



Sample Workshop Abstract Submission

Religious Conflicts: Decision Making When Religious Beliefs and Medical Realities Conflict (P17)

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Objectives

- Describe the essential aspects of compassionate presence in building a therapeutic alliance with families with strong religious beliefs.
- Utilize practical communication strategies, including a spiritual history, to negotiate discussions involving religious conflicts.
- Describe ways to access a professional chaplain for patient cases involving religious or spiritual beliefs around end-of-life care.

One of the most challenging encounters in medicine for clinicians and families are the ones between healthcare providers whose reality is rooted in science and medical data and patients and family members whose primary reality is rooted in religious beliefs. Researchers have documented that spiritual beliefs are viewed as a key means of coping. Belief in a higher power with the ability to perform miracles is a very sacred aspect of life and spirituality as are other deeply rooted religious beliefs. Thus, conversations about goals of care and prognosis can become adversarial and cause stress to the healthcare team and perhaps undue suffering for the patient. Resolutions often require ethics and legal consults.

Many healthcare professionals believe that resolution of these types of cases requires special skills and time that they do not have. An expressed belief that a miracle or another religious belief will or might occur can arise from several causes, not all of them rooted in religion or spirituality. Thus, it is important for the provider to first determine what the belief means to this particular family through a proper assessment and relationship building. Through didactics, discussion, and use of case examples, this workshop will present practical and time-efficient

processes for forming positive alliances with families who hold strong religious beliefs and are coming to decisions about end-of-life care that respect both the medical realities and the family's religious beliefs. Important elements of this process are respectful attentive listening, a thorough spiritual history, and specific practical communication strategies for aligning with the patient and identifying common goals of care. Differentiating situations truly based on religious issues and situations in which the issues are actually emotional but framed in religious language will be discussed.



Sample Concurrent Abstract Submission

“This Was Not What I Had in Mind,” and Other Palliative Challenges Encountered in Left Ventricular Assist Device (LVAD) Care (TH321)

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Objectives

- Be familiar with current left ventricular assist device (LVAD) technologies, eligibility, complications, and controversies, with specific attention to LVAD use as destination therapy, and cardiology gaps in LVAD management providing opportunities for palliative care collaboration.
- Building from The Joint Commission requirements for LVAD-DT advanced certification and concept of the palliative clinician as learner, develop framework for successful advanced heart failure-palliative care team collaboration through palliative medical and psychosocial assessment and management strategies for patients and family caregivers.
- Strategically develop PC program action items to build close collaboration with advanced heart failure teams at institutional level and supportive care network at local/regional level.

With the evolution and growing availability of mechanical circulatory support (MCS) technology for patients with advanced heart failure come new frontiers for palliative care (PC) teams.

Although data demonstrates that MCS devices, including left ventricular assist devices (LVADs), can improve survival and quality-of-life for patients with advanced heart failure, patients remain at risk for catastrophic events, like stroke or hemorrhage, persistent functional decline, or progression of other life-threatening medical conditions. Among patients receiving LVAD devices as destination therapy (DT), 30% will die within 2 years of implantation. Thus,

PC is increasingly invited by advanced heart failure teams to provide patient and family support, sometimes even prior to implantation. As of October 2014, the Joint Commission on Accreditation of Healthcare Organizations requires PC representation on the core interdisciplinary team for LVAD-DT advanced certification.

How can PC clinicians best navigate these unfamiliar waters? In this concurrent session, clinicians from a multidisciplinary advanced heart failure program will use case studies, clinical literature, and pilot data from this institution's experience to share challenges and solutions supporting patients receiving LVADs as destination therapy and building strong collaborative ties to an advanced heart failure program. Device eligibility, medical complications, and current controversies are introduced by an advanced heart failure specialist. Psychosocial assessment strategies that help risk-stratify patients, advance care planning approaches and challenges, and caregiver burden specific to LVAD therapy, will be described. Finally, presenters will broach challenges to implementing PC principles within an advanced heart failure team and describe opportunities for building bridges toward community-based supportive care networks. Building from the context of the palliative expert as a learner of advanced heart failure therapies, through concrete palliative strategies to meet LVAD patient/family needs, this session will offer clear concepts to facilitate PC program development for the LVAD-DT population.



Sample SIG-endorsed Abstract Submission

Will a Better Mousetrap Help when You Work in a Lion's Den? What is the Role of Abuse Deterrent Pharmaceuticals in Hospice and Palliative Care? (FR460)

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Objectives

- Identify the clinical concerns for the application of abuse deterrent products.
- Describe the currently available and soon-to-be-released abuse deterrent opioid formulations.
- Identify methods of application of abuse deterrent opioids.

Prescription drug abuse and mortality associated with substance abuse is a current national concern in the United States, even in the setting of hospice and palliative care patients. Strategies to prevent opioid abuse include screening for substance abuse, implementing prescription monitoring programs and urine drug screening, and using abuse deterrent pharmaceuticals. Abuse deterrent technologies, including physical barriers, aversion techniques, agonist/antagonist combinations, and modified delivery systems are under active development. The FDA is currently encouraging research on these pharmaceuticals, stating that the development of abuse resistant products is a “high public health priority.” Legislation is being introduced to incentivize pharmaceutical companies to develop new abuse deterrent medications and the National Association of Attorneys General of the United States has requested that the FDA ensure that all generic extended-release opiates have tamper resistant properties, as well. Several concerns exist regarding the mainstream use of these medications, including adverse effects in patients with legitimate pain and suffering, significant increased costs to patients or healthcare organizations, legal liability for prescribers who use non-tamper resistant formulations when an abuse deterrent product is available, and the potential for discouraging the therapeutic

use of opioids. This concurrent session will provide a review of current technologies; the current evidence for their use, benefits, and side effects; and will discuss evolving abuse deterrent methodologies and medications soon to be released. Through historic case examples and a review of the literature, we will discuss patient selection, cost considerations (including insurance and hospice formulary issues), drug availability, and techniques for surmounting clinical difficulties. Patient safety, including the prevention of abuse (a focus of legislation and law enforcement), is an important part of good symptom management. The understanding of abuse deterrent technology as a tool in this effort is essential for hospice and palliative care practitioners.