advisory Group (CAG) of community leaders was formed. CAG met regularly to determine steps to develop the culturally-based training program. The focus group was planned by CAG, in full partnership with the research team. Seven questions that focus on pastors' preference for care of patients with serious illness were discussed over two focus group sessions.

Results. Ten local AA pastors, from multiple Christian denominations, attended two focus groups. Key findings included: physicians must treat their AA patients respectfully, recognize that faith plays a key role in life of AA rural patients, and when discussing illness and treatment options, always provide hope. Lack of trust in physicians remains strong.

Conclusion. Key concepts raised by the pastors will be incorporated into the training program for healthcare providers that will take place in Phase 2. Pastors will participate in the training of healthcare providers in Phase three.

Implications for Research, Policy, or Practice. Training clinicians to provide culturally-based care enhances likelihood of increasing trust and enhancing AA patients' satisfaction with care.

Factors that Impact Family Perception of Preference-Concordant Care at the End of Life (SA518B)



Lindsay Haines, MD, Mount Sinai Hospital, New York, NY. Amy Kelley, MD MSHS, Icahn School of Medicine

at Mount Sinai, New York, NY. Omari-Khalid Rahman, MA, Mount Sinai Hospital, New York, NY.

Objectives

- Describe how patients and their proxies perceive whether patients receive preference-concordant care at the end of life
- Describe how demographic factors are associated with the perception of preference-concordant care
- Describe how the presence of end-of-life care instructions relate to the perception of preference-concordant care

Original Research Background. Preference-concordant care has been advanced as a measure of high quality end-of-life care and is often measured by family report after a patient's death. It is unknown how this measure is related to and affected by patient characteristics.

Research Objectives. To examine family report of the frequency that patients received preference-concordant care at the end of life and whether this assessment was associated with patient characteristics.

Methods. Using the Health and Retirement Study, a nationally-representative longitudinal cohort of adults over the age of 50, we sampled subjects who died between 2012 and 2014, whose families reported how often decedents received preference-concordant care at the end of life. Bivariate logistic regression models assessed the association between decedent characteristics and family report of medical care that "usually/always" matched decedent preferences.

Results. Of the 1,175 decedents, 76% reported usually/always receiving preference-concordant care. Decedents who were US born (OR=1.74; $p=0.02$), were religious (OR=1.36; $p=0.03$), had a history of cancer (OR=1.65; $p<0.01$), heart disease (OR=1.3; $p=0.03$) or multiple chronic medical conditions (OR=1.39; $p=0.02$), had a health care proxy (OR=1.57; $p<0.01$), or had written end-of-life instructions (OR=1.59; $p<0.01$) were more likely to have family report preference-concordant care. Decedents who were non-white (OR=0.64; $p<0.01$), less than 65 years-old (OR=0.51; $p<0.01$), or without a history of chronic medical conditions (OR=0.52; $p=0.04$) at death were less likely to have family report preference-concordant care.

Conclusion. Minorities, younger patients, and those without chronic medical conditions may be less likely to receive preference-concordant care, while those with end-of-life care instructions and a health care proxy may be more likely to receive preference-

concordant care. The use of post-death family report without prospective assessment of goal-concordant care makes it difficult to determine whether these associations exist or are secondary to unobserved confounding variables.

Implications for Research, Policy, or Practice. We identified factors that can be targeted to improve quality at the end of life.

Transition to Comfort-Focused Care: A Metasynthesis of Patient, Family, and Provider Perspectives (SA518C)



Mary Ann Meeker, DNS RN, University at Buffalo, Buffalo, NY. Mary Ann Jezewski, PhD RN FAAN, University at Buffalo, Buffalo, NY. Jacqueline McGinley, LMSW, University at Buffalo, Buffalo, NY.

Objectives

- Describe current evidence addressing the process of transition to comfort-focused care in patients with advanced life-limiting illness.
- Identify sources of conflict affecting the transition process and evidence-based strategies that can be utilized in response.

Background and Objective. Transitioning to comfort-focused care is inherently difficult with fear, loss, and a sense of powerlessness common. Failure to assist patient and family with a timely transition increases suffering, truncates the opportunity for meaningful life closure, and subjects patients to needless interventions, draining healthcare resources while adversely impacting patient and family outcomes. The purpose of this study was to synthesize available qualitative evidence to describe and explain the process of transition from life-prolonging to comfort-focused care as reported by patients, family members, healthcare providers.

Study Identification. Literature was sourced from systematic searches of Medline, CINAHL, and PsycInfo databases. Inclusion criteria were: (a) published report of a primary study using qualitative methods, (b) addresses some aspect of transition process to comfort-focused care, (c) participants were patients, family members, or healthcare providers, or any combination, (d) published in English from any country, and (e) all participants were adults. No date limitations were placed. The Joanna Briggs tool was used for quality appraisal.

Data Extraction and Synthesis. Information was abstracted and placed in a matrix. Data was first synthesized by participant group and then integrated across groups.

Results. Included were 57 reports of 51 studies. The transition process of moving toward a shared view

was dependent on sub-processes of (1) engaging and establishing connection and (2) sharing decision-making. Connection was influenced by ethical behavior and emotional support, while decision-making was reliant on information and involvement. Achieving a shared view and moving to comfort-focused care led to preparation for dying and emphasis on relationships. Inability to achieve a shared view led to conflict and moral distress. A biomedical vs. person-centered context strongly affected the transition process.

Conclusions and Implications for Practice, Policy, and Research. The findings provide a framework to guide clinicians in reducing conflict and facilitating a patient's transition to comfort-focused care when appropriate and congruent with patient goals as well as directions for needed research.

Parenting with Cystic Fibrosis: Balancing Roles as Parent and Patient with a Life-Limiting Illness (SA518D)



Claire Hailey, MD, University of Chicago, Chicago, IL. Julia Tan, MD, University of North Carolina, Chapel Hill, NC. Elisabeth Potts Dellon, MD, University of North Carolina School of Medicine, Chapel Hill, NC. Eliza Park, MD, University of North Carolina, Chapel Hill, NC.

Objectives

- Describe parenting concerns of individuals with CF who are considering having children and parenting experiences of individuals with CF who have children.
- Acquire skills to improve communication with individuals living with CF by enhancing their understanding of parenting and related psychosocial concerns of individuals with CF.
- Translate general concepts of this study to improve supportive care for parents and potential parents with other life-limiting illnesses.

Background. Life expectancy for cystic fibrosis (CF) has increased in recent decades, and more individuals with this life-limiting illness are becoming parents. The few published studies of parenting with CF offer interesting insights but are limited in scope.

Objectives. 1) To describe the parenting concerns of parents and non-parents with CF and 2) To identify supportive care needs of individuals with life-limiting illness who are parents or are considering parenthood.

Methods. Twenty adults with CF participated in semi-structured interviews addressing reproductive decision-making, parenting concerns, and supportive care needs of parents with life-limiting illness. We performed thematic content analysis of interview data and descriptive statistical analysis of participants' demographics and health variables.

Results. Of the 20 participants (mean age 32 years, range: 22-44): 10 were parents; 10 were men; lung illness severity ranged from mild to severe (median FEV1: 66% predicted). Participants expressed concerns about practical and emotional implications of their illness on their children and family. Among parents, the time and energy required to meet their children's needs often superseded their own health maintenance responsibilities. Participants were concerned about engaging in illness-related communication with children. They also reported difficulty preparing for their children's future in anticipation of their own progressive illness and early mortality. Participants' recommendations to health care providers to improve supportive care for parents included: initiating more discussions with patients about parenting with life-limiting illness; counseling patients to establish robust social support before having children; providing opportunities to discuss experiences with other parents with CF.

Conclusions. Results from this study can provide guidance for CF clinicians and palliative care providers to address their patients' concerns related to parenting with CF.

Implications. Raising children can have a substantial impact on the illness experience of individuals with CF. The parenting concerns and experiences of CF patients may have broad applicability to the care of patients with other life-limiting illnesses.

2:45–3:45 pm

Concurrent Sessions

Ready, Set, Go: Preparing for Interprofessional Education in Palliative Care (SA520)



Barbara Head, PhD CHPN FPCN, University of Louisville, Louisville, KY. Mark Pfeifer, MD, University of Louisville, Louisville, KY. Tara Schapmire, PhD MSW OSW-C FNAP, University of Louisville School of Medicine, Louisville, KY.


Objectives

- Use a definition of IPE and the core competencies to design an oncology IPE activity.
- List and complete tools and for assessing faculty and institutional readiness for IPE activities in oncology education.
- Name four important considerations when building an interprofessional faculty team.

Purpose. This workshop will provide methods and tools for building interprofessional faculty teams and planning interprofessional education (IPE) offerings in palliative care.

Rationale. IPE in palliative care is essential to prepare students to practice in today's healthcare environment where they will work on teams and collaborate with other disciplines in order to provide holistic, patient-centered care. Faculty preparation and planning is key to the success of IPE curricula and activities. Inadequate preparation can contribute to failed initiatives and stymie further efforts.

Methods and Content. A faculty team experienced in the development of a mandatory IPE curriculum in oncology palliative education will lead this interactive workshop. Participants will review the definition and core competencies for IPE as a basis for designing activities and curricula. They will learn how to evaluate their own and their institution's readiness for participation in IPE using standardized tools and an evaluation of their strengths, weaknesses, and opportunities in this area. The importance of faculty development and examples of activities for such development will be explored. Common barriers to IPE will be delineated and solutions offered. Methods for designing IPE activities will be presented and attendees will be able to develop a draft plan for an IPE activity by the end of the session.

Voluntary Stopping of Eating and Drinking: Ethical Analysis and Clinical Approach (SA521) 


Adam Marks, MD, University of Michigan, Ann Arbor, MI. Jane Charget, MD, University of Michigan, Ann Arbor, MI.

Objectives

- Understand the historical, ethical, and legal background of voluntary stopping of eating and drinking (VSED).
- Discuss a step-wise approach to the patient who requests to engage in VSED including anticipatory guidance to patients and families.
- Review the expected physiologic changes and potential symptoms that occur when a patient engages in VSED.

Voluntary stopping of eating and drinking (VSED) involves a competent individual making the decision to no longer take in oral hydration or nutrition. While historically controversial, it is an increasingly accepted means by which an individual can hasten their end of life and there have been several high-profile cases of VSED over the past several years. As awareness of physician assisted dying (PAD) increases in the general public, more patients may explore this option and hospice and palliative medicine providers should feel comfortable responding to questions

about VSED; counseling patients and families regarding what to expect when a patient engages in VSED; and managing the symptoms associated with such a process. This case-based concurrent session will provide the attendee with an ethical framework with which to understand VSED and will propose a step-wise approach when faced with a patient who wishes to engage in VSED. Finally, we will review common symptoms associated with VSED and how to manage them safely in patients as they approach the end of life.

I'm Confused! Should I Be Using Drugs to Treat Delirium or Not? (SA522) 


David Hui, MD MS MSC, MD, Anderson Cancer Center, Houston, TX. Eric Prommer, MD HMDC FAAHPM, University of California Los Angeles and VA HPM Program, Los Angeles, CA. Mary Lynn McPherson, PharmD MA MDE BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA.

Objectives

- Discuss the fundamental basics of delirium management in the palliative care setting.
- Provide an updated review on the use of neuroleptics and benzodiazepines for management of delirium in palliative care.
- Examine the strategies to manage patients with severe refractory delirium despite first line pharmacologic therapy.

Delirium is highly prevalent and underdiagnosed in the medically ill and contributes significantly to increased morbidity and mortality. Delirium occurs in the hospitalized medically ill, postoperative patients, hospitalized cancer patients, hospitalized elderly patients, as well as hospice patients. Up to 80% of those with terminal illness develop delirium near death. Fifty percent of delirium is irreversible. Management begins with looking for reversible causes and instituting non-pharmacological measures. If these are insufficient, pharmacologic treatment is recommended. Recent clinical trials question the utility of neuroleptics in the palliative care setting. This can be hard to reconcile given that hyperactive delirium, occurring in over 50% of delirious patients, can be highly distressing to patients, caregivers and health professionals. The use of benzodiazepines for delirium is also highly controversial, with some clinicians concerned that they could worsen delirium, while others feel they are effective. The session, which is presented by a panel of experts in delirium allows

attendees to gain confidence in a solid approach to the management of delirium despite conflicting research results. The session will 1) Hone skills regarding identification of reversible causes of delirium. 2) Review current strategies regarding pharmacologic (and non-pharmacologic management) of delirium in the palliative care setting, weighing the risks and benefits of each approach. 3) Examine treatment approaches for patients with persistent delirium despite first line neuroleptics. Treatment strategies to be covered included neuroleptic dose escalation, neuroleptic rotation, combination therapies (e.g. addition of a benzodiazepine or another agent). We will conclude this session with 10–15 minutes of questions from the audience.

Watch Your Mouth: Expanding Awareness of Clinical Language to Promote Quality Care and Culture Change (SA523) 

Terry Altilio, LCSW, Mt Sinai Hospital Beth Israel Deaconess Medical Center, New York, NY. J Hunter Groninger, MD FAAHPM, Medstar Washington Hospital Center, Washington, DC. Anne Kelemen, LICSW ACHP-SW, MedStar Washington Hospital Center, Washington, DC. Vickie Leff, MSW LCSW BCD, Duke University Hospital, Durham, NC.

Objectives

- Identify common language and word choice taught in healthcare settings to raise consciousness about the influence of words, metaphors and phrases.
- Use palliative patient videos and chart notes to help participants identify their unconscious bias.
- Describe pilot data to introduce language and word choice alternatives in medical education.

As hospice and palliative care (HPC) proliferates across disciplines, so do language and phrases uniquely infused into palliative care parlance, education, practice, and documentation. While much attention is focused on delivering “bad” news and communication strategies, less attention is paid to word choice which is fundamental to communication. Beyond the specialty of HPC, clinicians across health care settings make word choices that have attributed meanings and unintended consequences that directly affect patient and family care. Consider multiple interpretations of the term “palliative chemotherapy.” Consider the evolution of the term “physician-assisted suicide” to “physician-assisted death” or “physician aid in dying.” What have been linguistic, cultural, and

clinical forces and consequences behind these word choices?

This session aims to raise consciousness, to consider both conscious and unconscious biases expressed by our words, and to highlight unintended consequences of written and spoken words. A brief review of language and word choices commonly taught and employed in health care—with a focus on HPC settings—sets the stage to engage participants through open dialogue and audience response technology about their own clinical experiences regarding language and word choice. Actual palliative patient videos will generate participant brainstorming of clinician unconscious biases in word choice. Shared palliative patient clinical documentation examples turn participant attention to the power of electronic health records as both instigator and corrective agent of “chart lore.” Finally, using institutional pilot data implementing word choice culture change through medical education initiatives, we will introduce concrete strategies for participants to raise clinical language awareness, implement related education, and trigger culture change at their respective institutions.

Who Will Speak for Me? The Growing Trend of the Unbefriended Elderly Population and Its Effect on End-of-Life Care (SA524) 

Theresa Vickey, ACHPN, Carolinas Healthcare System Northeast, Concord, NC. Brian Darr, LCSW, Carolinas Healthcare System, Charlotte, NC.

Objectives

- Describe the predicted eruption of unbefriended older adults including risk factors and current strategies that are used for medical decision making in this population.
- Determine legal and institutional barriers that may hamper decision making for an unbefriended patient who becomes seriously ill or nears the end of life.
- Explore strategies that may be adopted to lessen the incidence of unbefriended patients and develop processes that may be implemented to address medical decision making for an unbefriended patient that will serve to respect and safeguard their rights as an individual.

The core of palliative medicine centers around a person’s individual concept of quality of life and goals of care. The ability to make autonomous decisions allows a patient to pick and choose treatments and

interventions that support their values and preferences. This principal of autonomy is particularly important when an individual approaches end-of-life (EOL). As our population ages, the incidence of cognitive impairment tends to increase putting our elderly at risk for diminished capacity, leaving decision making to a willing surrogate who has some familiarity with the patient. Recent trends however, have indicated an increasing number of elderly are "unbefriended" without family or friends to function in this role. Patients without a surrogate are often subject to full scope of treatment even at EOL until an appropriate decision maker can be designated. Current methods of obtaining a surrogate may involve legal avenues such as appointment of a guardian, a process that is often long and cumbersome. Once a guardian has been appointed, there is often continued confusion due to the disparity in state statutes that govern a guardian's authority, further complicating the process of decision making.

This concurrent session will address recommendations made by the American Bar Association Commission on Law and Aging regarding strategies aimed at decreasing the number of unbefriended elders and creating mechanisms that would allow decision making to be made using methods that are consistent and free of bias. In addition, the American Geriatrics Society position statement regarding the unbefriended elderly will be presented with similar strategies focused on improvement of patient care and respect for individual patient rights. Palliative care teams are in a key position to initiate change and advocate for this vulnerable patient population by developing guidelines and policies that are consistent, unbiased, focused on quality of life and respectful of patient autonomy.

Global Palliative Care: Improving the Quality of Spiritual Care in Global Palliative Care (SA525) 

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Objectives

- Describe the current status of global palliative care clinical programs which integrate interprofessional spiritual care.

- Identify currently available training programs in global palliative care which integrate spiritual care.
- Describe challenges in developing spiritual care professionals in different regions of the world.

In 2014 the World Health Organization Assembly passed a resolution on palliative care. This resolution advances the efforts to assure that people worldwide have access to quality whole person care in which suffering or total pain is addressed and attended too. The number of people currently requiring palliative care is estimated as over 40 million worldwide and growing given the aging of the population and the increased prevalence of non-communicable disease and complex health conditions. The WHO resolution aims to support palliative care initiatives and calls for the inclusion of spiritual care as a full component of palliative. In order to provide a quality palliative care all clinicians should address spiritual distress and ideally all palliative care teams should include a trained spiritual care professionals and rely on physicians and nurses who have few resources including training in spiritual care.

In this concurrent session, global health interdisciplinary leaders will present on educational, clinical care and policy initiatives aimed to promote whole person palliative care including spiritual care. Dr. Betty Ferrell's Elnec program has been taught in 91 countries and includes spiritual care. Dr. Kathy Foley and Dr. Christina Puchalski will describe several global initiatives which promote the practice of whole person palliative care with an emphasis on including the spiritual domain of care. Rev. Anke Flohr will describe a clinical pastoral education program with students from Asian countries. Dr. Puchalski will discuss a chaplaincy training program in Mexico and Chile. Dr. Katherine Pettus will focus on how spiritual care professional in other countries in Latin America are developing "indigenous models of palliative care that are context specific. Presenters will showcase material from colleagues in other countries.

Moving Forward Together: Enhancing the Oncologist-Palliative Care Clinician Relationship for Comanagement Care Models (SA526) 

Andrew Epstein, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Toby Campbell, MD MSCI, University of Wisconsin, Madison, WI. Bridget Fahy-Chandon, MD, University of New Mexico, Albuquerque, NM. Rebecca Cammy, MSW LCSW, University of Pennsylvania Health System, Philadelphia, PA.

Joshua Jones, MD MA, University of Pennsylvania Health System, Philadelphia, PA. Kimberly Chow, ACHPN ANP, Memorial Sloan-Kettering Cancer Center, New York, NY. Esme Finlay, MD, University of New Mexico, Albuquerque, NM.

Objectives

- Reduce the potential for conflict between the oncologist and palliative care clinician around treatment decisions.
- Enhance the capacity for empathy for each other as oncology and specialty palliative care clinicians.
- Develop strategies for effective relationship building between oncology clinicians and specialty palliative care clinicians.

As the evidence base for specialty palliative care integration in oncology grows, and the spectrum of oncology interventions broadens, understanding the perspectives of oncology clinicians becomes increasingly important. Oncology clinicians (medical, nursing and other professionals) often have unique medical and psychosocial perspectives about their practices that influence care delivery to cancer patients and their loved ones. These perspectives often differ from those of specialty palliative care clinicians. For example, oncology clinicians may initiate and/or continue anti-cancer treatment despite marginal patient performance status, due to either new, potentially effective treatments, therapeutic optimism, prognostic uncertainty, and/or other clinician, patient, or disease-related factors. Oncology and palliative care clinicians may also have different concepts of, and approaches to, suffering, especially in the setting of advanced disease. As palliative care continues to integrate upstream in oncology care, palliative care clinicians must learn to foster the oncologist-patient relationship to support both the patient/family and the oncology clinical team. An understanding of these complex medical and relational issues is essential for palliative care specialists to provide optimal consultative, inter-professional and concomitant care for cancer patients and their caregivers. This concurrent session will employ a case-based format interspersed with “fish bowl” role-play to demonstrate the multifaceted perspectives and disparate needs of both the oncology and palliative care clinicians, and how best to support them both. Different iterations of the role-play will illustrate common “pressure points” for both oncology and specialty palliative care clinicians and will demonstrate communication techniques that can benefit cross-specialty and inter-professional team building. Oncology sub-specialties and patient care topics will include medical, radiation and surgical oncology. Interprofessional collaboration will be highlighted and will entail

participation in the role-play by medical, nursing and social work professionals.

Paper Session (SA527)

The Experience of Healing for Family Caregivers Following the Death of a Loved One in the Intensive Care Unit (SA527A)



Susan Desanto-Madeya, PhD RN CNS, Boston College, Chestnut Hill, MA. Danny Willis, DNS RN PMHCNS-BC FAAN, University of Wisconsin-Madison, Madison, WI. Aristotle Boslet, BSN (Candidate), Boston College, Chestnut Hill, MA.

Objectives

- Describe the experience of healing for family caregivers following the death of a loved one in the ICU.
- Identify strategies that can foster healing before, during, and following the death of a loved one in the ICU.

Original Research Background. Family caregivers suffer from a high burden of emotional and psychological distress following the death of a loved one in the intensive care unit (ICU). The burden is especially high for family caregivers who were intimately involved in the end-of-life decision-making process for their loved ones. These family caregivers often struggle to heal, that is find meaning in their experience, decisions, and lives in the weeks following their loss.

Research Objectives. The purpose of this hermeneutic phenomenological research was to describe and interpret the experience of healing for family caregivers following the death of a loved one in the ICU.

Methods. Semi-structured telephone interviews were conducted with a purposive sample of twenty-three family caregivers six weeks following the death of their loved ones in the ICU. Qualitative analysis techniques were used to identify common themes central to the experience of healing across all interviews.

Results. Seven themes were interpreted from the data: searching for clarity in a time of uncertainty; riding an emotional rollercoaster; seeking peace in one's decisions; taking comfort in the memories; valuing layers of support; moving forward with each new day; and discovering life on one's own.

Conclusion. Healing following the death of a loved one in the ICU is a multi-faceted and continuous process. Findings reveal the reality of grief and bereavement for family caregivers in the weeks following the death of their loved ones. The themes provide nurses, physicians, and other healthcare providers with an awareness and appreciation for the construct

of healing, as experienced by family caregivers before, during, and following the death of a loved one in the ICU.

Implications for Research, Policy, or Practice. By identifying and gaining an understanding of the experience of healing following the death of a loved one in the ICU, nurses, physicians, and other health-care providers have an opportunity to foster healing and positively impact family caregiver's bereavement.

The Impact of Reiki Versus Massage on Symptoms for Hospitalized Patients: A Single Rural Academic Center Prospective Cohort Study (SA527B)



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Objectives

- Understand differences in symptom control between reiki and massage in hospitalized patients.
- Discuss implications on a healing arts program.

Original Research Background. Healing arts, including reiki and massage, are offered as part of the interdisciplinary services for patients seen by hospice or palliative care programs. Data exists to support their use to improve symptoms, particularly in cancer outpatients, but there is no data regarding the comparative effectiveness of reiki versus massage.

Research Objectives. We aimed to assess the impact of reiki versus massage on the symptoms of hospitalized participants with adjustment for other factors including primary diagnosis (cancer vs non-cancer), age, gender, length of session (< 15 minutes vs 15-30 minutes vs > 30 minutes), and baseline symptom score.

Methods. Participants admitted to Dartmouth-Hitchcock Medical Center (DHMC) from June 1st, 2010 through December 8th, 2015, received reiki and/or massage from the healing arts program, and completed a pre-therapy and post-therapy questionnaire were included. A database was maintained prospectively of this cohort and included age, sex, self-report of previous session with healing arts, which healing arts intervention was received, pre- and post-

treatment symptom scores, and session length. For the statistical analysis, we used a saturated model with main effects.

Results. The database included 4,660 encounters of 1,327 unique patients. The reiki cohort consisted of more females, longer session lengths, more non-cancer diagnoses, older age, and higher anxiety at baseline. There was a statistically significant difference in fatigue (-1.53; 95% CI -1.27,-1.80 vs -1.84; 95% CI -1.53, -2.15) favoring reiki (p=0.03). In addition, there was a statistically significant difference in overall wellbeing (1.58; 95% CI 1.27, 1.89 vs 1.25; 95% CI 0.92, 1.58) favoring massage (p=0.02). No differences seen in pain, nausea, anxiety, and depression.

Conclusion. Massage and reiki seem equivalent for pain, nausea, anxiety, and depression. Reiki may improve fatigue while massage may improve overall wellbeing preferentially.

Implications for Research, Policy, or Practice. Given relatively equivalent symptom control, teams may consider adding the lowest cost healing arts practitioner to support hospitalized patients.

Independent Hospice Home Visits by Hospice Fellows: Meeting Educational Milestones by Fostering Self-Reflection (SA527C)



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Objectives

- Describe Hospice and Palliative Medicine fellows' perceptions of their experiences in performing unsupervised hospice home visits
- Illustrate how a hospice-based clinical rotation gathered evidence related to specific ACGME competencies and milestones

Original Research Background. Home visits provide unique learning opportunities for trainees, and have been incorporated in undergraduate and graduate medical education curricula. A new rotation featuring independent home visits by Hospice and Palliative Medicine fellows requires them to reflect on experiences and self-assess weekly. The practice-based learning and improvement competency calls for fellows to self-assess, and documentation of this was sparse prior to the rotation.

Research Objectives. This mixed methods study examined fellows' perceptions of experiences in

performing unsupervised hospice home visits, and gathered evidence related to specific ACGME milestones.

Methods. Visits on the month-long rotation consisted of start-of-care, symptom management, and Medicare-required face-to-face encounters. Fellows completed weekly self-reflections, which also captured demographic and practice data. Narrative data were collected from fellows' responses to open-ended prompts. A thematic analysis generated both themes and subthemes.

Results. Eight fellows completed 217 home visits (2014-2016). Themes included the following: freedom and independence, working as a team, self-efficacy, developing resourcefulness, commitment to professional growth, practice-based learning and improvement, systems-based care, patient- and family-centered care, finding purpose and meaning in work, enhancing clinical skills and knowledge, and unique learning opportunities. All fellows felt prepared to perform home visits throughout the rotation and after training. Usefulness of the rotation was highly rated by participants.

Conclusion. Results of the study demonstrated that independent home visit rotations, with multiple opportunities for fellows to work alongside interprofessional team members, can enhance skills associated with ACGME competencies, and provided milestone-based evidence that fellows were able to successfully self-assess and plan for practice improvements during subsequent visits.

Implications for Research, Policy, or Practice. A similar rotation highlighting self-reflection and interdisciplinary team exposure can be implemented by other specialties, such as Internal Medicine or Geriatrics, aiming to expose trainees to hospice care, and may be explored by other hospital microsystems.

Characteristics of Persons with Severe Dementia in Home Versus Residential Care Settings (SA527D)



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University of California, San Francisco, San Francisco, CA.

Objectives

- Describe the epidemiology of persons with severe dementia in different care settings.
- Identify specific targets for palliative care for home-dwelling persons with severe dementia and their loved ones.

Original Research Background. We know little about the characteristics and palliative care needs of persons with severe dementia living outside of nursing home settings.

Research Objectives. To describe characteristics of home-dwelling persons with severe dementia compared to those in assisted living or residential care (RC) settings.

Methods. We used data from round 1 of the National Health and Aging Trends Study (NHATS), a nationally-representative in-person survey of 132#community-dwelling Medicare beneficiaries age 65 and older (8,245 participants, response rate 71%). To identify people with severe dementia, we combined the NHATS algorithm validated to identify probable dementia with criteria for FAST stage 6C (difficulty with dressing, bathing, or toileting, and managing medications or finances). We use 132#descriptive statistics to compare demographic and clinical characteristics by setting, comparing home to RC.

Results. Among round 1 participants, we identified 913 with probable dementia and 479 with severe dementia. Among those with severe dementia, 84% lived at home and 16% in RC; proxies responded for 75% of individuals with severe dementia. Compared to RC, a higher proportion of home-dwelling persons with severe dementia were age 85+ (54% home vs. 77% assisted living), male (35% vs. 16%), non-white (50% vs. 21%), and born outside the United States (15% vs. 7%). Home-dwelling persons with severe dementia typically had annual assets of less than \$25,000 (75% vs. 68%) or education less than high school diploma (54% vs. 31%). Clinical characteristics included ratings of poor health (30% home vs. 15% in assisted living), 5+ chronic conditions (34% vs. 24%) and being bothered by pain (71% vs. 55%).

Conclusion. Characteristics of persons with severe dementia differ by residence, where home-dwelling persons have multiple sources of sociodemographic and clinical vulnerabilities.

Implications for Research, Policy, or Practice. This is the first known description of home-dwelling persons with severe dementia in a nationally-representative dataset.