Wednesday, March 13

8 am—5 pm

**AAHPM & HPNA Preconference Workshops**

**VitalTalk: Intensive Small Group Training—Addressing Goals of Care (P01)**
Renee Claxton, MD MS, University of Pittsburgh, Pittsburgh, PA. Lyle Fettig, MD, Eskenazi Health, Indianapolis, IN. Anthony L. Back, MD, University of Washington, Seattle, WA. Robert Arnold, MD FACP FAAHPM, University of Pittsburgh, Pittsburgh, PA. James A. Tulsky, MD FACP FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

*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

**Hospice Medical Director Update and Exam Prep (P02)**
Ronald J. Crossno, MD FAAFP FAAHPM, Kindred Healthcare, Rockdale, TX. Kathleen Faulkner, MD FAAHPM, Good Shepherd Community Care, Newton, MA. Earl Quijada, MD HMDC FAAHPM, Kaiser Permanente Home Health, Riverside, CA. Patrick White, MD HMDC FACP FAAHPM, BJC Hospice, St. Louis, MO.

*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.

**Community Based Palliative Care: Beyond the Business Case—Operationalizing and Sustaining (P03)**
Bob Parker, DNP RN CENP CHPN CHP, Intrepid USA, Dallas, TX. Lori Bishop, MHA BSN RN CHPN, National Hospice and Palliative Care Organization, Alexandria, VA. Kathleen Kerr, BA, Kerr Healthcare Analytics, Mill Valley, CA. Jean Acevedo, LHRM CPC CHC CENTC AAPC, Acevedo Consulting, Delray Beach, FL.

*Objectives*
- Analyze the value of revisiting the business case.
- Identify one action to evolve your care model for sustainability.
- List three metrics that can be leveraged to demonstrate value.
- List two “successful practices” when providing community-based palliative care services.

This fast-paced and interactive program focuses on operationalizing and sustaining a community-based palliative care program. Whether you are just beginning or a mature program, the content is applicable. Program
delivery model evolution will be discussed, as will use of metrics to demonstrate program value. A panel of experts from mature programs will share their secrets of success. We will explore how key partnerships are essential to sustainability. Finally, a deep dive into reimbursement, including regulatory and compliance considerations and payer/provider relationships completes the conference. Tools and resources will be collected from our faculty and panel to provide each participant with a Playbook for implementing your action plan.

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

Kerstin Lappen, MS ACNS-BC ACHPN FPCN, Minneapolis Oncology, Minneapolis, MN. 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.

**Deprescribing by the Specialists: Best Practices in Drug Therapy in Serious Illness (P05)**

Mary Lynn McPherson, PharmD MA MDE BCPS, University of Maryland School of Pharmacy, Baltimore, MD, Kathryn A. Walker, PharmD BCPS CPE, Medstar Health, University of Maryland School of Pharmacy, Baltimore, MD. Vincent Jay Vanston, MD FAAHPM, University of Pennsylvania Health System, Philadelphia, PA. Jean S. Kutner, MD MSPH, University of Colorado School of Medicine, Aurora, CO. Eric Prommer, MD HMDC FAAHPM, UCLA School of Medicine, Los Angeles, CA. Jessica McFarlin, MD, University of Kentucky College of Medicine, Louisville, KY.

**Objectives**

- Recall best-practice considerations when prescribing and deprescribing medications in serious illness including goals of care, remaining life expectancy and treatment target.
- Discern a consistent process to evaluate the appropriateness of medications for a patient with a serious illness, weighing the benefits and burdens of medication therapy.
- Use a validated approach and evidence where available to lead critical deprescribing conversations to engaging patients, informal caregivers, and healthcare practitioners about “right sizing” the medication regimen in serious illness.

Patients in hospice or receiving palliative care often are found to be receiving numerous medications. While we all agree that deprescribing, in practice, is a good idea, it can be difficult to discern which medications to stop, and at what point in the disease process. This all-day pre-conference will provide guidance to hospice and palliative care practitioners on deprescribing, as taught by experts in each therapeutic area. Learn about slimming down medications for heart disease, COPD, metabolic syndrome, cancer and more. Discontinuation strategies will be covered, and strategies to have those critical conversations with patients, families and other health care providers, including evidence where available.

**8–11:45 am**

**HPM Fellowship Directors Forum: HPM Reporting Milestones and Combined HPM Fellowships—Partnering Among and Within Institutions (P06)**

Toluwalase Ajayi, MD, Scripps Health, University of California/Rady Children’s Hospital, San Diego, CA. Gary T. Buckholz, MD HMDC FAAHPM, University...
of California, San Diego, CA. Laura Edgar, EdD CAE, Milestones Development, ACGME, Chicago, IL. Helen Fernandez, MD MPH, Icahn School of Medicine at Mount Sinai, New York, NY. Jillian Gustin, MD FACP FAAHPM, The Ohio State University Wexner Medical Center, Columbus, OH. Jennifer S. Linebarger, MD FAAHPM, The Ohio State University Wexner Medical Center, Columbus, OH. Zachary Sager, MD MA, PharmD, Ohio State University Wexner Medical Center, Columbus, OH. William Jangro, DO, Thomas Jefferson University, Philadelphia, PA. Justin Kullgren, DO, University of Pittsburgh, Pittsburgh, PA. Julie Childers, MD MS FAAHPM, University of Pittsburgh, Pittsburgh, PA. William Jangro, DO, Thomas Jefferson University, Philadelphia, PA. Justin Kullgren, PharmD, Ohio State University Wexner Medical Center, Columbus, OH. Zachary Sager, MD MA, BIDMC/Boston VA, Boston, MA.

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 every day 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.

Treating Opioid Use Disorder with Buprenorphine: A Course for Hospice and Palliative Care Clinicians (P08)

Julie Childers, MD MS FAAHPM, University of Pittsburgh, Pittsburgh, PA. William Jangro, DO, Thomas Jefferson University, Philadelphia, PA. Justin Kullgren, PharmD, Ohio State University Wexner Medical Center, Columbus, OH. Zachary Sager, MD MA, BIDMC/Boston VA, Boston, MA.

Objectives

- Discuss the medical and psychiatric comorbidities associated with opioid use disorders.
- Diagnose opioid use disorder.
- Select appropriate patients for treatment of opioid use disorder with buprenorphine.

This session prepares physicians, nurse practitioners, and physician assistants to prescribe buprenorphine to treat opioid use disorder, with a focus on the treatment of individuals in outpatient palliative care clinics and in hospice. Additional team members, such as pharmacists and nurses, would also benefit from the information in this session to provide better care to patients with opioid use disorder and other addictions. The curriculum includes the science of addiction as a brain disorder, the pharmacology of buprenorphine, and the regulatory requirements around prescribing this medication. In addition to addressing the management of buprenorphine treatment in the general population, particular attention will be devoted to the special considerations involved in treating opioid use disorder in patients with a life-limiting illness. Attendees will learn to screen patients for treatment with buprenorphine and be able to choose a model for managing the risk of precipitated withdrawal in initiating buprenorphine. Participants...
will learn options for managing pain in patients who are taking buprenorphine for opioid use disorder, both in the inpatient and outpatient setting, as well as in hospice. We will discuss cases that present dilemmas in buprenorphine prescribing particularly relevant to hospice and palliative care, including managing pain crises and transitions to hospice care.

**Improve the Care of Culturally Diverse Patients: Strategies to Address and Navigate the Elephant in the Room (P09)**

Kimberly Johnson, MD MHS, Duke University Medical Center, Durham, NC. Sean O’Mahony, MD MS FAAHPM, Rush University Medical Center, Chicago, IL. Ronit Elk, PhD, University of Alabama, Birmingham, AL. Ruth Thomson, DO MBA HMDC FAAHPM FACOI, Jack Byrne Center for Palliative and Hospice Care, Hanover, NH. Alvin Reaves, MD FACP FAAHPM, MedStar Southern Maryland Hospital, Clinton, MD. Alexis Terry, ASAE, Washington, D.C.

**Objectives**

- Describe the importance of and challenges to discussing cultural beliefs and values when interacting with diverse patients and their families.
- Demonstrate at least 3 culturally-competent strategies that clinicians may use to inquire about and address what matters most to culturally-diverse patients and their families.
- Identify communication “red flags” which suggest that the clinician and patient may not be “speaking the same language” and practice communication strategies to promote shared understanding and improve patient care.
- Describe how principles of conflict management can be used in goals of care discussions to promote acceptance of the beliefs, values, and preferences of diverse patients and families when these beliefs differ from those of the clinician.

Cultural beliefs often shape perceptions of illness, prognosis, and suffering and may inform preferences for end-of-life care. With the increasing cultural diversity of seriously ill patients and their families, clinicians must frequently care for patients whose beliefs, values, and preferences may differ from their own. Studies suggest that both clinicians and patients and their families find these interactions particularly challenging. In addition, diverse patients and families rate the quality of communication lower in these culturally-discordant interactions. As such, intentionally recognizing and addressing the importance of culture is one strategy to promote access to equitable, high quality care for diverse patients and their families. The session will include facilitator-guided experiential, interactive learning with dyads and small groups using a variety of instructional methods, such as videos, role play, teach-back, and Q&A. Participants will observe and practice culturally-competent strategies to: (1) inquire about and explore the cultural beliefs of patients and families, particularly those which guide care; (2) develop shared understanding with patients and work to ensure clinicians and patients are “speaking the same language” in culturally-discordant interactions; (3) manage conflict in a way that promotes clinician’s acceptance of cultural beliefs which impact decision-making and that also facilitates high quality patient care. The session will challenge the beliefs and assumptions which may guide our interactions with culturally diverse patients and their families and help participants to develop a best-practice approach based on current evidence. Following the session, we anticipate that learners will feel more confident inquiring about the cultural ‘elephant in the room’ and recognize the importance of addressing culture in improving the care of diverse patients and families.

**Palliative Nursing Leadership Essentials (P10)**

Constance Dahlin, MSN ANP-BC ACHPN® FPCN FAAN, Hospice and Palliative Nurses Association, Pittsburgh, PA. Patrick Coyne, MSN ACNS-BC ACHPN® FPCN FAAN, Medical University of South Carolina, Charleston, SC.

**Objectives**

- Differentiate Essential Nursing Leadership Qualities.
- Apply 3 areas of palliative leadership.
- Create an action plan of next steps of leadership.

Leadership within palliative nursing is not defined or grounded by level of nursing practice nor education but rather on qualities. 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 such as clinical practice, policy/advocacy, research, education, public health, and metrics. 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; Dahlin and Coyne, 2018; Dahlin, Coyne, Goldberg and Vaughn, 2018). Nurse leaders must 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). More specifically, the nurse leader must first assess their personal leadership capabilities prior to moving towards team development and competence. Through didactic, role play, and interactive media, this session will examine palliative nursing leadership, describe key leadership characteristics, explore leadership possibilities, and create an action plan to move into leadership.

**Succeeding with What You Wished For:**

**Alternative Payment Models and Key Success Factors (P11)**

Torrie Fields, MPH, Blue Shield of California, San Francisco, CA. Allison Silvers, MBA BA, Center to Advance Palliative Care, New York, NY. Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI. Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY. Dana Lustbader, MD FAAHPM, ProHEALTH, New York, NY.

**Objectives**
- Describe how different types of health plans approach payment for palliative care services.
- Describe what process is being followed to develop a serious illness alternative payment model in traditional Medicare, and what palliative care programs must do to be prepared.
- Articulate at least three operational features that are needed to succeed under alternative payment.

The drive towards alternative payment continues across all types of payers, including Medicare, Medicare Advantage, commercial health plans, and Medicaid managed care organizations. Many palliative care programs now have a variety of opportunities to secure payment outside the hospice benefit, beyond traditional fee-for-service reimbursement for physician and advanced practice professional (NP/PA) services. This interactive workshop will help attendees to understand both the opportunities and challenges in alternative payment for community-based palliative care, and to identify strategies that can work for their particular circumstances.

The Workshop is held in four parts. It begins with a review of the current landscape of alternative payment for palliative care services, including an inside look at how two health plans—one commercial and one Medicaid—have developed their payment models, and work with their providers under these new models. The Workshop then continues with a spotlight on an upcoming Medicare alternative payment model, reviewing its history and what is known about its status. Then, with a better understanding of what alternative payment models might be available, the Workshop then turns to what it takes to remain financially-viable under these payment models, which often provide a fixed payment per patient regardless of the service intensity delivered along with an additional payment based on performance on quality measures and/or cost savings. Throughout these sections, attendees will be participating in exercises to think through both the benefits and challenges of alternative payment participation, ending the workshop with a structured exercise to develop strategies and specific next steps for their particular program, drawing on the support of both faculty and fellow attendees. Participants will also leave the session with several take-home tools to enable their ongoing engagement with a rapidly changing payment environment.

**My Life, My Story: Connecting Patients, Providers, and Student Learners with Life Stories (P12)**

Eileen Ahearn, MD, VA Hospital, Madison, WI. Carole Ewald, MSW LCSW BCD, Tomah VA Medical Center, Tomah, WI. Susan Nathan, MD, VA Boston Healthcare System, West Roxbury, MA. Thor Ringler, MFT, Department of Veterans Affairs, Madison, WI.

**Objectives**
- Conduct an interview and write up a first-person narrative based on that interview.
- Explain the difference between a diagnostic interview, a life story interview, and the respective narratives that are written from them.
- Develop an action plan for formalizing a narrative life history interview program at their respective institutions, both VA and non-VA alike.

My Life, My Story is a novel healthcare intervention that interviews palliative care (and other) patients, writes up their stories, and places them in the chart where they are easily accessible to providers. At the VA these stories have become a common thread in the care conversation. They heal:

“Going through this process of writing my life story has helped relieve some of the pain (physical and emotional) but more importantly just when I thought I hadn’t made an impact on anyone’s life, after sharing my story with family/friends, I realize that I did.”

They inform clinical care:

“Yesterday I met with a Veteran who has recently received a terminal diagnosis. He completed his My Story this week, reported it was a powerful experience, and had several copies at his bedside. We used the document not just to look back at his life, but as a way to think through what he feels is most important to do and say in his remaining time.”
And they train future providers:

“I had the privilege to interview a veteran I had worked with earlier in the year at my Psychology rotation, this time in the recovery unit after major surgery. He was beyond touched when I read his story out loud to him. I felt it was something he needed to let out for so long, and he finally did through this project. It was truly a humbling and great learning experience.”

Our interdisciplinary team of co-presenters includes representatives from three institutions and varied disciplines. Attendees will conduct practice interviews and write up stories, understand the difference between diagnostic and life interviews, and develop action plans for formalizing a narrative life history interview program at their respective institutions, both VA and non-VA alike.

1:15–5 pm

HPM Educators Forum: Mentoring Trainees to Produce Scholarly Work—A Roadmap with Expert Guides (P13)

Jane deLima Thomas, MD FAAHPM, Harvard Medical School, Dana-Farber Cancer Institute/Brigham and Women’s Hospital, Boston, MA. Joanne Wolfe, MD MPH FAAHPM, Harvard Medical School, Dana-Farber Cancer Institute/Boston Children’s Hospital, Boston, MA. Christina Ullrich, MD MPH FAAHPM, Harvard Medical School, Dana-Farber Cancer Institute/Boston Children’s Hospital, Boston, MA. Justin Sanders, MD MSc, Harvard Medical School, Dana-Farber Cancer Institute/Brigham and Women’s Hospital, Boston, MA. Laura Morrison, MD FAAHPM, Yale School of Medicine, New Haven, CT. Alexander K. Smith, MD, MS, MPH, UCSF Division of Geriatrics and San Francisco VAMC, San Francisco, CA.

Objective

- Review helpful approaches in mentoring trainees to produce scholarly work.
- Describe best practices for producing each of four types of scholarly work: case/scientific abstracts, poster presentations, lectures, and written work for publication.
- Practice editing and strengthening scholarly works with the aid of expert guidance, faded examples, and group discussion.

A core task for faculty in academic palliative care programs is mentoring trainees in producing scholarly work, such as abstracts, posters, lectures, and publications. Not all faculty have received formal instruction in producing academic work themselves, however, and only a subset of them have received guidance about mentoring others for scholarly productivity.

This interactive preconference will provide participants with expert guidance in mentoring trainees to produce scholarly work. Participants will identify challenges in mentoring trainees to produce scholarship and then discuss best practices in doing so, including providing mentees with opportunities for scholarship, providing constructive guidance and editing, balancing redirection with taking over, and deciding authorship. Presenters will provide roadmaps for preparing each of four types of academic work: scientific/case abstracts, poster presentations, lectures, and written work for publication. Presenters will also provide cases to work through, giving participants an opportunity to use guidelines to edit and strengthen sample works. Participants will leave the session with a deeper understanding of what comprises high-quality scholarship, and how to mentor trainees successfully through the process of producing it.

AAHPM Leadership Forum: Ignite—Woke Up One Day to Find Out I’m In Charge—Practical Tips for Early Stage Leaders in Hospice and Palliative Care (P14)

Ellissa Tiller, MD CPE FAAHPM, Medical Affairs, Hope West, Grand Junction, CO. Jacob J. Strand, MD FACP FAAHPM, Mayo Clinic Center for Palliative Medicine, Rochester, MN. Kevin Nguyen, MD, Kaiser Permanente, Oakland, CA. Christina Rowe, MSOL, The Collaborative LLC, Denver, CO.

Objectives

- Learn how to develop a functional team, starting with building trust.
- Use identified strengths to develop a plan for translating their vision into an operational strategy, including obtaining buy in.
- Discuss practical tips to improve communication and give appropriate feedback to direct reports that empowers rather than discourages.

Hospice and palliative care is a rapidly growing field with increasing demand for the growth of clinical services. Palliative care and hospice physicians are often thrust into leadership roles with minimal leadership experience and limited resources for leadership training and advancement. This program will allow participants to explore vision, strategy and operations as it applies to leadership in different levels of the organization as well as from the perspective of their own strengths. Three leaders who have experienced common challenges such as 1) translating a vision through the lens of institutional priorities, 2) developing teams, both established teams and teams needing to be created and 3) giving appropriate feedback will guide participants and provide a framework throughout the session. An experienced leadership and strength-based coach
will provide additional perspective and assistance to the challenges participants are facing as leaders. During the program, practical take-home tips will be shared so that participants come away from the session ready to develop a strategy for leading in their organization. Just as importantly, common day-to-day strategies for surviving and thriving in a leadership position will be explored.

**Objectives**

- Identify common sources of drug diversion in hospice and palliative care.
- Employ practical strategies for dealing with missing medications and suspected diversion.
- Modify policies and practices to help prevent drug diversion.

Hospice and palliative care providers are touted as experts in pain and symptom management. They are also known for liberal opioid prescribing practices, which is appropriate given the challenges of managing progressive terminal illness. A large majority of hospice and palliative care patients (>90%) are prescribed a controlled pain medication and many are given multiple narcotic medications for the purposes of symptom management. Many hospice and palliative care patients receive care at home. When at home, family caregivers often manage and administer patient medications. Prescription pain medications in the home are a well-known entry point for unauthorized family members or visitors to begin experimenting with addictive substances. Furthermore, patient medications are also at risk for diversion if family members have a prior history of misuse or addiction. Hospice and palliative care providers, however, have struggled with how to identify and care for patients and families who are at risk for substance misuse or addiction. Preventative strategies are vital to stem the burgeoning epidemic of opioid misuse, addiction, and overdose.

Within the context of hospice and palliative care context, key prevention strategies include vigilant prevention of diversion through consistent assessment of substance use history within the home, background checks for new hospice hires, thorough medication surveillance (e.g., routine pill counts), and effective drug disposal procedures.

This presentation uses fresh data from hospice and palliative care providers (collected summer of 2018) to inform cutting-edge strategies for detecting, addressing, and preventing drug diversion. After participating in the workshop, attendees will be able to: (1) identify common sources of drug diversion in hospice and palliative care; (2) employ practical strategies for dealing with missing medications and suspected diversion; and, (3) modify policies and practices to help prevent drug diversion.

**Improve the Quality of Care—A Practical Quality Improvement Skill-Building Workshop (P16)**

Kara Bischoff, MD, University of California, San Francisco, San Francisco, CA. Amy L. Davis, DO MS FACP FAAHPM, Drexel University, Philadelphia, PA. Susan DeSanto-Madeya, PhD APRN, Boston College Connell School of Nursing, Boson, MA. Arif Kamal, MD MBA MHS, Duke University, Durham, NC. Kelly L. Wu, MD FAAP, Mayo Clinic, Phoenix, AZ. Barbara Messinger-Rapport, MD CMD HMDC FACP, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, Cleveland, OH.

**Objectives**

- Define a practical, adaptable framework for quality improvement projects.
- Apply the quality improvement framework to a real-world quality improvement project relevant to the field of Hospice & Palliative Medicine.
- List common challenges encountered in quality improvement work and consider ways to overcome these challenges.

Hospice and palliative care teams are increasingly expected to engage in quality improvement activities and demonstrate the value of their work for the purposes of sustaining their services, accreditation, and reimbursement. Despite this, many hospice and palliative care clinicians have not had sufficient training in quality improvement methods and/or would benefit from ongoing support for this important aspect of their work. In this practical quality improvement workshop, presenters will provide participants with an adaptable framework for quality improvement initiatives. We will present this framework in brief didactic modules, incorporating examples from successful quality improvement projects. The majority of the workshop will be spent in moderated small group exercises that will give participants an opportunity to apply, with guidance from quality improvement experts, quality improvement methods to real-world projects relevant to the field of hospice and palliative care. Participants will also have an opportunity to share challenges they have encountered while engaging in quality improvement work and receive advice for overcoming these hurdles. The goal of this preconference workshop is to empower participants to conduct successful and sustainable initiatives that truly improve the quality, safety, and value of care.
It is appropriate for everyone, from quality improvement novices to experienced practitioners.

**Personal Resilience and Sustainability 2019: Tools for Happiness in a Complex Environment (P17)**

Katy Lanz, DNP AGPCNP-BC ACHPN FPCN, Aspire Health, Pittsburgh, PA. Nancy O’Brien, BS BA, Experience Happiness, LLC, Minneapolis, MN. Linda Saggau Experience Happiness, LLC, Minneapolis, MN.

**Objectives**
- Distinguish the links between happiness, well-being, engagement, and performance.
- Recognize the physical, emotional, and behavioral toll of unhealthy stress & burnout and why self-care is essential to wellbeing.
- Improve individual levels of resilience and sustainability through redefining happiness as an authentic, inside-out state that can be cultivated with practice.

The magnitude and impact of stress and burnout have received much attention from researchers, however, evidence-based solutions to effectively and measurably address it have not been widely available until now. This ½ day pre-conference is designed to provide learners with the resources to build a high-performance culture of wellbeing by equipping participants with transformative life practices to reduce unhealthy stress and burnout and its physical, emotional and behavioral effects, while simultaneously increasing happiness and its byproducts—including engagement, resilience, innovation, sustainability and performance.

**Oncologist in My Pocket: What the Hospice & Palliative Clinician Needs to Know About Hematology/Oncology and Radiation Oncology (P20)**

Kristina Newport, MD FAAHPM, Penn State Health and College of Medicine, Hershey, PA. Shanthi Sivendran, MD, Penn Medicine at Lancaster General Health, Lancaster, PA. Joshua Jones, MD MA, University of Pennsylvania Health System, Philadelphia, PA. Thomas LeBlanc, MD MA MHS FAAHPM, Duke University School of Medicine, Durham, NC.

**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.
- List chemotherapy-related most common toxicities, and management.

Care of adult patients with hematologic or oncologic malignancies is increasingly complex. Hospice and palliative care (HPC) clinicians are increasingly asked to care for them, given the growing evidence that early palliative care improves survival, symptoms, mood, cost, and patient satisfaction. To ensure success of upstream involvement, HPC clinicians must be equipped to competently care for these patients and “speak the language” of the hematologist/oncologist and radiation oncologist, particularly in the outpatient setting. This workshop will provide HPC clinicians the essentials needed to approach the care of these patients, including: terminology, treatment options, prognostic uncertainty, targeted therapies, immunotherapy, hematology/oncology emergencies, financial toxicity, radiation therapy, caregiver support, expected side effects of treatments, models of implementation 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 third generation workshop builds on the well-attended 2017 & 2018 sessions 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.

**Whoa, This Patient Is How Young? Strategies for Adult Providers Caring for Pediatric Patients (P21)**

Patricia Keefer, MD, University of Michigan, Ann Arbor, MI. Lisa Humphrey, MD, Nationwide Children’s Hospital, Columbus, OH. Elissa Miller, MD, Nemours/Alfred I. duPont Hospital for Children, Wilmington, DE. Michael Barnett, MD MS FACP FAAP FAAHPM, UAB/Children’s of Alabama, Birmingham, AL. Adam Marks, MD, University of Michigan, Ann Arbor, MI. Kristen Moyer Nationwide Children’s Hospital, Columbus, OH.

**Objectives**
- Describe the significance and an approach to prognostic uncertainty in pediatrics.
- Apply established communication approaches to pediatric patients and demonstrate approaches unique to this population.
- Identify three modifications to enhance care for pediatric patients within the traditional hospice service model.

Pediatric palliative care is a limited resource outside of academic centers. Pediatric patients and their families, however, may live in diverse geographic
locations, remote from their subspecialty medical home. This challenge is well-recognized among pediatric providers, but current projections and care extensions are unlikely to meet this demand as the population of medically fragile children continues to grow. To fill this need, many adult-focused hospice and palliative medicine (HPM) providers are asked to use their palliative skill set to care for these patients. This necessitates HPM providers to gain comfort and competency in the care of pediatric patients and their families as well as the ability to lead interdisciplinary teams in this work. This workshop is designed as a succinct primer for adult providers in the community with an additional focus on trainees who have limited exposure to pediatrics. Highlighted topics include prognostication, communication, hospice challenges, inpatient palliative care strategies, and ethical dilemmas in pediatrics. Through didactics, case presentations, and group activities, presenters will highlight the similarities between adult and pediatric palliative management and to provide effective pediatric specific tools and resources in the areas where the two practices diverge.
Thursday, March 14

7–8 am

Concurrent Sessions

Palliative APRN Fellowship Guidelines—A Strategy for Quality Specialty Practice: Report of the HPNA APRN Fellowship Council (TH300)
Constance Dahlin, MSN ANP-BC ACHPN FPCN FAAN, Hospice and Palliative Nurses Association, Pittsburgh, PA. Dorothy Wholihan, DNP AGPCNP-BC ACHPN FPCN, NYU College of Nursing, New York, NY. Marianne Johnstone-Petty, MSN FNP-C ACHPN, Providence Medical Group, Anchorage, AK.

Objectives
- Discuss the current HPNA standards for Fellowships.
- Describe core components of Palliative Care APRN Fellowships.
- Delineate the pertinent aspects of program development, curriculum, and competencies for Palliative APRN Fellowships.

With the United States population of 375 million and some 5 million licensed health care providers, there is a significant shortage of providers. There are estimates of a shortfall of at least 7,000 – 10,000 of specialty palliative providers. New models must be created to expand palliative education of qualified providers. Currently there are only approximately 6 Palliative APRN fellowships with the plan to develop a few more. Ensuring adequate education and training of clinicians is not a simple task. Currently most Palliative APRN fellowships have developed out of physician fellowships. While this has been successful in terms of content, the challenge is to ensure has been to ensure adequate APRN role development, reflection of hospice and palliative nursing and its significant role in the development of hospice and palliative care in the United States as well as nursing literature in the curriculum. Moreover, competencies must be grounded in nursing practice. This session will summarize the work of the HPNA Fellowship Council which has created Palliative APRN Fellowship Guidelines.

Moving Advance Care Planning Upstream: ACP Goes to the Community (TH301)
Seiko Izumi, PhD RN FPCN, Oregon Health & Science University, Portland, OR. Carey Candrian, PhD, University of Colorado School of Medicine, Aurora, CO. Hillary Lum, MD PhD, University of Colorado School of Medicine, Aurora, CO. Janice Bell, PhD MN MPH, University of California, Davis, Sacramento, CA. Cynthia Carter Perrilliat, MPA, California State University East Bay, East Bay, CA. Kate DeBartolo, BA, Institute for Healthcare Improvement, Boston, MA. Rebecca Sudore, MD FAAHPM, UCSF & San Francisco VA, San Francisco, CA. Sarah Hooper, JD, UCSF/UC Hastings Consortium on Law, Science & Health Policy, San Francisco, CA.

Objectives
- Describe innovative approaches of community-based advance care planning including target populations, team members, settings, and strategies.
- Identify characteristics of different approaches that facilitate or hinder advance care planning in the community.
- Select appropriate strategies to facilitate advance care planning conversations that meet the needs of diverse communities and vulnerable populations including people with limited health literacy and English proficiency, older adults, LGBTQ individuals.

Advance care planning (ACP) is a process that supports people in understanding and sharing their personal values, life goals, and preferences regarding future care. While clinicians recognize the importance of ACP conversations earlier in illness trajectory and before a medical crisis, there is a need for programs to initiate and support early ACP conversations in the community and outside of a hospital setting. In this session, through high-yield IGNITE-style presentations, we will share six innovative approaches to promote early ACP outside of the hospital setting: (1) ACP classes in outpatient clinics for patients, families and people in the community; (2) community-based advance care planning certification with volunteers from vulnerable populations; (3) Alameda County Care Alliance (ACCA) faith-based care navigation intervention for advance care planning in denominationally diverse African American churches; (4) the Conversation Project to reach the public where they live, work, and pray; (5) PREPARE easy-to-read advance directives in multiple languages and the ACP PREPARE Movie Toolkits used in group visits, libraries, and senior centers; and (6) medical-legal partnerships to address health equity in ACP through comprehensive legal planning. For each approach, we will discuss specific characteristics and strategies for implementation and sustainability, challenges, and successes. At the end, presenters and audience will engage in discussions concerning how to create a cultural shift and to promote early ACP in their communities. To support dissemination and spread, resources and tips for implementing each innovative community-based ACP approach highlighted in this session will be available at www.ColoradoCarePlanning.org.
**Symptom-Driven Antibiotic Use: A Tool to Promote Antibiotic Stewardship in End-of-Life Care (TH302)**

Molly Sinert, PharmD, Optum, Montgomery, AL.

**Objectives**
- Evaluate benefits versus risks of antibiotic therapy in end-of-life care.
- Identify opportunities for end-of-life care providers to contribute to global antibiotic stewardship efforts and improve patient care.
- Describe an approach for optimizing antibiotic use for symptom relief of infections and documenting in the plan of care.

Responsible antibiotic prescribing is paramount to the success of global antimicrobial stewardship efforts. Hospice-based studies report antimicrobial use ranging 8-37%, but inappropriate and unnecessary antibiotic prescribing in end-of-life is poorly defined. Healthcare providers have limited guidance regarding the utilization of antibiotics in end-of-life care. According to the Centers for Disease Control, up to 50% of antibiotic use is classified as inappropriate in both inpatient and outpatient care settings, while nearly 75% of nursing home is reported to be inappropriate. Further, at least 30% of outpatient antibiotic treatment courses are deemed unnecessary. Hospice and palliative care providers have a responsibility to further define appropriate use of antibiotics based on symptom management and quality of life goals. 

Antibiotic stewardship has rapidly grown across all healthcare settings, including those serving the hospice and palliative care patient population. Improvements in antibiotic prescribing, to ensure patients receive the right antibiotic for the right indication, dose, and duration, promotes the underlying principles of effective antibiotic stewardship. In end-of-life care, conventional measures for determining antibiotic appropriateness must be considered; however, appropriateness should be weighed against anticipated symptom benefit versus side effect burden. Antibiotic prescribing in end-of-life care should also factor in the patients’ overall prognosis and each individual’s goals of care. Responsible antibiotic prescribing coupled with palliative care principles will positively contribute to global stewardship efforts and improve individual patient care and quality of life. This concurrent session will review the current landscape of antibiotic use and associated outcomes in end-of-life care, illustrate the relationship between palliative care and antibiotic stewardship (including review of new long-term care requirements), and describe how to integrate principles of palliative care with antibiotic use to improve symptom management. Clinical case scenarios will be used to demonstrate an approach for implementing symptom-driven antibiotic use, across all healthcare settings, for end-of-life patients.

**Blueprint for a Palliative Advanced Practice Registered Nurse Fellowship (TH303)**

Anessa Foxwell, MS RN, Hospital of the University of Pennsylvania, Philadelphia, PA. Barbara Reville, DNP ACHPN NP, Dana-Farber Cancer Institute, Boston, MA. Sheryl Cosme, DNP RN-BC, American Nurses Credentialing Center, Arlington, VA.

**Objectives**
- Describe the landscape of advanced practice fellowships in palliative and non-palliative nursing.
- Examine blueprint for palliative APRN fellowship design.
- Evaluate feasibility and readiness to start a fellowship at home institution using an interactive process.

As Americans age they are developing an ever-increasing frequency of complex co-morbid medical conditions. In order to care for seriously-ill and dying Americans, there is a critical need for palliative care (PC) specialty-trained advanced practice registered nurses (APRN). Unfortunately, there is minimal PC content integrated within undergraduate and graduate nursing academics. Moreover, post-graduate residencies or fellowships in palliative nursing are extremely limited. Fellowships for APRNs have begun to emerge across many specialties, including oncology and critical care. These training programs provide successful models for clinical immersion and mentorship that launch careers for new-to-practice clinicians, as well as practitioners transitioning into new specialties. In PC training, there is a disparity between the number of hospice and palliative medicine fellowships and the handful of fellowships offered for palliative APRNs. There is opportunity for collaboration and sharing of resources to expand these existing programs into rich, interprofessional fellowships with the goal of growing the PC workforce. However, guidance in developing or revising curricula to train the palliative APRN is lacking.

In this session, attendees will review frameworks for APRN fellowships both within and outside our PC specialty. Faculty—including one palliative APRN fellowship director, one palliative APRN, and one Accreditation Program Director at the American Nurses Credentialing Center—will review the landscape of advance practice fellowships. Faculty will also share lessons learned to help PC educators who are eager to design programs. This blueprint includes the necessary infrastructure, stakeholders, professional standards, opportunities for funding, curricula, and competency evaluation to build a fellowship. Attendees will be tasked to review the status of each domain in their home institution and assess readiness to support a fellowship using a case study and evaluation tools. Eventually, these pioneering efforts will grow into more programs at which point an
accreditation process to distinguish quality programs will be necessary.

**Filling Big Needs in Big Areas (TH304)**
Andrew Esch, MD MBA, Center to Advance Palliative Care, New York, NY. Tammy Stokes, BSN RN CHPN, Maury Regional Medical Center, Columbia, TN.

**Objectives**
- Describe the essential aspects of delivering high quality palliative care to underserved rural communities.
- Utilize innovative yet practical staffing, outreach, identification, and training strategies to overcome challenges in delivering high quality palliative care in rural communities.
- Describe ways to increase access to high quality hospice and palliative care in rural communities. Discrepancies between needed and received hospice and palliative care services exist everywhere. Access to high quality, timely, and effective palliative and hospice care is an even bigger challenge for seriously ill residents of rural communities. Small rural hospices have decreased in numbers over the last 10 years, but they are often the only hope for residents of these communities to have their suffering addressed. Even with the support of their communities, challenges for these hospices include geographic spread of patients, lack of hospitals and other community services, transient medical providers (many work off loan forgiveness and move on), lack of support services, and little access to mental health services. An example is Orleans County, which covers 391 square miles in northwestern New York. Its population is approximately 43,000; roughly 18 percent live below poverty level, and almost 15 percent are older than 65. The number one employer is Walmart. Another example is Maury Regional Medical Center, which serves a population of more than 250,000 people in six rural Tennessee counties. How can hospices or regional health systems such as these provide high quality palliative care to rural areas in a cost effective and sustainable way? How can they get access to highly trained, board certified clinical staff in the face of a national workforce shortage? How are patients identified, who sees them and how often? In this interactive session, representatives from a small hospice and a regional health system will share their own experiences and present practical and replicable processes for overcoming the challenges facing rural communities in finding and caring for their seriously ill—implementing innovative workforce strategies, leveraging technology, developing a proactive educational plan for training staff and onboarding new hires, and utilizing community outreach strategies to find and serve patients who may be suffering.

**Guiding Families to Mindfulness Supports Decision Making for Adults and Children (TH305)**
David Steinhorn, MD FAAP FAAHPM, Children’s National Medical Center, Washington, DC. Jana Din, BA, Teaching Credential, Tao Center for Healing, Sacramento, CA.

**Objectives**
- List at least three ways to help individuals/families achieve mindfulness.
- Identify three ways in which indigenous and first nation people view illness and healing.
- Experiential exercise using traditional methods for creating mindfulness.

**Background.** Mindfulness-based techniques focus one’s attention on the moment, acknowledging feelings, thoughts, and sensations. Meditation, devotional prayers, guided imagery create an inner space where new wisdom may be gained. Mind-body approaches commonly achieve a tranquil inner state in which new insights may ‘appear’ to patients, family members, or caregivers. A priest, rabbi, shaman, or integrative healer can guide people to a mindful state when the patient is too ill to actively participate. This state can aid patients/families in making difficult decisions regarding healthcare, especially in those world cultures which do not easily embrace Western cognitive behavioral approaches to decision making.

**Methods.** Journeying into one’s inner self, i.e. becoming mindful of the moment, is facilitated in many cultures through the use of a sonic drive such as drum to focus the attention and achieve a tranquil inner state. In this state, one becomes open to new insights, visions, understandings, epiphanies, and information that may not be accessible in our usual state of awareness and inner talking.

**Results.** We have conducted dozens of mindful journeys with patients and their families over the last few years. Families report new insights/understanding during the process and achieve new clarity on what decisions they feel they need to make. No negative psychological events occurred. Several patients were critically ill, terminally ill or legally brain dead. Families found the experience comforting, reassuring, and helpful in achieving insights they were not able to achieve with conventional Western approaches. Our work supporting patients’ spiritual healing needs was featured on a national public television segment, Healing Quest. Workshop attendees will have an opportunity to experience this process to understand how it may benefit their patients.

**Summary.** Our experience guiding patients and families to mindfulness will be shared with the attendees through this experiential session.
**Level Up: The Utility of the “Advanced Comfort Kit” at End of Life in the Pediatric Population (TH306)**


**Objectives**

- Recognize pediatric palliative care diagnoses and symptomatology that may require advanced symptom management at the end of life.
- Understand the different mechanisms of action of the varied drug options considered for use at pediatric end of life.
- Develop a multifactorial end of life care plan for pediatric patients in the outpatient hospice or inpatient setting.

Although evidence-based guidelines exist for pain and symptom management and palliative sedation at the end of life, many pediatric cases exhibit refractory symptoms that require a multimodal approach to facilitate a comfortable death. Researchers have documented that the etiology of refractory symptoms tend to be overlapping and variable. These refractory symptoms can include physical, emotional, and existential suffering. Clinical practice patterns have illuminated the need for an innovative approach to pediatric end of life management. Providers should be knowledgeable and flexible in their approach of advanced symptoms at the end of life. A multidisciplinary approach that includes anticipatory planning and access to resources in the face of refractory symptoms at the end-of-life in any setting is also crucial for success.

Many pediatric palliative care (PPC) providers express some distress with managing refractory symptoms at end of life when the cause of the escalating symptoms is not clear-cut and the dosing of medications is atypical. The differing levels of resources and support in the home hospice setting make this situation particularly challenging. As a result, it is important for PPC providers to learn from the experiences and resource utilization from their colleagues. Through the use of didactics, case examples and discussions, this workshop will highlight a practical and step-wise approach to refractory symptom management at pediatric end of life. Practical elements of this process will include a case based review of pain and symptom assessment, a review of pharmacologic tools and mechanism of action, a step-wise approach for pharmacologic escalation in responsive to refractory symptoms, and resource utilization in both the inpatient and home hospice settings. This workshop will also highlight how PPC providers can support one another during and after the emotionally, physically, and morally charged management of these refractory symptoms.

**Surgical and Perioperative Palliative Care: Updates from 2018 (TH307)**

Ana Berlin, MD MPH FACS, Rutgers New Jersey Medical School, Newark, NJ. Christopher Woodrell, MD, Icahn School of Medicine at Mount Sinai, New York, NY. Rebecca Aslakson, MD PhD FAAHPM FCCP, Stanford University School of Medicine, Stanford, CA. Miriam Arnheim, MSW LCSW ACHP-SW, University Hospital, Newark, NJ.

**Objectives**

- Cite recently published literature on evidence and best practices 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.
- Describe the application of surgical palliative care research and its impact on patient, family, and caregiver outcomes using concrete examples.

Recent years have seen rapid expansion of the evidence base supporting the implementation of palliative care programs across health systems, ranging from the community to the intensive care unit. Surgical patients face uniquely complex decisions, significant symptom burden, and prognostic uncertainty, and their needs warrant surgery-specific palliative care delivery. Different models have been developed to address these needs, including communication training for surgical providers, embedded inpatient and outpatient surgical palliative care programs, improved prognostication models, and advanced care planning interventions. The core principles of surgery and anesthesiology closely mirror those of palliative care, and the intersection between them is characterized by an increasing annual volume of emerging research. This session will summarize landmark peer-reviewed papers on surgical palliative care published in 2018. The authors will search PubMed and hand-review key journals in surgery, anesthesiology, critical care, and palliative medicine to identify and select articles for inclusion based on journal impact factor and broad interest to the AAHPM/HPNA audience. Using a case-based format to provide clinical context, the panel will present literature drawn from the following topic domains: communication around surgical decision-making, frailty and surgical risk assessment, perioperative advanced care planning, specialty palliative care triggers and delivery models for surgical patients, innovative caregiver and...
Introduction to a Novel Palliative Care Intervention for Family Caregivers of Children and Adolescents Living with Rare Diseases (TH308)
Sarah Friebert, MD FAAFP FAAHPM, Akron Children’s Hospital, Akron, OH. Karen Fratantoni, MD MPH, Children’s National Medical Center, Washington, DC. Lori Wiener, PhD LCSW, National Cancer Institute, Bethesda, MD. Jennifer Needle, MD MPH, University of Minnesota, Minneapolis, MN. Jamie Fraser, MD PhD, Children’s National Medical Center, Washington, DC. Jessica Gaines Children’s National Health System, Washington, DC. Melissa Alderfer, PhD, Nemours Children’s Healthcare System, Wilmington, DE. Maureen Lyon, PhD, Children’s National Health System, Washington, DC.

Objectives
- Establish the need for a family caregiver intervention for parents of children with rare diseases.
- Introduce the intervention and its components.
- Disseminate findings from the piloting of this intervention.

In the U.S. a rare disease is defined as a condition affecting fewer than 200,000 persons. Pediatric patients with rare diseases experience high mortality. Pediatric advance care planning (pACP), a key component of pediatric palliative care, has been proven to improve communication and spiritual and emotional well-being for children with cancer and HIV and their families. For providers, pACP involves preparation and skill development to facilitate discussions about goals of care and future medical care choices. Due to the uncertainty surrounding a rare disease diagnosis, social isolation and the likelihood of parents being asked to make complex medical decisions for their child, rare diseases exact a severe emotional toll on families. There is an urgent need for interventions to ease the suffering of these families, yet few empirically validated interventions exist to address these issues. Moreover, children with rare diseases are a heterogeneous group who because of co-morbidities are often excluded from research, thereby creating a health disparity. Available research lacks scientific rigor. Our consultation with families of children with rare diseases and with the National Organization for Rare Disorders revealed that basic palliative care needs should be addressed prior to a pACP intervention. Thus, we pilot tested the innovative FACE-Rare intervention, integrating two, previously adapted for pediatrics, evidence-based interventions: Carer Support Needs Assessment Tool (Sessions 1 & 2) plus Respecting Choices (Sessions 3 & 4). For acceptability, feasibility and safety purposes, we pilot tested the 4-session intervention, conducted exit interviews, baseline and 2-week post-intervention assessments. This session will review the existing research on the palliative care needs of family caregivers of children with rare diseases, introduce this innovative intervention and its components, disseminate findings from the beta testing and pilot testing, and discuss future directions for research. Video clips will also be presented.

Tear Down the Wall and Build a Bridge: Understanding Latino Cultural and Spiritual Values to Enhance the Delivery of Palliative Care in the Latino Population (TH309)
Sandra Alvarez, MD FAAFP, Orlando Veterans Administration Medical Center, Orlando, FL. Sara Munoz-Blanco, MD FAAFP, Johns Hopkins Hospital, Baltimore, MD. Mayra Sanchez, MD, Scripps Health, San Diego, CA. Perla Macip, MD, Boston Medical Center, Boston, MA. Jose Fernandez, MD FAAHPM, Chapters Healthcare, Temple Terrace, FL. Lissa Berroa-Garcia, MD, Holy Cross Home Care and Hospice, Silver Springs, MD.

Objectives
- Illustrate the complexity of Latino cultural constructs and its impact on the delivery of palliative care services.
- Explore Latinos’ perceptions and barriers to seeking palliative care services.
- Appraise how integrating culturally sensitive education could help improve palliative care for Latinos.

The Latino population is currently the largest minority group in the United States and is expected to double by the year 2050. The goal of palliative care is to alleviate physical, psychological, and spiritual pain and suffering. Health systems have an ethical responsibility to provide this service; however, Latinos face significant health disparities and are less likely to receive palliative care in comparison to non-Latino whites. A narrative literature review was conducted to identify unique characteristics, other than language, that contribute to this inequality. Even though Latinos represent a heterogeneous group, they share distinct cultural values, beliefs, attitudes and...
Emergency Department Admission Triggers Sustainably Generate High-Value Palliative Care Consultations (TH310A)

David Wang, MD, Scripps Health, San Diego, CA. Ryan Heidt, MHA, Scripps Health, San Diego, CA.

Objectives
- Describe how admission triggers can be implemented in the ED to effectively facilitate earlier palliative care consultation during the inpatient course.
- Demonstrate that specificity in trigger design can capture high value consultations while maintaining sustainable workflows.

Background. Capturing admitted patients for palliative care (PC) consultation earlier in their hospital course helps achieve better alignment with the quadruple aim. Emergency department (ED) admission triggers have been proposed to facilitate earlier engagement, however their impact is not adequately studied.

Aim Statement. Demonstrate that specific admission triggers can generate early palliative care consultations directly from the ED while maintaining sustainable workflows.

Methods. ED admission triggers were derived from literature review and prior quality improvement initiatives. Only three criteria were implemented to ensure actionability and sustainability: presence of serious illness, chair/bedbound >50% of time, and unsurprised if the patient dies this hospitalization. Eligible patients met all three criteria. Any ED interdisciplinary staff could identify eligibility. After verifying, the emergency physician coupled the admission with a “heads-up” PC consult. PC evaluated the patient within 24 hours; they were not expected to call back or come to the ED. High specificity enabled the mature PC consult team to prioritize their fully-stretched resources. Institutional alignment acquired from all stakeholders (ED, ICU, hospitalists, administration) designated this workflow as “standard of care.” Data from 03/2018-06/2018 were tracked through the Palliative Care Quality Network registry.

Results. ED-initiated consults during this four-month pilot increased 180% year over year (50 vs. 18, p=0.000). Compared to usual PC consults, ED-initiated consults were comparable in age, gender, and palliative performance scale; however, they had significantly shorter median length of stay prior to consultation (0 days vs. 4 days, p=0.000). Among live discharges, more ED-initiated consults received hospice services (51% vs. 38%, p=0.148). Eight planned admissions were avoided. Overall PC consult volume remained proportionately steady, although 21% now originated from the ED. ED-initiated consults were evenly distributed across weeks. Stakeholders valued this new workflow and approved continuing as “standard of care.”

Conclusions and Implications. Emergency department admission triggers can effectively and sustainably drive earlier palliative care consultation to achieve the quadruple aim.

Opioid Risk Stratification in an Outpatient Palliative Care Clinic (TH310B)

Isaac Chua, MD, Dana-Farber Cancer Institute, Boston, MA.

Objectives
- Explain why opioid risk stratification is important within the outpatient palliative care population.
- Interpret the results of a statistical process control (SPC) chart and understand when to consider using a SPC chart for a QI project.

Background. Approximately a quarter of patients in academic cancer centers are at high risk for opioid abuse. At Dana-Farber Cancer Institute, we sought to create a high-reliability process within our palliative care clinic that risk stratifies our patients for opioid abuse using the Opioid Risk Tool (ORT).

Aim Statement. Our aim was to increase ORT completion rate from 0% to 70% for eligible new consults.

Methods. Our primary outcome measure was the percentage of ORT completed among eligible consults. Eligible consults were defined as new consults seen in the outpatient palliative care clinic who were prescribed opioids by their oncologist or palliative care provider. Charts were audited retrospectively to determine if the ORT was completed. We used a statistical process control (SPC) chart to track percentage of completed ORT over time and to differentiate between special cause and common cause variation. We implemented multiple Plan-Do-Study-Act (PDSA) cycles that included clinician education about ORT.
Assessing End-of-Life Care Quality Across Settings in an Integrated Healthcare Delivery System (TH310C)
Margaret Wang, PhD MPH, Kaiser Permanente, Oakland, CA. Daniel Johnson, MD FAAHPM, Kaiser Permanente, Aurora, CO. Helene Martel, MA, Kaiser Permanente, Oakland, CA. David Glass, PhD, Southern California Permanente Medical Group, Pasadena, CA. Jim Bellows, PhD, Kaiser Permanente, Oakland, CA.

Objectives
- Describe the development and testing of a patient- and family-centered end-of-life care survey to strengthen the evaluation of quality of end-of-life care across a large and diverse integrated delivery system.
- Discuss how insights from the survey can be used to promote and guide quality improvement.

Background. Kaiser Permanente has implemented programs aiming to improve care at the end of life. To better understand patient care experience, we adapted existing instruments to develop and test a survey assessing quality of end-of-life care (EOLC) across all care settings.

Aim Statement. To assess the feasibility and value of using the KP EOLC Survey across an integrated delivery system.

Methods. Survey domains were prioritized through a key stakeholder consensus building process. We scanned relevant literature on EOLC quality measurement and adapted items from validated instruments that mapped to each prioritized domain, drawing primarily from the VA’s Bereaved Family Survey (BFS). We conducted cognitive testing of drafted instrument on next-of-kin (NOK) respondents of deceased KP members. The final survey was administered via mail and followed up by telephone outreach to NOK respondents six months after decedent’s death date.

Results. 2,701 surveys were completed (25.6% response rate). Respondents were similar to non-respondents in decedent’s age, gender, and clinical profile. Respondents were mostly family members (85%) and reported being familiar with decedents’ health issues and treatment decisions (88%) and had discussed EOLC preferences with decedents (84%). Overall care in the last month of life was rated “excellent” by 53% of respondents and varied across regions and care settings. Eighty-eight percent of respondents agreed that KP gave care and treatment concordant with decedent’s wishes and 78% reported decedent passed away in preferred setting. Regional leaders are using survey results to inform quality improvement.

Conclusions and Implications. The KP EOLC Survey was acceptable to family members and yielded response rates comparable to those reported in the literature. It provided valuable patient-centered information about EOLC outcomes across settings. Further assessment of survey psychometrics is warranted, and strategies to incorporate regular administration of the KP EOLC Survey across the organization are under development.

Successes and Challenges in One Organization’s Process of Implementing Multiple System-Wide Primary Palliative Care Quality Improvement Projects (TH310D)
Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Judith Resick, MSN MPH RN, University of Pittsburgh, Pittsburgh, PA. Megan Glance, MPH, University of Pittsburgh Medical Center, Pittsburgh, PA. Zachariah Hoydich, BS, University of Pittsburgh, Pittsburgh, PA. Scott Freeman, MD, University of Pittsburgh Medical Center, Pittsburgh, PA. Robert Arnold, MD FACP FAAHPM, University of Pittsburgh, Pittsburgh, PA.

Objectives
- Describe common barriers and facilitators to implementation and management of primary palliative care quality improvement.
- Devise a systematic process to streamline the conduct and management of multiple concurrent primary palliative care QI proposals in a large healthcare system.

Background. The palliative needs of seriously ill patients will always overwhelm the capacity of palliative care (PC) specialists. As such, a central mission of PC is to develop and disseminate primary PC interventions to relieve the reliance on our already taxed workforce.
**Aim Statement.** Using two projects as case studies, we will delineate one academic healthcare system’s step-wise approach to developing and conducting quality improvement (QI) related to primary PC across an entire healthcare system, offering challenges, lessons learned, and solutions.

**Methods.** We solicited proposals from PC clinical faculty regarding interventions to fulfill an overarching mission to expand the provision of primary PC. Second, we translated proposals into logic models to delineate inputs, outputs, and anticipated outcomes. Third, we worked closely with data engineers to design semi-automated data reports. A steering team met monthly, adopting a “plan, do, study, act” framework to evaluate data, troubleshoot barriers, and brainstorm strategies to mitigate weaknesses and improve on successes.

**Results.** In FY2018, we implemented 7 interventions, ranging from a thrice-weekly coaching intervention to improve residents’ competency in GOC discussions, to the implementation of a nursing checklist to identify unmet palliative needs and trigger GOC consultations, in settings ranging from the CCU to outpatient general medicine clinics. Projects began meeting milestones within 6 months of deployment, overcoming impediments such as determining comparator and denominator populations, and extracting data. In the coaching intervention (n=35), rates of documented GOC among high-risk patients increased from 17% to 54% pre/post-hospitalization. In the CCU intervention, a PC physician provided on-going education sessions about family meetings to residents resulting in an increase in documented GOC for CCU patients from a monthly average of 35.6% to 53.5%.

**Conclusions and Implications.** While challenging, simultaneously rolling out multiple primary palliative care QI initiatives was made possible through standardization tools such logic model templates as well as the use of common data elements whenever possible.

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**8:15—10 am**

**Plenary Session**

**Getting the Results that Matter: Addressing Quality in Hospice and Palliative Care (101)**
Shantanu Agrawal, MD MPhil, National Quality Forum, Washington, DC.

**Objectives**
- Recognize the role of quality measurement in the overall healthcare landscape and how quality improvement can impact behavior and outcomes.
- Explain how and why quality will continue to be essential to the drive toward value and the important role of the hospice and palliative care community.
- Identify how the National Quality Forum (NQF) is evolving to focus on quality improvement initiatives that add value to the healthcare system and make care safer, more effective, and more affordable for patients and their families.

This session will provide an overview of how quality measurement is evolving to address the shift to value, tools and resources available to providers to focus on quality care at the bedside, and opportunities to provide quality hospice and palliative care. The session will also discuss how to involve patients and families more fully in quality improvement activities. Panelists Martha Twaddle, MD HMDC FACP FAAHPM, and Betty Ferrell, MA CHPN FAAN FPCN, and will join moderator Amy Melnick, MPA, executive director of the National Coalition for Hospice and Palliative Care in a discussion with Dr. Agrawal on the intersections of quality with palliative care and hospice.

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**10:45—11:45 am**

**Concurrent Sessions**

**Nurses as Sources in Health News: Developing Media Competencies (TH311)**

**Objectives**
- Discuss the importance of media for leadership in nursing and health policy.
- Describe key media competencies nurses must have for strategic engagement of news media.
- Identify how to successfully craft three strong, clear media messages to prepare for future media opportunities.

Nurses continue to be left out of dominant media narratives. A recent study, The Woodhull Study Revisited: Nurses Representation in Health News Stories, which replicated the original research published in 1998, reported on nurses’ representation in health news. The study found that, although nurses are the largest group of health professionals, they are cited as sources in only 2% of articles published by newspapers, news weeklies and trade publications. A companion study of health journalists provided some explanations, including newsrooms’ biases about women and nurses, a lack of understanding of what nurses do, and difficulty in finding nurses with specific expertise. Nurses are diverse, dynamic, front-line experts who know the latest real-world effects of healthcare and health policy. There are solutions that could help bring nurses to the forefront as media sources. Learn
how to engage with the media and become a source on all media platforms to change the health narrative on palliative care and hospice. Get your voices in health news to help the public understand and normalize end-of-life care.

What’s the Deal with Blood Cancers? Navigating a New Frontier in Palliative Cancer Care (TH313)

Thomas LeBlanc, MD MA MHS FAAHPM, Duke University School of Medicine, Durham, NC. Areej El-Jawhari, MD, Harvard Medical School, Boston, MA. Eric Roeland, MD FAAHPM, Massachusetts General Hospital, Boston, MA. Jason Webb, MD, Duke University School of Medicine, Durham, NC. Areej El-Jawhari, MD, Harvard Medical School, Boston, MA. Eric Roeland, MD FAAHPM, Massachusetts General Hospital, Boston, MA. Jason Webb, MD, Duke University and Health System, Durham, NC.

Objectives
- Recognize evidence about areas of unmet palliative care needs in the blood cancer population.
- Understand oncologists’ unique perspectives about blood cancers, and identify barriers to palliative care integration.
- Develop strategies to align the palliative care and oncology teams to improve integration and promote early palliative care in the blood cancer setting.

Blood cancers account for over 55,000 annual U.S. cancer deaths, a number higher than the 40,000 expected from breast cancer, yet they receive comparatively little attention in discussions about palliative care cancer. While concurrent palliative care is heralded as a standard for patients with advanced solid tumors, those with blood cancers are less likely to use palliative care services, and are more likely to receive aggressive care at end of life, chemotherapy in their last 14 days, and to die in the hospital. These shortcomings highlight unmet needs that warrant further attention and education in the palliative care community. When we talk with blood cancer specialists, they often complain that palliative care practitioners do not understand blood cancers, and that this reduces their willingness to call a consult. Our session proposal will help remedy this knowledge gap.

Contrary to popular belief, these diseases are seen and treated in academic centers and community-based settings alike, often in outpatient settings. Yet blood cancers pose several unique challenges for palliative care clinicians, including highly-variable prognoses, greater responsiveness to treatment, rapidly-evolving treatments, and often a chance of cure. Our presentation highlights the unique challenges posed by this population, with attention to strategies that have paid dividends in our own practices caring for them. A multi-institutional, multi-disciplinary team of presenters with training in oncology and palliative medicine will utilize a case-based approach to discuss these issues, including perspectives from a clinician who built a palliative care program within a stem cell transplant unit, two who have done trials of early palliative care in hematologic malignancies, and one who is seeing these patients regularly in palliative care practice and as part of clinical trials. We have presented on this topic at national oncology venues, and wish to bring this important perspective to the palliative care community.

Interdisciplinary Team Training at the Art Museum: Breaking Down Hierarchy and Building Resilience (TH314)

Ali John Zarrabi, MD, Emory University School of Medicine, Atlanta, GA. Gordon Wood, MD MSCI FAAHPM, Northwestern University, Chicago, IL. Paul DeSandre, DO, Grady Hospital and Emory University School of Medicine, Atlanta, GA. Barbara Reville, DNP ACHPN NP, Dana-Farber Cancer Institute, Boston, MA. Jane deLima Thomas, MD FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Laura Morrison, MD FAAHPM, Yale School of Medicine, New Haven, CT. Marsha Joselow, MSW LCSW, Boston Children’s Hospital/DFCI, Boston, MA. Bryan Brooks, BA, The High Museum of Art—Atlanta, Atlanta, GA.

Objectives
- Describe the evidence supporting the use of museum-based education (MBE) to develop core clinician competencies of perception, empathy, reflective practice, and resilience.
- Recognize how MBE can improve interdisciplinary practice by decreasing perceived hierarchy and promoting team building.
- Experience an MBE session.

Burnout among palliative care practitioners can lead to poor performance and attrition. Museum-based education (MBE) is an innovative strategy that aims to reduce burnout by enhancing perception and empathy, flattening perceived hierarchy, and strengthening interprofessional teams. The goal of this session is to provide palliative care educators with evidence and approaches to use art as a strategy to promote team building and enhance clinically relevant observation and reflective competencies.

MBE employs specific pedagogical strategies to train participants to intentionally, thoughtfully, and reflectively perceive patients and their unique situations. It is also a strategy to lessen a sense of hierarchy among teams by connecting participants to others’ personal perceptions and histories, irrespective of professional role. MBE participants have improved perception, comfort with ambiguity, and empathy, making this an important tool for palliative care teams and training programs as they seek to foster effective interprofessional teams and professional resilience.
This session will highlight current evidence supporting MBE in healthcare, as well as ongoing work by palliative care programs with trainees and interprofessional teams. Finally, we will demonstrate examples of art-based teaching strategies with audience participation such that participants may begin to design MBE programs tailored to their home institution.

**Partnerships in Dialysis and Palliative Care & Hospice: ‘Innovative Models for End-of-Life Care for End-Stage Renal Disease Patients’ (TH315)**

Keith Lagnese, MD FACP HMDC, University of Pittsburgh School of Medicine, Pittsburgh, PA. Jane Schell, MD, University of Pittsburgh, Pittsburgh, PA. Robert Horowitz, MD FACP CPE FPCN, Dartmouth Hitchcock Medical Center, Lebanon, NH. William Jangro, DO, Thomas Jefferson University, Philadelphia, PA.

**Objectives**

- Describe the end of life outcomes for end stage renal disease (ESRD) patients and the need for innovative models of care for this population.
- Dialysis organization perspective: Describe an Innovative Model for concurrent hospice and dialysis patients.
- Hospice organization perspective: Expanding Access for ESRD patient’s within Current Medicare Hospice Benefit (MHB)

As multiple different studies and surveys continue to illustrate, palliative and hospice medicine has failed to have an appropriate impact on the quality of life for the end-stage renal disease (ESRD) population. People with Chronic Kidney Disease (CKD) remain less likely to die at home, spend more time in the hospital and at higher costs in the last 3 months of life. (Kerr M et al, NDT, 2016).

The tide does to be slowly changing ‘upstream’ as aggressive dialysis centered care intersects further with palliative patient-centered approaches for this fragile patient population. The evolution of movements such as Comprehensive Conservative Care (CCC) focus on holistic patient-centered care for patients with stage V CKD (Davison et al Kidney Int 2015). Another example would be similar work being done by The Coalition for Supportive Care of Kidney Patients. Nearly all CKD patients want to discuss their prognosis, treatment options and ultimately die comfortably at home. (Clin J Am Soc Nephrol 5: 2010)

Fortunately this has not gone unnoticed by the ultimate original payer, Medicare, and hence in 2013, CMMI’s demonstration project for ESRD holds renewed hope with creation of new coordinated programs with new acronyms: CEC (comprehensive ESRD Care) and ESCO (ESRD seamless care organizations). We will not only look at national U.S. ESCO outcomes data, but will share a detailed information about Dialysis Clinic Inc (DCI) experiences with this truly innovative model. As the largest non-profit dialysis provider in the U.S. we will go beyond the data and share first hand details of care coordination strategies and how the field of nephrology has begun to reset its paradigm for treating CKD. The role of palliative and hospice care in the ESCO model also be discussed.

Unfortunately, further downstream in the trajectory of life for ESRD patients, the dialysis churn for the Medicare population continues to limit access to hospice. In a very recent large cross-sectional study of 770,000 Medicare beneficiaries, only 20% of these patients enrolled in hospice and of this subset, nearly half only enrolled for 3 days or less. Although dying at home was more likely in the hospice patients, they did not fare any better in regards to hospitalization, ICU admits and overall healthcare costs in the last week of life. (Wachterman et al; JAMA Int Med April 30, 2018).

In order to increase hospice access for dialysis dependent patients, we will explore the history of ‘Open Access’ models as well as share outcomes on ‘Expanded Access’ program within a large not for profit hospice in PA. (UPMC Family Hospice). We will show how close coordination with Palliative nephrologists can result in significant increase in hospice length of stay as well as patient satisfaction and decreased hospitalization. Lastly, we will share our thoughts on how the Medicare hospice benefit ‘Carve-In’ model will likely increase hospice Los for dialysis patients through improved care coordination.

**No Patient Left Behind: Integrating Addiction Treatment with Buprenorphine into Your Outpatient Palliative Care Practice (TH316)**

Julie Childers, MD MS FAAHPM, University of Pittsburgh, Pittsburgh, PA. Robert Horowitz, MD FAAHPM, University of Rochester Medical Center, Rochester, NY. Kathleen Broglio, DNP ACHPN ANP-BC CPE FPCN, Dartmouth Hitchcock Medical Center, Lebanon, NH. William Jangro, DO, Thomas Jefferson University, Philadelphia, PA.

**Objectives**

- Describe the principles of buprenorphine (Suboxone) prescribing for opioid use disorder.
- Identify different strategies that outpatient palliative care practices can use to incorporate buprenorphine treatment of addiction into their setting.
- Discuss how to overcome barriers to implementing buprenorphine prescribing within their palliative care practices.

Patients with serious illness are not exempt from opioid use disorders raging through our communities. Outpatient palliative care clinicians are increasingly
challenged to manage patients with both serious illness and active opioid use disorders. In this population, the use of opioids for pain is particularly complicated, and we struggle to provide safe, rational, and appropriate care. Buprenorphine (brand names include Suboxone, Zubrsolv, and Bunavall) is a partial opioid agonist that can be used for maintenance treatment of opioid use disorders in the outpatient setting. In addition to providing analgesia, buprenorphine stabilizes the cycle of craving and withdrawal experienced by individuals with addiction. To prescribe buprenorphine for addiction in an office setting, clinicians of all specialties can complete 8 to 24 hours of online and/or in-person training and apply to the DEA for an ‘X’ waiver.

Individuals with serious illness often have difficulty attending a typical addiction treatment program due to their poor health and the need to continue treatments such as chemotherapy. A few palliative care clinicians across the United States have begun including addiction treatment with buprenorphine into their outpatient palliative care practice to provide care to this underserved and stigmatized population. This session will inform participants of different models of using buprenorphine for addiction within palliative care, and discuss common issues that arise when undertaking care of patients with addiction. Participants will be able to differentiate its use for addiction versus pain. After a brief review of the pharmacology of buprenorphine, we will describe patient selection, buprenorphine prescribing and monitoring in the treatment of addiction among patients with serious illness. Four palliative care clinicians from different medical centers, including two physicians, a nurse practitioner, and a psychiatrist, will discuss challenges and successes developing a buprenorphine program within their outpatient practices.

**Psychedelic-Assisted Therapies—Palliative Care Clinical & Research Priorities (TH317)**

Ira Byock, MD FAAHPM, Providence Institute for Human Caring, Torrance, CA. Anthony Bossis, PhD, NYU School of Medicine, New York, NY. Craig Blinderman, MD MA FAAHPM, Columbia University/NewYork- Presbyterian Hospital, New York, NY.

**Objectives**

- Identify types of suffering of 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.
- Critically evaluate published findings from the expanding evidence base of clinical research into psychedelic-assisted treatment of patients with depression, anxiety, demoralization, and existential and spiritual suffering.

People with advanced medical illness often experience anxiety, feelings of hopelessness and loss of meaning and value of life. Some conclude that their life is not worth living and desire to hasten their deaths. Currently available treatments for depression, anxiety, and spiritual distress often fail to alleviate suffering among people who are seriously ill. Research involving psilocybin and related compounds have shown significant benefit suggesting that this class of drugs may offer therapeutic potential in treating persistent, non-physical suffering.

During the 2018 AAHPM-HPNA Assembly Meeting a concurrent session on psychedelic therapy drew approximately 600 participants, indicating substantial interest among palliative care providers in the research, cautions, and potential clinical application of these medications.

The 2019 session will build on this interest and the content of the previous session to begin defining priorities for research and clinical use of psychedelics within palliative care practice. Recent and ongoing clinical studies pertaining to psychedelic-assisted therapies in care of seriously ill patients will be reviewed. Session faculty will present results of key informant interviews conducted with palliative care clinicians and researchers regarding their priorities for future studies and therapeutic application of these medications. Survey items will include considerations of: a) patient selection and screening, b) frequency and duration of treatment sessions with specific drugs, c) selection of medications (entheogens and empathogens) in treating syndromes of depression, anxiety, demoralization and PTSD, d) necessary levels of supervision, e) safety and therapeutic influence of different settings. These results will inform discussion among session participants. A distillation of this interactive discussion will inform priorities for a developing Special Interest Group on Psychedelic Therapies.

**Using PCRC Resources: Patient and Caregiver Assessment Tools for Quality Improvement and Research (TH318)**

Laura Hanson, MD MPH FAAHPM, University of North Carolina, Chapel Hill, NC. Antonia Bennett, PhD, University of North Carolina, Chapel Hill, NC. Betty Ferrell, MA CHPN FAAN FPCN, City of Hope National Medical Center, Duarte, CA. Jean Kutter, MD MSPH FAAHPM, University of Colorado School of Medicine, Aurora, CO.

**Objectives**

- Appraise clinical assessment tools using freely available Palliative Care Research Cooperative resources.
Objectives. Palliative care assessment is holistic, covering a broad array of domains important to comfort, quality of life and supportive needs for patients with serious illness and their caregivers. Clinical assessments may be enhanced with validated measurement instruments, yet finding those that are ready for application in clinical quality improvement or in a research project is a “needle in a haystack” problem. Session attendees will learn: 1) to appraise clinical assessment tools using freely available Palliative Care Research Cooperative resources, and 2) to apply selected clinical assessment tools for palliative care and hospice quality improvement research.

Session Content. Presenters for this session are leaders in the Palliative Care Research Cooperative group (PCRC). The PCRC is an interdisciplinary research community with over 400 members who are committed to advancing rigorous palliative care science and improving care for people with serious illness. With funding from the National Institute for Nursing Research (NINR), the PCRC Caregiver and Measurement Cores have compiled validated clinical assessment instruments relevant to palliative care clinical practice and research. The PCRC Instrument Library is a novel and freely available web-based resource to facilitate identification of relevant and high-quality instruments for patient assessments. The PCRC Caregiver Core has evaluated and compiled high-quality instruments for caregiver domains. Presenters will provide an overview of how to choose clinical assessment tools for quality improvement versus for research (Hanson), how to access and use the PCRC Instrument Library (Bennett), how to select and apply caregiver assessment tools (Ferrell), and how to select and apply patient assessment tools (Kutner). The session will include interactive learning components to demonstrate searching and selecting assessment instruments for patients and caregivers, as well as audience discussion of successes and barriers when incorporating validated clinical instruments in quality improvement and research. (Funding NINR U24 NR014637).

A Quantifiable Spiritual Assessment Model in Palliative Care: Putting Two and Two Together for Improved Spiritual Care

George Fitchett, PhD, Rush University Medical Center, Chicago, IL. Christine Hoffmeyer, MDiv, Advocate Lutheran General Hospital, Park Ridge, IL. Dirk Labuschagne, MDIV, Rush Oak Park Hospital, Oak Park, IL. Aoife Lee, DMIN, Rush Oak Park Hospital, Oak Park, IL. Anna Lee Hisy Pierson, MDIV, Advocate Aurora Good Samaritan Hospital, Downers Grove, IL. Karen Pugliese Northwestern Medicine Central Dupage Hospital, Winfield, IL. Stacie Levine, MD FAAHPM, University of Chicago, Chicago, IL.

Objectives
- Describe the limitations of current approaches to spiritual assessment in palliative care.
- Describe the development of a new model for spiritual assessment in palliative care that quantitatively summarizes the extent of a patient’s unmet spiritual needs.
- Use the model to perform a preliminary assessment of the unmet spiritual needs of a palliative care patient.

Spiritual care is a well-established component of quality palliative care (PC) with board-certified chaplains considered the spiritual care specialist on the PC team. Spiritual assessment is a key activity performed by the chaplain; however, there is no consensus on best practices for spiritual assessment in PC. Currently, most chaplains use locally-developed, narrative models for spiritual assessment that were designed to be used within all clinical contexts. The limitations of these one-size-fits-all narrative models for spiritual assessment are becoming increasingly apparent in clinical practice.

This workshop will report the work of a team of PC chaplains participating in a regional interdisciplinary PC training program, the Coleman Palliative Medicine Training Program. A team of 7 chaplain champions developed a quantifiable model for assessing and reporting unmet spiritual needs in patients receiving PC. The model assesses 7 areas of unmet spiritual needs: 1) need for meaning in the face of suffering, 2) concerns about family and/or significant others, 3) need for a legacy, generativity, 4) concern or fear about dying or death, 5) issues related to making decisions about treatment, 6) religious/spiritual struggle, and 7) other unmet needs. A review of literature provided the initial list of needs which has been modified based on monthly case discussions by the team. The scoring of the needs was adapted from the Spiritual Distress Assessment Tool (Monod et al. 2010). Through monthly case discussions team members have developed reliability in using the model to assess unmet spiritual needs.

In this workshop we will describe the model, its conceptual foundations and its development. The session will include the opportunity for participants to actively apply the model to assess unmet spiritual needs in a PC case. The strengths and weaknesses of the model, as well as areas for future research in spiritual assessment in PC will be discussed.
Integrating the ENABLE Early Palliative Care Approach in Community Cancer Centers: Results of an Implementation Trial (TH321A)

Marie Bakitas, DNSc NP-C FAAN, University of Alabama at Birmingham School of Nursing, Birmingham, AL. James Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham, Birmingham, AL. Maria Pisu, PhD, University of Alabama at Birmingham, Birmingham, AL. Andres Azuero, PhD, University of Alabama at Birmingham, Birmingham, AL. Dilip Babu, MD, University of Rochester Medical Center, Rochester, NY. Lucy Gansauer, MSN, Spartanburg Medical Center, Spartanburg, SC. James Bearden III, MD, Spartanburg Medical Center, Spartanburg, SC. Keith Swetz, MD MA HMDC FACP FAAPM, UAB Center for Palliative and Supportive Care, Birmingham, AL. Leigh Minchew, DNP RN WHNP-BC PMHNP-BC, University of South Alabama, Mobile, AL. Margaret Sullivan, MS, University of South Alabama, Mobile, AL. Rachel Wells, MSN RN CNL, University of Alabama at Birmingham, Birmingham, AL. Richard Taylor, DNP CRNP ANP-BC, University of Alabama at Birmingham, Birmingham, AL. Yasemin Turkman, PhD MPH CRNP, University of Alabama at Birmingham, Birmingham, AL. Thomas Ramsey, PhD, University of Alabama at Birmingham, Birmingham, AL. Lisa Zubkoff, PhD, Geisel School of Medicine at Dartmouth, Hanover, NH.

Objectives
- Describe the use of ENABLE (Educate, Nurture, Advise, Before Life Ends) model of early, concurrent oncology palliative care.
- Describe the findings of an early palliative care (EPC) implementation of ENABLE for individuals with newly diagnosed metastatic cancer in rural-serving community cancer centers.

Background. Despite national guidelines recommending early palliative care (EPC) for individuals newly-diagnosed with metastatic cancer, it is rarely available in rural community cancer centers serving underserved populations.

Purpose. We conducted the first implementation trial of EPC in rural cancer centers using the evidence-based ENABLE (Educate, Nurture, Advise, Before Life Ends) model of early, concurrent oncology palliative care.

Methods. Mixed methods case study of a 4-year American Cancer Society-funded 4-site, implementation trial using a virtual learning collaborative in AL and SC. Guided by the RE-AIM (Reach Effectiveness Adoption Implementation Maintenance) framework, we gathered qualitative and quantitative data via monthly reports and yearly in-person site visits using: 1) a RE-AIM Self-Assessment Tool completed by site staff to measure objectives; 2) EPC General Organizational Index (GOI) to measure capacity for EPC services and implementation progress; and 3) field notes from site interviews and final reports.

Results. Baseline patients (n=62) characteristics included: mean age of 58, 70% female, 17% Black or minority, 57% some college, 49% rural dwelling, and 57% non-gynecologic cancer. Sites enrolled at least 58% of the patients they planned to enroll (range: 58%–100%; average: 84%), of which 60% received at least two-thirds of ENABLE content. Reasons for not completing all six sessions included death, unrecorded contacts, or lost to follow up. Longitudinal GOI scores indicated a trend of improved capacity for EPC services at 3 of 4 sites.

Conclusions. A 4-site implementation trial found that community cancer centers were able to successfully implement a nurse-led model of early concurrent palliative care facilitated by a virtual learning collaborative that successfully served minorities and rural-dwellers affected by cancer.

Implications for Research, Policy, or Practice. Trial feasibility findings will be used to further enhance implementation (early referral, personnel development) strategies in a comparative effectiveness trial in a national cohort of community cancer practices.

Factors Associated with Community Residence at the End of Life: A Population-Based Study (TH321B)

Melissa Aldridge, PhD MBA BA, Icahn School of Medicine at Mount Sinai, New York, NY. Karen McKendrick, MPH, Icahn School of Medicine at Mount Sinai, New York, NY. Jennifer Reckrey, MD, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives
- State the prevalence of decedents by residential setting (community, community with supportive services, and nursing home) at the end of life in a national sample of Medicare beneficiaries.
- Compare the clinical characteristics of decedents across residential setting (community, community with supportive services, and nursing home) at the end of life.
- Explain how socioeconomic factors of decedents are associated with end of life residential setting (community, community with supportive services, and nursing home).

Original Research Background. Residence in the community in the last phase of life has increased substantially in the last two decades and encompasses a range of different types of residential care environments.
Research Objectives. Determine the associations between demographic, clinical, and socioeconomic characteristics and residential setting at the end of life.

Methods. We used the Medicare Current Beneficiary Survey (2011-2013) linked to administrative data. We characterized residential setting as community, community plus supportive services (e.g., personal care, medication assistance, meal preparation, transportation), or nursing home. We used multinomial logistic regression to identify characteristics associated with residential setting at the end of life.

Results. Of 1,385 decedents, 53.8% resided in the community, 7.7% in the community with supportive services, and 38.5% in nursing homes. Those in the community with supportive services and those in nursing homes had similar clinical characteristics including high rates of dementia (36.4% and 43.2%) and ADL impairment (2.3 and 3.1) but different socioeconomic characteristics. Those in the community without supportive services had higher rates of cancer and were more likely to be younger, married, and non-white than those in other settings. Higher education was independently associated with residing in the community with supportive services versus nursing homes (OR=2.1, 95% CI 1.1, 4.2) and versus residing in the community without supportive services (OR=3.4, 95% CI 1.7, 6.8).

Conclusion. Socioeconomic factors are associated with whether individuals remain in the community with supportive services or reside in nursing homes at the end of life independent of clinical and functional characteristics. A combination of clinical, functional, and socioeconomic factors are associated with residing in the community without supportive services at the end of life.

Implications for Research, Policy, or Practice. Understanding characteristics associated with use of varying residential care models will lead to a more comprehensive picture of the palliative care needs and consequences of the increase in community residence at the end of life.

Community-Based Conversations About Advance Care Planning Using Patient Navigators (TH321C)

Regina Fink, PhD AOCNCHPN FAAN, University of Colorado Anschutz Medical Campus, Aurora, CO. Danielle Kline, MS, University of Colorado Denver, Aurora, CO. F. Amos Bailey, MD FACP FAAHPM, University of Colorado Hospital, Aurora, CO. Daniel Handel, MD, University of Colorado School of Medicine, Denver, CO. Hillary Lum, MD PhD, University of Colorado School of Medicine, Aurora, CO. Stacy Fischer, MD, University of Colorado School of Medicine, Aurora, CO.

Objectives
- Develop an effective model for community-based advance care planning activity in rural Colorado populations facing traditional barriers created by low rates of English language fluency and healthcare access.
- Adapt, refine, and evaluate a program that can be implemented in other community settings and underserved populations.

Background. Widespread community engagement in advance care planning (ACP) is achievable in community settings through multi-faceted approaches, as supported by implementation literature.

Aim Statement. To adapt an ACP group visit model to increase ACP engagement in rural underserved Colorado communities.

Methods. Our statewide rural initiative utilizes patient navigators (PNs) to facilitate ACP conversations in churches, libraries, schools, businesses, nursing homes, clinics, local government districts, and area health education centers. Two bilingual lay PNs trained in an ACP group session framework facilitated one-hour English and Spanish sessions in a comfortable, confidential space. Participants receive bilingual informational materials including Frequently Asked Questions, an easy-to-read Advance Directive (AD) (www.prepareforyourcare.org), and goal setting worksheets. Participants are encouraged to discuss their understanding and concerns about choosing a medical decision maker and completing a comprehensive AD. Participants are invited to complete the ACP Engagement survey (ACP-4) immediately post session.

Results. To date, we conducted 67 community-based sessions engaging 929 participants; 64.6% female, 42% ethnically diverse. Post session ACP-4 (51% response rate) showed 28% planned on naming a decision maker in the next 6 months and 22% in the next 30 days; 25% were ready to talk about future healthcare decisions with their decision maker in the next 6 months and 22% in the next 30 days; 31% were ready to talk about future healthcare preferences in the next 6 months and 16% in the next 30 days; 31% were ready to complete an AD in the next 6 months and 23% in the next 30 days. Evaluations showed 56% were extremely satisfied, 43% were satisfied, with 98% reporting the session was the right length of time.

Conclusions and Implications. PNs effectively engaged underserved and ethnically diverse rural Colorado populations in community-based settings. Our model can be readily adapted by other healthcare settings to improve ACP in underserved populations.
Is Socioeconomic Status a Fundamental Cause of Racial Differences in End-of-Life Care Use? (TH321D)

Sarah Cross, LMSW MPH, Duke University, Durham, NC.

Objectives
- Articulate how social theories can help our understanding of inequities in EOLC use.
- Describe social characteristics associated with hospice use, life support use, and hospital death.

Original Research Background. Racial differences in end-of-life care (EOLC) are well documented. De-medicalized care is now the innovation at EOL. Sociological theories suggests those with more education should be the first to use palliative care/less aggressive care and this will lead to inequities in EOLC.

Research Objectives. To determine whether socioeconomic status (SES), as measured by level of education, mediates the relationship between race and three commonly accepted indicators of quality EOLC: hospice use, life support use, and place of death.

Methods. I used modified poisson regression to analyze Health and Retirement Study 2014 Core and Exit Interviews data. The HRS is a longitudinal study surveying a representative sample of Americans age 50 and older. The Exit Interview collects data for respondents who have died during the study. Separate analyses were run for each outcome (hospice use n=1,193; life support use n=893; place of death n=1,198).

Results. In unadjusted models, Blacks were less likely to use hospice (unadjusted risk ratio [RR] = .813; 95% CI=.679-.974; P=0.023), more likely to use life support use (unadjusted RR=1.48; 95% CI=1.18-1.86; P=0.001), and more likely to have a hospital death (aRR=1.29; 95% CI=1.06-1.57; P=0.013) than Whites. After adjusting for education and patient characteristics, Black race was no longer a significant predictor of hospice use (aRR=.993; 95% CI=.826-1.19; P=0.940) or hospital death (aRR=1.17; 95% CI=.942-1.46; P=0.151). Blacks were still significantly more likely to use life support (aRR=1.41; 95% CI=1.09-1.82; P=0.008) than Whites.

Conclusion. Race is significantly associated with indicators of poor quality EOLC. Higher levels of education are significantly associated with a greater risk of hospice use and a lesser likelihood of life support use and hospital death. SES appears to be a fundamental cause of racial inequities in hospice use, but not in life support use or hospital death.

Implications for Research, Policy, or Practice. EOLC quality indicators may ignore cultural heterogeneity of patient preferences. Efforts should be made to better educate persons of lower SES groups about hospice.

Association of Timing and Type of Advance Care Planning Documentation on End-Of-Life Care for Patients with Serious Illness (TH322A)

Seelwan Sathitratanacheewin, MD, Chulalongkorn University, Bangkok, Thailand.

Objectives
- Describe the association between earlier advance care planning documentation and intensity of care at the end of life.
- Describe the association between late advance care planning documentation and intensity of care at the end of life.

Original Research Background. It is unclear how the timing of advance care planning (ACP) documentation and type of documentation influence the intensity of end-of-life care for patients with chronic illness.

Research Objectives. To examine associations between timing and type of ACP documentation and intensity of end-of-life care for patients with chronic illness receiving care in one healthcare system.

Methods. We developed a retrospective cohort using Washington State death certificates and electronic health records (EHR) to identify patients with chronic illnesses who died between 2010 and 2015. Association between timing and type of ACP documentation and end-of-life care were examined with multivariate probit regression analysis, adjusted for patient characteristics.

Results. Of 22,100 eligible decedents, 6,660 (30%) had an ACP document in the EHR and most (69%) were completed before the last six months of life, with 11% completed in the last 30 days of life. POLST forms (13%) were the least common ACP document, with increasingly higher documentation of health care directives (14%) and DPOA (20%). Earlier completion of ACP specifying treatment limitations were associated with reduced intensity of end-of-life care, whereas completion in the last 30 days of life was associated with increased intensity. Treatment-limiting POLST before the last 180 days had the strongest influence on end-of-life care, followed by treatment-limiting POLST between the last 30-180 days of life and healthcare directives before the last 180 days of life.

Conclusion. Treatment-limiting ACP documentation was associated with reduced intensity of care when completed more than 180 days prior to death. However, treatment-limiting ACP documentation in the last 30 days of life was associated with higher intensity care, suggesting an inverse causal relationship that many of these documents are completed during hospitalization and that higher intensity care is leading to increased ACP documentation.
Implications for Research, Policy, or Practice. These findings are important for healthcare systems when exploring the association between ACP and intensity of care.

What Do Adolescents Want? Values, Goals, and Beliefs of Teens with Cancer (TH322B)
Sarah Friebert, MD FAAP FAAHPM, Akron Children’s Hospital, Akron, OH. Jessica Gaines, BSN RN CPN, Children’s National Health System, Washington, D.C. Jennifer Needle, MD MPH, University of Minnesota, Minneapolis, MN. Justin Baker, MD FAAP FAAHPM, St. Jude Children’s Hospital, Memphis, TN. Yao Cheng, MD, Children’s National Health System, Washington, D.C. Maureen Lyon, PhD, Children’s National Health System, Washington, D.C.

Objectives
• Describe patient-reported palliative care needs of teens with cancer.
• Discuss implications of patient-reported outcomes for family-centered advance care (ACP) planning.

Original Research Background. The National Cancer Institute’s (NCI) 2016 recommendations advise parents to have open and honest communication about cancer with their children. Parents are interested in their adolescents-patient’s voice. Best timing and strategies to structure and facilitate this communication is unknown.

Research Objectives. This study examined patient-identified palliative care needs, goals, and values of teens with cancer.

Methods. Surveyed adolescents with cancer randomized to a pediatric ACP intervention using the Lyon Advance Care Planning Survey-Adolescent Version-Revised.

Results. Adolescents’ (N=45) mean age 17 years (range ≥14-<21 years); 39% male; 81% white. Though 91% felt that being able to complete an advance directive (AD) was important, most teens had never talked about EOL care wishes. 96% would want their family to be involved in EOL decisions. Problems rated as worse than death were: not being able to communicate wishes to family, 58%; living with great pain, 42%; and total physical dependency, 22%. At EOL, adolescents desire honest answers from physicians (100%), being at peace spiritually (98%), physical comfort (93%), feeling strongly about being able to stay in own home (73%), understanding treatment choices (98%), saying everything I want to say to people in my family (100%), not being a burden to loved ones (89%), and knowing how to say good bye (91%). 56% of teens want to die at home with or without hospice and 9% in hospital. 58% of teens preferred to have ACP conversations early (when healthy, first diagnosed).

Conclusion. Communicating EOL wishes to their family is very important to teens with cancer, consistent with ACS recommendations. Crucial information surrounding ADs and EOL wishes can be gained from teens with cancer.

Implications for Research, Policy, or Practice. Structured, adolescent/family-centered, evidence-based ACP interventions are one way to facilitate open communication about their cancer with their families.

Differences by Race, Religion, and Mental Health in Preferences for Life-Prolonging Treatment in Adverse Health States: Results from a National Sample of Medicare Beneficiaries (TH322C)
Justin Sanders, MD MSC, Dana-Farber Cancer Institute, Boston, MA. Anna Berrier, BSPH (C), University of North Carolina at Chapel Hill, Chapel Hill, NC. Leonce Nshuti, MS, Vanderbilt University Medical Center, Nashville, TN. Charllotta Lindwall, MD PhD, Dana-Farber Cancer Institute, Boston, MA. James Tulsky, MD FACP FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives
• Discuss factors that predict patient preferences for life-prolonging treatment in the setting of adverse health states that some would deem intolerable relative to death.
• Consider hypotheses to explain findings regarding preferences for life-prolonging treatment, including those from behavioral economics that might apply across multiple findings.
• Incorporate strategies to effectively elicit patient preferences.

Original Research Background. Goal-concordant care aligns patients’ preferences with their medical treatments and is important for patients with serious illness, whose treatments may hasten death or prolong suffering. We lack population-level data on patient preferences, which can help prepare clinicians for advance care planning or goals of care discussions.

Research Objectives. To understand factors that underlie individual preferences regarding life-prolonging treatment in the setting of two adverse health scenarios using a nationally representative sample of Medicare beneficiaries.

Methods. Using the National Health and Aging Trends Study, we used descriptive statistics and multivariable logistic regression to compare sociodemographic and illness characteristics of patients who said they would accept or reject life-prolonging treatments in the setting of severe, constant pain and inability to walk, talk, or recognize others.

Results. Patients in all demographic groups were more likely than not to express a preference for...
rejecting life-sustaining treatments in the setting of severe pain or disability. However, multivariable logistic regression demonstrated that respondents from racial or ethnic minority groups, those who indicated religious to be somewhat or very important, received less than $25,000 in annual household income, and reported frequent depressed mood or hopelessness had significantly higher odds of expressing a desire to accept life-prolonging treatments in these scenarios. 

**Conclusion.** Hypothetical preferences for life-prolonging treatments differ among groups defined by race, religiosity, mental health and other sociodemographic characteristics. Findings suggest that different groups may evaluate suffering differently in relation to death. They raise questions about the potential role of perspective in determining the relative acceptability of two adverse health states and distinguishing between them.

**Implications for Research, Policy, or Practice.** Clinicians leading advance care planning or goals of care discussions can effectively utilize these findings not to make assumptions about a given patient’s preferences, but to prepare themselves to discuss the meaning of different health states with patients by developing effective communication skills.

### 1:30—2:30 pm

**Concurrent Sessions**

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

Sunilkumar Mupliyath Madhavan, MBBS MSc, Thiruvananthapuram, India. Spandana Rayala, MBBS MD, Pain Relief and Palliative Care Society, Hyderabad, India. Sayed Ali, MD, Aga Khan University Hospital, Nairobi, Kenya. Martin Mindeguia, PhD, Sanatoria Mater Dei, Buenos Aires, Argentina.

**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.

**PC-FACS—Year in Review (TH331)**

Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA. Robert Arnold, MD FACP 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. 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 P Davis and Associate Editor-in-Chief Robert Arnold will take you on a tour of some of the most impactful 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.
My Life Matters! Honoring the Voice of the Intellectually and Developmentally Disabled and Other Marginalized Patients (TH332)

Heather Mikes, DO, Legacy Health, Portland, OR. Lori Eckel, MSW, Legacy Health, Portland, OR.

Objectives
- Examine the role of implicit bias and its influence on medical treatment and quality of life perspectives of marginalized patient populations, including the Intellectually and Developmentally Disabled (IDD).
- Construct a robust social history for IDD patients using four key elements.
- Describe three communication strategies used to help engage IDD patients in health discussions.

Our country is currently engaged in vital conversations about stereotyping and implicit bias. In an attempt to root out our collective prejudices, we now appreciate the necessity to talk about the underlying thoughts, beliefs, and values that inform our everyday actions and behaviors. Though many of us are drawn to the work of hospice and palliative care to practice compassion and advocate for patients’ values, we may not realize how implicit bias influences our practice. The Intellectually and Developmentally Disabled (IDD) population has a history of social injustice and wrongful medical treatment that accentuates the harm of implicit biases. The IDD population is a particularly vulnerable group that deserves our attention and requires astute considerations by palliative care or hospice providers in order to effectively meet their needs. Highlighting this marginalized population allows us to identify the subtler iterations of bias with other patient populations as well. During this presentation, we will use a case discussion to facilitate the identification of implicit bias and strategies for overcoming it. This case highlights the common landscape of social adversity for this population and how it effects their access to healthcare and providers’ perceptions on their quality of life. We will explore the components of a rich social history for IDD patients and how it can inform values and goals of care that are free of judgment. We will offer communication strategies and tools to help include these patients in conversations about their healthcare, alongside their legal guardians or healthcare decision makers. We will discuss challenges in decision-making when patient participation is not possible and offer ways to support healthcare decision makers. Through this presentation, participants will gain better insight into working with IDD patients and be able to identify and mitigate biases when working with other marginalized patient populations.

Walking the Tightrope: Palliative Care and Organ Donation (TH333)

Paul DeSandre, DO, Grady Hospital and Emory University School of Medicine, Atlanta, GA. Joanne Kuntz, MD FACEP FAAHPM, Emory University School of Medicine, Atlanta, GA. Leslie Hunter-Johnson, APRN, Sunrise Hospital and Medical Center, Las Vegas, NV. Jason Lesandrini, MA PhD(c), Wellstar Health System, Atlanta, GA. Myrick Shinall, MD PhD MDiv, Vanderbilt University Medical Center, Nashville, TN.

Objectives
- Identify the value for Palliative Care teams to include organ donation consideration with end-of-life decision-making.
- Discuss novel approaches to the integration of Palliative Care teams in the organ donation processes in both academic and community hospital settings.
- Examine the ethical challenges faced by Palliative Care teams in providing adequate information regarding the potential for organ donation with the duty to advocate for the values of our patients and families.

Palliative Care teams often assist patients and families in the full range of end-of-life decision-making. Organ donation is generally omitted from these conversations unless explicitly brought up by the family. It is often through organ donation decision-making that one can turn an otherwise tragic situation into one of meaning and legacy. Palliative Care teams offer a unique opportunity to assure holistic end-of-life care decision-making, including organ donation, regardless of the clinical circumstance. Using a panel of five clinicians (three physicians, one advance practice nurse, and one clinical bioethicist) from a variety of backgrounds and clinical practice environments, we will explore the tenuous balance of considering organ donation in end-of-life care discussions and process integration. Case examples and novel models of Palliative Care and organ donation integration will be presented as we examine the related ethical challenges facing Palliative Care teams. Participants will be given the opportunity to have questions addressed directly by the panelists.

Yes, and… Lessons Borrowed from Improvisational Theater to Teach Primary Palliative Medicine Skills (TH334)

Gitanjli Arora, MD, Children’s Hospital Los Angeles, Los Angeles, CA. Isaac Chua, MD, Dana-Farber Cancer Institute, Boston, MA. Rachel Rusch, MSW MA, Children’s Hospital Los Angeles, Los Angeles, CA.

Objectives
- Describe concepts and themes from Improvisational theater to strengthen clinicians’
The XYZs of Billing and Clinical Revenue: Going Way Beyond the ABC’s (TH335)
Christopher Jones, MD MBA HMDC FAAHPM, Perelman SOM at the University of Pennsylvania, Philadelphia, PA. Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI.

**Objectives**

- Describe five commonly used groups of billing codes applicable to palliative care teams’ clinical work.
- List the 3 components of a relative value unit (RVU) and compare the relative differences between commonly used codes.
- Consider the clinical components of a billable encounter to choose the correct billing code or codes to compliantly maximize revenue.

Routinizing Goals of Care Conversations—Improving Patient Outcomes and Satisfaction (TH336)

**Objectives**

- Discuss how quadruple aim goals can be achieved by embedding palliative care knowledge, attitudes, and skills within routine patient care.
- Identify educational and operational components of a goals of care conversation initiative.
- Outline key informatics and analytic principles that allow for automated storage and retrieval of goals of care conversations from an EHR.
The Institute for Human Caring (Institute) was founded in 2014 and charged with advancing models of goal-aligned care across the Providence St. Joseph Health system. The Institute has focused on operationalizing a scalable pilot to demonstrate the feasibility of delivering high quality goal-aligned care, while also attending to patients’ emotional, spiritual, interpersonal, social and mental wellbeing. Using resources from Ariadne labs, CAPC, and ACP Decisions, the Institute deployed a mutually-reinforcing strategic change program at a 327 bed hospital in California. A core element of this program empowers non-palliative care clinicians to conduct goals of care (GOC) conversations with seriously ill patients. All inpatient clinicians were encouraged — and some mandated — to attend in an educational, skill-based training session focused on GOC conversations. Electronic health record (EHR) tools were created to document GOC conversations, which allowed for the creation of automated dashboards displaying unit-based performance. On site, project management support was deployed to inpatient units to assist clinicians in utilizing patient-education and EHR tools.

A total of 5,148 GOC conversations occurred over a two-year period. During the initial launch quarter, only 1% (32/3186) of hospitalized patients with a chronic serious illness had a documented GOC note; the frequency rose to 42% (1235/2928) in the final quarter of the pilot program. These conversations were associated with important differences in code status preferences. During hospitalization, 4% of seriously-ill patients without a GOC note changed their code status, compared to 8% with a GOC conversation in their EHR. Palliative care consultation further increased the percent of code status changes. Additionally, patient experience, measured by key Press-Ganey items showed improvement in domain of nurse and physician communication when a GOC conversation was documented.

Detailed, updated results will be presented along with methodologies, tools, and lessons learned for implementing a program of this type.

Objectives
- Describe immunotherapy and its use in pediatric cancer treatment, including the risks and benefits of immunotherapy.
- State what symptoms are expected for patients receiving immunotherapy.
- Recognize how immunotherapies are changing prognosis for pediatric cancer patients.

Background. Use of Immunotherapy for pediatric cancer treatment is rapidly increasing. Medications such as blinatumomab, dinutuximab, tisagenlecleucel and others are dramatically changing the field of pediatric Oncology, and it is imperative that Pediatric Palliative Care (PPC) providers understand pain and symptom management needs as well as changes in prognosis for patients undergoing intensive immunotherapy.

Discussion. Using a case-based discussion, we will review immunotherapies currently in use and being studied for treatment of pediatric cancers. We will discuss the risks, benefits and symptom burden that accompany each medication. We will also discuss which medications are being used for management of which pediatric cancers, and how these medications are changing prognosis and patient outcomes. We will talk in-depth about what PPC teams should know when providing decision-making support to patients and families who are considering immunotherapies for cancer treatment.

Conclusions. Given the rapid pace at which pediatric cancer treatment is changing, PPC providers must add management of immunotherapy side effects and counseling around treatment risks and benefits to their palliative toolbox. This session will help keep providers up to date on the changing landscape of pediatric cancer therapy.

GeriPal Podcast Live! Podcasting in Hospice and Palliative Care (TH338)
Alexander Smith, MD MPH MS, UCSF Division of Geriatrics, San Francisco, CA. Eric Widera, MD FAAHPM, University of California, San Francisco, Larkspur, CA.

Objectives
- Describe the steps in developing a podcast on a limited budget.
- Utilize effective interview strategies to engage guest speakers about their work.
- Commit to one change in their use of social media following the session.

One in four Americans listen to podcasts on at least a monthly basis. Apple features more than 500,000 active podcasts in more than 100 languages. Despite the growing importance of this medium from a clinical, research, and educational perspective, there is a
dearth of content on hospice and palliative care. This session aims to change that by giving tools to hospice and palliative care practitioners to develop and disseminate their own podcasts.

The workshop will be led by GeriPal Co-Founders Alex Smith and Eric Widera. GeriPal is one of the premier blogs in the hospice and palliative care space, with over 10,000 regular subscribers and listeners across social media platforms.

In the first portion of the session, Alex and Eric will discuss the importance of social media to promote the palliative care movement. We will then describe the steps needed to create one’s own hospice and palliative care podcast, drilling down to the nuts and bolts including recording equipment and software, conducting live and remote interviews, and working in a team vs. solo.

In the second portion of the session, we will conduct a live Podcast on a cutting edge published paper, chosen in advance at a date closer to the meeting. We will model for the audience how talk with an author about: how they became interested, what they did, what they found, and why this matters. The audience will have an opportunity to ask questions of the guest speaker during the podcast.

In the third phase, we will discuss the steps that follow the podcast. These steps include post production editing, transcription of the podcast for persons who prefer to read rather than listen, hosting the podcast, and dissemination. Audience members will create individualized goals of commitment to use social media to advocate for hospice and palliative medicine.

“Too Good to be True? No!” Exploring Self, Incorporating a Quick and Easy Reflective Writing Exercise that Anyone Can Do (TH339)
Kristin Forner, MD, Mission Palliative Care, Asheville, NC. Lucille Marchand, MD BSN FAAHPM, University of Washington, Seattle, WA. Cory Ingram, MD MS FAAHPM, Mayo Clinic, Rochester, MN.

Objectives
- Identify innate qualities of Self, such as feelings, beliefs, expectations, values, and yearnings, and how they relate to how we define ourselves.
- Construct a self-reflective and insightful 6-10 word phrase.
- Integrate a brief mindfulness exercise into clinical practice and teaching to improve individual and team well-being, resiliency, compassion, and hope and minimize burnout and compassion fatigue.

Narrative medicine is defined as clinical practice strengthened by the ability to “recognize, absorb, interpret, and honor the stories of self and other.” [1]

In the form of reflective writing, it has been shown to help healthcare providers improve critical thinking, understanding of self, cultural humility, and psychological resilience, as well as to better connect with each other, their patients, and their families. [2,3,4] But reflective writing can feel intimidating or overwhelming to clinicians who have never had any formal experience or training in writing or the reflective practices.

We will set the expectation for self-contemplation by reading a poem, completing a mindfulness exercise, and then examining the deeper structures of our coping stances. We will explore our feelings, beliefs, perceptions, expectations, values, and yearnings as they all make up our sense of self. Participants will engage in an innovative self-reflective writing exercise that anyone can adopt and gain insight from, whether professional writer or novice learner. It begins with pen to paper and, through a distillation process, culminates in a 6-10 word revelation. The exercise becomes one of purification, where the result is a precise truth or an unveiled discovery. [5]


Estimating Costs Across Hospice Episodes (TH340A)

Objectives
- Describe variation in costs across hospice enrollment periods.
- Compare costs across hospices that provide high quality of care and those that provide low quality of care.

Original Research Background. Routine home care (RHC) payments under the Medicare Hospice Benefit
are intended to align with average costs of providing hospice care. Little is known about variation in costs across hospice enrollment periods.

Research Objectives. Estimate RHC costs across days of hospice enrollments and examine their association with payment, accounting for differences in the quality of care.

Methods. Our analytic file was based on 100 percent hospice claims ending in Federal Fiscal Year 2016 and Medicare cost reports for freestanding hospices. For each day of hospice, we estimated costs of care based on minutes of care provided monetized using Bureau of Labor Statistics (BLS) wage rates and the costs reported in the cost reports. We combined this information with measures of quality (overall hospice rating) based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) data.

Results. While mean RHC costs per day of about $121 were below mean payment rates of $153 per day, hospice costs in the first and last week of hospice enrollment substantially exceeded payment rates. Mean payment per day exceeded mean costs for the majority (78.6 percent) of hospices. Relative to hospices that provided the lowest quality of care, hospices that provided the highest quality of care tended to incur higher costs and receive lower payment across all hospice enrollment periods. Payments exceeded costs by about $16.9 per day for hospices in the top decile of quality and by about $41.0 per day for hospices in the bottom decile of quality.

Conclusion. RHC payments exceeded costs on average even for those hospices that provide the highest quality of care.

Implications for Research, Policy, or Practice. Understanding the nature of heterogeneity in costs across days of hospice episodes will help to gauge the adequacy of payments for an efficient delivery of hospice care.

Comparative Study of Quality of End of Life Between LGBTQ and Non-LGBTQ Hospice Patients (TH340B)
Stephanie Kemery, MSN RN, University of Indianapolis, Indianapolis, IN.

Objectives
- List the similarities and differences in the quality of dying and death in LGBTQ and non-LGBTQ individuals receiving hospice care.
- Describe the need for research in LGBTQ experiences in hospice care.
- Discuss need for incorporating LGBTQ training for hospice providers.

Original Research Background. While there is evidence that lesbian, gay, bisexual, transgender, and queer (LGBTQ) people experience health inequities when compared to the non-LGBTQ population, this phenomenon has not been adequately explored in hospice care. Understanding whether disparities exist at the end of life may assist health care providers in supporting LGBTQ patients and family members.

Research Objectives. The purpose of this study was to compare the quality of dying and death of LGBTQ people with non-LGBTQ people in order to determine whether the inequities found in other healthcare settings extend to hospice.

Methods. A primarily quantitative comparative descriptive study was implemented to explore the difference between groups. The Quality of Dying and Death Version 3.2a Family Member/Friend After-Death Self-Administered Questionnaire was modified to exclude ICU-specific instructions to collect quantitative data via online surveys. This instrument contains 22 items measuring aspects of the end-of-life experience (QODD-22) and an additional single item rating the overall quality of dying and death (QODD-1). Family members and close friends of adults who died under hospice care in the previous five years were recruited. A total of 122 data sets (66 from family members of non-LGBTQ individuals and 56 from family members of LGBTQ individuals) were included in the final analysis.

Results. These results are from preliminary analysis, final analysis will be completed by February 2019. The non-LGBTQ group had eleven QODD-22 mean scores higher than the highest QODD-22 mean score in the LGBTQ group, indicating better quality of dying and death in the non-LGBTQ group across numerous aspects of the end-of-life experience. A comparison of QODD-1 scores between the LGBTQ and non-LGBTQ groups revealed statistically significant differences (p=0.035).

Conclusion. Based on these findings, there is evidence that LGBTQ individuals experience a poorer quality end of life than non-LGBTQ individuals.

Implications for Research, Policy, or Practice. Hospice providers should consider implementing provider training to improve LGBTQ end of life.

More Professional Staff Visits in the Last Days of Life Are Associated with Better Hospice Care Experiences (TH340C)
Joan Teno, MD MS, Oregon Health and Science University, Portland, OR. Rebecca Anhang Price, PhD, RAND Corporation, Arlington, VA. Layla Parast, PhD, Rand Corporation, Santa Monica, CA. Ann Haas, MS MPH, RAND Corporation, Pittsburgh, PA. Marc Elliott, PhD, Rand Corporation, Santa Monica, CA.

Objectives
- Describe the importance of professional staff visits in the last days of life with bereaved primary
caregiver perceptions of the experience of hospice care.
- Discuss how to interpret composite and single items scores on the CAHPS hospice survey.

**Original Research Background.** As a person dies, symptoms increase, and family caregivers need both practical and emotional support. Previous research has found striking variation in professional staff visits in the last two days of life, but the association between these visits and patient and family experiences of hospice care is unknown.

**Research Objectives.** Examine the association between professional staff visits in the last two days of life and hospice care quality.

**Methods.** Using 2016 claims and survey data, we ran hospice-level cross-sectional regression models to examine associations between proportion of professional staff visits in the last two days of life and hospice performance on CAHPS Hospice Survey composites (e.g. timely care, caregiver training, emotional support) and items (e.g. willingness to recommend the hospice), adjusting for case mix and mode of survey administration.

**Results.** Among the 2,236 hospices in our dataset (50.5% for-profit, 51.6% chain), the proportion of patients receiving professional staff visits in the last two days of life varied from 0% to 100%, with a median of 84.6 (IQR 15.1). For all CAHPS outcomes with the exception of caregiver training, we observed significant positive associations between the proportion of patients receiving staff visits and hospices' performance starting at the sixth decile of visits (87.5% and higher). Family caregivers in hospices in the highest decile of professional staff visits (97.4% and higher) rated the hospice 5.2 points higher on timeliness of care, and between 2.3 and 4.5 points higher on other outcomes, than caregivers in hospices in the lowest decile (67.5% and lower).

**Conclusion.** Professional staff visits to actively dying patients may impact the quality of hospice care.

**Implications for Research, Policy, or Practice.** Promoting visits from professional staff in the last days of life may improve patient and family experiences of hospice care.

**Pediatric Hospice and Palliative Care: A State-Wide Needs Assessment (TH340D)**

Khaliah Johnson, MD HMD, Children’s Healthcare of Atlanta, Atlanta, GA. Katharine Brock, MD MS, Emory University, Children’s Healthcare of Atlanta, Atlanta, GA.

**Objectives**
- List the key components in conducting a comprehensive statewide community needs assessment (CNA) of palliative care resources, using Georgia as an example.
- Describe the key hospital-based, community, and university collaborators in conducting a statewide needs assessment of palliative care resources.
- Consider findings of the presented state-based needs assessment, and identify an approach to conducting a similar assessment in your own setting.

**Original Research Background.** As awareness increases regarding the benefits of palliative care services for children, additional studies will be needed to examine the scope of pediatric palliative care (PPC) and hospice services available, gaps in care, and opportunities for improvement. In Georgia, the Children’s Healthcare of Atlanta’s Palliative Care Team, Georgia Hospice and Palliative Care Organization, and Rollins School of Public Health at Emory University collaborated to conduct a statewide community needs assessment (CNA) of pediatric palliative care (PPC) and hospice resources.

**Research Objectives.** The CNA sought to identify the following:
- What is the scope of pediatric palliative care clinical services at the inpatient, outpatient, and community levels within the state of Georgia?
- What are the gaps in pediatric palliative care services within the state of Georgia?
- What is needed to grow pediatric palliative care services within the state of Georgia?

**Methods.** A mixed-method descriptive design with multiple stages incorporating different methodological approaches was utilized. These included: (1) literature review and community profile, (2) survey and interview questionnaire development, (3) windshield survey, (4) identifying and interviewing key informants, and (5) quantitative and qualitative survey of the state’s hospice organizations.

**Results.** Four key themes and 10 key subthemes were identified, which were triangulated across all existing data collection techniques. Ten recommendations were created and organized by both importance and feasibility.

**Conclusion.** While pediatric palliative care services have been established at the hospital level in key geographic locations within Georgia, there is significant need for growing resources at the community level. Pre-existing models of care within the state could be leveraged to improve quality and access to care through alliances and networking.

**Implications for Research, Policy, or Practice.** This methodological approach can be utilized by other state organizations, institutions, or governments looking to perform a CNA of pediatric palliative care and hospice resources, or could be applied to other geographical settings or types of care.
The Construct of Financial Toxicity and Association with Quality of Life in Poor Populations (TH341A)

Farya Phillips, PhD CCLS, University of Texas at Austin, Austin, TX. Elizabeth Kvale, MD FAAHPM, Dell Medical School, University of Texas, Austin, TX. Barbara Jones, PhD MSW, University of Texas, Austin, TX. Jennifer Currin-McCulloch, MSW, University of Texas at Austin, Austin, TX. Anastasiya Byelousova, University of Texas at Austin, Austin, TX.

Objectives
- Explain three predictors of quality of life for vulnerable populations diagnosed with cancer.
- Illustrate how the construct of financial toxicity may need to be operationalized differently based on the unique needs of vulnerable patient populations.

Original Research Background. There is growing recognition that patient reported outcome (PRO) measures complement traditional biomedical measures in conveying important information for cancer care decision making. With increasing cancer care costs understanding how the cost of medical care affects patient outcomes, particularly for patients in vulnerable populations, is imperative.

Research Objectives. This is a sequential mixed methods study (n=115) that aims to identify financial, psychosocial, and cancer related factors that affect patient outcomes. Our secondary aim was to explore the construct of financial toxicity among the poor and underserved populations diagnosed with cancer.

Methods. Adult (age 18+) patients diagnosed with cancer requiring drug therapy at an infusion center focused on serving uninsured, underinsured and low income patients were enrolled in the PRO study and data was collected at 2 time-points. Standardized assessment instruments were used including: the Functional Assessment of Cancer Therapy (FACT-G), the CAHPS Cancer Care Survey, the PROMIS NIH (Anxiety, Depression, Fatigue, Pain Interference, and Physical Function), and the Comprehensive Score for Financial Toxicity (COST). Qualitative interviews were conducted to assess the relevance and utility of the COST measure for patient’s financial stressors.

Results.
- 61.5% of our study population has a household income less than $25,000 (compared to 21.4% of patients in the national CanCORS II cancer cohort study).
- 20% of our study population had private insurance (compared to 80% of patients in CanCORS II).
- Depression, pain interference, and financial toxicity were found to be consistently significant predictors of quality of life in our study population, controlling for demographics and disease specific variables.

Conclusion. Financial toxicity continues to be a strong predictor of quality of life but qualitative data reveal the specific financial burdens experienced by financially vulnerable populations differ from typical cancer populations reported in the literature.

Implications for Research, Policy, or Practice. Opportunities for future research include creating a validated scale appropriate for poor population.

Caregiver-Reported Concerns and Challenges with Medications: Findings from Structured Interviews with Primary Caregivers of Patients with Cancer (TH341B)

Cara McDermott, PharmD PhD, University of Washington Cambia Palliative Care Center of Excellence, Seattle, WA. Ruth Engelberg, PhD, University Of Washington, Seattle, WA. J. Randall Curtis, MD MPH, University of Washington, Seattle, WA. Cossette Woo, BASW, University of Washington, Seattle, WA. Helene Starks, PhD MPH, University of Washington, Seattle, WA.

Objectives
- Describe caregiver-reported challenges to understanding and managing medications when caring for a family member with cancer.
- Recognize and address caregivers’ difficulties with integrating and applying information about safe and efficacious medication use.

Original Research Background. For patients with cancer, family caregiver-administered medication is often essential for high-quality care. While previous studies have focused primarily on analgesics, other medication-related issues may pose challenges for caregivers.

Research Objectives. We conducted a qualitative study to elicit caregivers’ concerns about medications to inform future interventions.

Methods. From October-December 2017, we audio-recorded semi-structured phone interviews with 35 adults who were primary caregivers for a patient who died with cancer between July-December 2016. Two analysts independently coded transcripts using content analysis and summarized results as major themes.

Results. Most caregivers were white (91%), female (63%), spouses (89%) with a college education (60%). Twenty-seven (77%) had concerns about medications. We identified three major themes. First, caregiver overload that impeded understanding: “I am in shock… I didn’t ask the questions. Looking back, there were a lot of things I should have asked.” Second, stigma/fear resulting in under-treatment of patient pain: “I didn’t want to take a chance on overdosing him.” “My family is drug-resistant, we don’t
like to take drugs.” Third, marginalization of caregiver concerns: “They kept giving opiates which I had objected to but was told it was not my decision...by then they had him addicted.” “I did not feel like he was a good candidate...he had a blood clot...diabetes, was weak...I asked, ‘Do you really think he’s a good candidate?’(The doctor) said, ‘Yes’ so that’s what we did, but that was my complaint.”

Conclusion. Most caregivers had concerns about managing and understanding medications, and some felt their concerns were not heard by prescribers.

Implications for Research, Policy, or Practice. Family caregivers may have trouble processing information about medications. Acknowledging caregiver concerns may reduce caregiver stress and improve caregiver understanding. Future interventions should incorporate regular inquiries to assess caregivers’ understanding of and concerns with medications.

Engaging Primary Care Physicians: Lessons Learned Seeking Buy-In and Patient Referrals for a Home-Based Palliative Care Program (TH341D)
Alexis Coulourides Kogan, PhD MSG, University of Southern California, Los Angeles, CA. Michael Kersten, MDiv MPH, Hill Physicians Medical Group, San Ramon, CA. Torrie Fields, MPH, Blue Shield of California, San Francisco, CA.

Objectives
- Describe the factors that may impede primary care physician buy-in and patient referrals for a home-based palliative care program.
- Discuss the lessons-learned and possible facilitators to better engaging primary care physicians in a home-based palliative care program and initiating patient referrals.

Original Research Background. Home-based palliative care (HBPC) is an important model originally developed for managed care. It surpasses the continuity and access barriers plaguing inpatient palliative care by providing palliative care in patients’ homes in collaboration with primary care. Repeated studies have demonstrated that HBPC can improve patient outcomes while decreasing costs of care, however, replication of this model in fee-for-service has been stymied by a lack of reimbursement structure. To overcome this barrier, a large California-based health insurer (Blue Shield of California) has begun to reimburse contracting medical group providers for HBPC. However, over 12-months later, primary care physician (PCP) engagement and patient referrals for the HBPC program are dismal.

Research Objectives. The purpose of this secondary mixed-methods study was to explore the impact of PCP outreach efforts by a physician champion for the HBPC program.

Methods. PCPs were identified as practicing in the Sacramento, CA region and having a greater percentage of Blue Shield patients in their practice. The physician champion contacted PCPs to arrange one-hour in-person meetings to discuss the HBPC program. Biweekly field notes from the 12-month study period were analyzed using the constant comparison method.

Results. From June 2017-2018, 18 solo practitioners (66.7%) and clinicians at 9 group practices (33.3%) were contacted by the physician champion (average contacts=3). On average, practice sizes were 1,108 patients (±1,050.5; range 210-5,639) with 33% (±7.4%; range 23%-54%) comprising Blue Shield patients. Qualitative findings revealed four themes: overburdened PCPs; fear of losing patient control; facing mortality; and dilemma for mid-level providers (managing patient care in light of PCP oversight).

Conclusion. Findings highlight the specific challenges to engaging PCPs and obtaining their buy-in for a HBPC program and a set of implementation strategies have been developed.

Implications for Research, Policy, or Practice. As increased attention is directed to new payment models for palliative care, results of this study may inform widespread replication of HBPC.

3–4 pm

Education Forums

State of the Science in Pediatric Palliative Care Forum (TH351)
Katharine Brock, MD MS, Children’s Healthcare of Atlanta, Atlanta, GA. Christopher Collura, MD MA, Mayo Clinic, Rochester, MN. Margaret Root, MSN RN CPNP-AC CHPPN, UCSF Benioff Children’s Hospital, San Francisco, CA. Caitlin Scanlon, MSW LSW, Riley Children’s Hospital, Indianapolis, IN. Megan Thorvilson, MD MDiv, Mayo Clinic, Rochester, MN. Pat Weikart, MDiv, Nemours/Alfred I. duPont Hospital for Children, Wilmington, DE.

Objectives
- Discuss with a colleague one new article relevant to the clinical practice of pediatric palliative care.
- Describe a fact, skill or attitude that you are reconsidering 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.
With the growth of Pediatric Palliative Care, it is essential for practitioners to find ways to stay current on the most recent literature. In the spirit of the State of the Science plenary which is part of each Assembly, the presenters will endeavor to review the literature published since 2017 which should inform the practice of Pediatric Palliative Care. Our interdisciplinary 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.

**Gender Equity and Career Advancement: Implications for Hospice and Palliative Medicine (TH352)**
Kimberly S. Johnson, MD MHS, Duke University School of Medicine, Durham, NC. Sean O’Mahony, MD MS FAAHPM, Rush University Medical Center, Chicago, IL. Helen Chen, MD, Hebrew SeniorLife/Harvard Medical School, Boston, MA. Susan Hingle, MD, SIU School of Medicine, Springfield, IL. Darily Moyer, MD, American College of Physicians, Philadelphia, PA.

**Objectives**
- Describe disparities in the experience of female physicians compared to their male counterparts.
- Describe specific challenges more commonly faced by female physicians and potential consequences with case examples.
- Illustrate strategies for addressing gender disparities and promoting gender equity.

Over the last 25 years, the proportion of physicians who are women has doubled from 17% to 36%. Furthermore, 46% of physicians in training and over half of U.S. medical students are women. While this significant increase in gender diversity has rapidly changed what the physician workforce “looks like”, there is a significant and persistent gap in the experience of female physicians. Compared to their male counterparts, studies show that female physicians are paid less across specialties and are disproportionately underrepresented in leadership positions despite their increasing representation in the physician workforce. Women may also experience lack of mentorship, workplace discrimination, gender bias, sexual harassment and challenges related to work-life integration based on their roles outside of the workplace. While gender equity is a salient issue across all specialties, efforts to improve the experience of women are especially important to the field of hospice and palliative medicine where women make up two-thirds of the total workforce, 47% of physicians, and over 60% of HPM fellows in training—proportions considerably larger than in general physician workforce. Given the important contribution of women to the field of hospice and palliative medicine not only in terms of the volume of clinical care provided but also related to leadership, education, and research, addressing gender equity is essential to efforts to ensure that the field is able to meet the demands of the growing population of seriously ill patients and their families. In this interactive session, using real life case examples, scenarios and questions submitted by the audience, experts actively involved in developing the ACP position statement on Gender Equity, will share best practices and illustrate strategies for promoting gender equity.

**Finding Your Highest and Best Use as a Palliative Nursing Leader (TH354)**
Abraham A. Brody, PhD RN FAAN FPCN, Hartford Institute for Geriatric Nursing and New York University, New York, NY.

**Objectives**
- Understand how to perform a self-exploratory, introspective survey of oneself.
- Formulate possibilities for one’s highest and best use based on self-exploration and needs of the field of palliative care.

Dr. Nessa Coyle found her highest and best use as one of the founders of palliative care in the United States, developing one of the first supportive care programs in 1981. Throughout her career she championed interdisciplinary palliative care practice and research. This presentation will honor Dr. Coyle’s legacy by discussing how each of us in the successive generations of palliative care clinicians, scholars, administrators, and supporters can find our highest and best use from the “bedside” to the C-suite to inspire the field and move it forward. This talk will walk participants through the journey of considering how to find and implement your highest and best use in palliative care, and make a difference for seriously ill patients, families and caregivers, communities, and the field at large.

**4:30—5:30 pm**

**Concurrent Sessions**

**Clinical Practice Guidelines for Quality Palliative Care: The 4th Edition of the NCP Guidelines (TH360)**
Gwynn Sullivan, MSN, National Coalition for Hospice, Richmond, VA. Betty Ferrell, MA CHPN FAAN FPCN,
City of Hope National Medical Center, Duarte, CA. Martha Twaddle, MD FACP FAAHPM HMDC, Northwestern Feinberg School of Medicine, Lake Forest, IL.

Objectives
- Explain the importance of the National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care, 4th Edition.
- Describe the process of developing the 4th edition of the Guidelines.
- Differentiate the 4th edition from the previous edition of the Guidelines.

Palliative care has expanded into new settings and is being offered by diverse types of organizations, such as health systems, office practices, cancer centers, dialysis units, home health agencies, hospices, long-term care providers, and more. Driven by this tremendous innovation within the field, the National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care were revised and the 4th edition was published fall 2018.

The goal of the 4th edition of the Guidelines is to improve access to quality palliative care regardless of setting, diagnosis, prognosis, or age by encouraging organizations and clinicians across the care continuum to integrate palliative care principles and best practices into their routine assessment and care of their patients. The Guidelines formalize and delineate evidence-based processes and practices for the provision of safe and reliable high-quality palliative care for adults and children with serious illness, and their families, in all care settings. Those seeking to develop or expand palliative care can integrate the Guidelines into all aspects of their organization to ensure the highest quality care is provided to all patients and their families. This session will review how the 4th edition of the Guidelines was developed, what changes were made from the 3rd edition, and what the implications are to deliver quality palliative care across settings. In addition, the key findings from the systematic review of the Guidelines that was completed by the RAND Evidence-based Practice Center will be discussed.

Drilling It Down: Designing Workshops to Practice Generalist Palliative Care Skills (TH361)

Stephen Berns, MD, University of Vermont Medical Center, Burlington, VT. Caroline Hurd, MD, University of Washington, Seattle, WA. Lindsay Dow, MD MS, Icahn School of Medicine at Mount Sinai, New York, NY. Nicole Loving, MSN BSN APRN NP, Icahn School of Medicine at Mount Sinai, New York, NY. Laura Morrison, MD FAAHPM, Yale School of Medicine, New Haven, CT.

Objectives
- List the advantages and challenges to teaching with drills and the evidence for use in health professions education.
- Appreciate and apply drill based practice to teaching palliative care skills.
- Describe the educational and behavioral theories of drill design; this includes the components and structure of a successful drill.

Instructors of athletes, dancers, and musicians have been perfecting the art of practice for years, developing efficient ways to improve skills. Research has shown that the most effective forms of practice always include learner concentration on a specific task, feedback from teachers, and learner introspection. One example is a drill. The goal of drill based practice is to transfer key skills from working memory to long term memory, moving them from being consciously controlled to automatic. Drills differ from other forms of practice because they concentrate on isolated skills and control for other variables, often distorting reality. Many examples of drills exist in sports, music, and primary education but are less commonly found in health professions education. Instead, medical education frequently uses simulation, OSCE, role-play, and case-based sessions to teach skills. These methods are often both resource and time intensive. Drills can be an efficient and effective alternative in which learners can obtain and practice the most fundamental skills flexibly and can be utilized for interprofessional learning settings. Some examples of drills that have been designed are converting opioids, recognizing and responding to emotion, and introducing palliative care to patients. This concurrent session will start with the audience participating in a palliative care skill drill. After participating in the drill, we will guide the audience through the components of the drill, highlighting educational theory for health care professions. A brief presentation of the steps of creating a drill will follow this exercise and we will share our experiences in designing drills. Audience members will then practicing writing a drill in groups.

Opportunities and Implications of Payment Reform for Serious Illness Care (TH362)

Julia Driessen, PhD, University of Pittsburgh, Pittsburgh, PA. Turner West, MPH, Bluegrass Care Navigators, Lexington, KY. Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI.

Objectives
- Describe recent payment reform efforts that affect hospice and palliative care delivery.
- Identify the opportunities and challenges of recent payment reforms for hospice and palliative care delivery.
Serious illness care faces long-standing challenges that are consequences of the fee-for-service reimbursement climate. The hospice care benefit is financially siloed, which clinically has resulted in isolation of hospice care from the rest of the care continuum. This lack of integration has contributed to substantial variation in how hospice care is utilized. Similarly, team-based palliative care is largely regarded as financially unsustainable under a fee-for-service model, despite the abundance of evidence showing palliative care’s positive impact on patient experience and potential averted downstream utilization. However, there are policy indications that the “value over volume” payment movement is starting to engage serious illness care. For example, hospice care is included the expenditure calculations for CMS’s accountable care organization (ACO) models.

This panel will address the potential opportunities and implications of value-oriented payment reform for hospice and palliative care, with an emphasis on the current ACO inclusion of hospice care, the response to palliative care models that have been reviewed by the Physician-Focused Payment Model Technical Advisory Committee, the expanded flexibility for Medicare Advantage plans to offer palliative care as a supplemental benefit, and the potential carve-in of hospice into Medicare Advantage. In addition to a general overview of these payment advances, this session will encourage lively discussion with participants about potential implications of these payment changes, and consideration of how delivery models could be affected, adapted, and potentially strengthened as a result.

Serious illness care, largely untouched in healthcare reform efforts until recently, will potentially undergo radical changes as it is brought under the microscope of Medicare Advantage plans, ACOs, and risk-bearing entities. This panel explores how the transition towards more accountable, value-oriented reimbursement may impact serious illness care delivery, examining the perspective of payers and providers regarding the unique challenges and opportunities for both hospice and palliative care.

“I Am Barely Breathing”: Experiences and Outcomes of an Integrated Palliative Care-Pulmonary Clinic Utilizing an Opioid and Benzodiazepine Review Board for Safety (TH363)


Objectives
- Describe the current available evidence for management of dyspnea in advanced pulmonary disease, specifically regarding the use of opioids and benzodiazepines.
- Describe the steps to setting up an integrative palliative-pulmonary clinic model including as a Quality Improvement project using a PDSA model.
- Describe and plan for the utilization of an opioid and benzodiazepine review board.
- Identify positive outcomes of an integrated palliative-pulmonary clinic.

Patients with advanced pulmonary disease including COPD report a poor quality of life. These patients also live with a great amount of prognostic uncertainty. Symptoms include dyspnea, pain, fatigue, and mood changes. Patients note changing and diminishing functional status and quality of life. Often, conversations about goals of care are not pursued early. Literature exists to support the treatment of subjective dyspnea in advanced COPD with opioids, however, studies are small and limited.

We established an innovative Pulmonary-Palliative Care integrated clinic model in September 2016. Patients are most often referred by pulmonary providers, and are also referred by primary care. We have been following 37 patients since the clinic opened. Patients are seen either in tandem or joint visits, with active collaboration. Visits focus on goals of care, advance care planning and symptom management. We have been prescribing opioids for management of dyspnea with minimal exertion in approximately half of the patients. Due to the current concern around opioid use and safety, in December 2017 we established a medication review board. This board includes pulmonary and palliative care physicians and nurse practitioners, a psychiatrist, and a pharmacist. The board meets monthly to review patient cases and make medication recommendations. The board has also established universal opioid risk assessment, urine drug testing, and opioid agreements.

In this concurrent session, clinicians from a multidisciplinary Palliative Care-Pulmonary clinic will use case studies, clinical literature, and pilot data from this institution’s experience to share challenges and solutions supporting patients with advanced pulmonary disease and building strong collaborative ties to a pulmonary program. We will share our experiences with advance care planning, POLSTs, symptom
management and hospice referral. Additionally, clinicians will share experiences and data from implementation of an opioid assessment tool and an opioid management protocol in this population.

**Image-Guided Palliative Care (TH364)**
Jay Requarth, MD FACS, Catawba Regional Hospice, Newton, NC.

**Objectives**
- Develop a treatment plan that differentiates between those with a fully expanding lung and those with a fibrinothorax.
- Determine different diagnostic tests and maintenance options that would be realistic and effective for that clinical setting.
- List the 3 therapeutic options for celiac plexus blocks and their relative effectiveness areas of planning for physical therapy services.

Image-guided palliative care is an underused therapy that can provide pain and symptom relief. These treatments can be provided by any physician with access to quality ultrasound, fluoroscopy, and computed tomography (CT) equipment. However, the efficacies and risks of the therapies may be different based on the technique and equipment used for the image-guided treatment and the timing of these treatments.

This session will describe commonly encountered palliative problems that can be mitigated with image-guided and percutaneous therapies. A continuance of the 2018 interventional radiology presentation, this discussion will address different topics and will include efficacy, options, and risk data on each of the image-guided treatment options. Celiac plexus neurolysis will be reviewed again this year because of its importance in pain management, but we will concentrate on non-radiology based options (endoscopic ultrasound directed versus percutaneous CT-guided) and optimal timing of these 2 treatment options.

The following topics will be discussed: the decision-making process and treatment of recurrent benign and malignant pleural effusions with special emphasis on the diagnosis and treatment of fibrinothorax (trapped lung), celiac plexus neurolysis for upper abdominal cancer pain, treatment options for recurrent cirrhotic and malignant ascites, gastrostomy tube insertion options and risks as well as recognition and treatment of late complications such as skin burns and intussusception, and patient-based palliation of obstructive jaundice and cholecystitis.

Finally, the presenters will review the efficacy and risks of intercostal neurolysis (rib blocks) for chest wall pain as well as how any physician can master this simple technique which can be performed without any image-guidance.

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**The Untold Story of the Opioid Crisis: An Interdisciplinary Approach to Patients with Life-Limiting Complications of Opioid Addiction (TH365)**
Britni Lookabaugh, MD, OhioHealth, Columbus, OH. Jessica Geiger-Hayes, PharmD, OhioHealth Riverside Methodist Hospital, Columbus, OH. Jill Yahner, MED LSW, OhioHealth, Columbus, OH. Wendy Ungar Rabbi, OhioHealth, Columbus, OH. Alan Murphy, PhD, OhioHealth, Columbus, OH.

**Objectives**
- Collaborate with interdisciplinary team members to navigate the complex biopsychosocial care of patients suffering from the complications of opioid use disorder.
- Negotiate the ethical considerations of recurrent cardiac surgery for infective endocarditis related to ongoing intravenous opioid use.

According to the CDC, in 2016, 62,632 Americans died from drug overdose, with 66% of these deaths related to opioid use. Even with the media’s increased attention to the opioid crisis, the stories of patients with recurrent medical complications of addiction remain untold. Medically, these patients are at high risk for recurrent, life-threatening infections, such as endocarditis. Potential survival may entail multiple major surgeries. Surgeons may be reluctant to provide these surgeries, and when surgery is provided, patients suffer post-operative pain that is challenging to control because of patients’ opioid tolerance, a challenge compounded when the time comes to transition to outpatient plans for pain management. Patients dying of medical complications of opioid use disorder can suffer from severe symptoms that are similarly difficult to manage. Socially, opioid use disorder may complicate relationships between patients and their families, with the result that surrogate decision making may be vexed by estrangement or codependence. Spiritually, patients struggle with distress due to loss of function and identity; younger patients, disproportionately affected by opioid use disorder, struggle with the threat to, or impending loss of, what they expected to be a longer life. Organizationally, the palliative care team may also assist in palliating the moral distress that bedside staff may feel in caring for these young and complex patients. The myriad challenges that arise in providing palliative care to patients with opioid use disorder necessitates a robust interdisciplinary approach; to that end, this session will include a physician, social worker, chaplain, pharmacist and clinical ethicist who will discuss the difficulties presented by opioid use disorder in their respective fields and suggest interventions to address them.
“It Can’t Be the Dialysis that Kills the Child…” Partnering Pediatric Palliative Care with Care for Children with End-Stage Renal Disease (TH366)


Objectives
- Explain key issues in end-stage renal disease in the pediatric population.
- Summarize dialysis care, including the various forms, eligible populations, contraindications, and complications.
- Identify opportunities and challenges for palliative care and hospice collaboration in the care of pediatric patients with end-stage renal disease.

As chronic kidney disease progresses to end-stage renal disease (ESRD), important discussions regarding when and if to initiate dialysis occur. ESRD affects more than 660,000 Americans, less than 10,000 (1.5%) of those are pediatric patients whose time on dialysis is typically meant as a bridge to transplant. In rare circumstances, comorbidities, such as multiorgan failure, progression of other life-threatening medical conditions, congenital anomalies, and size restrictions limit pediatric candidates’ access to transplant. In addition, dialysis-related infections and thrombosis can limit patients’ access to future transplant. Overall, this leads to a 5-year mortality for children with ESRD of 11%. Despite these mortality rates, very little has been published on pediatric palliative care (PPC) and hospice in ESRD.

How can nephrology and PPC teams partner with each other, patients and caregivers to optimize care in pediatric ESRD? In this session, our multidisciplinary team will use recent cases, clinical literature, and Medicaid/Medicare regulations to inform attendees about shared challenges and solutions supporting patients with ESRD and their families. An overview of modes of renal replacement therapy, their limitations, and complications will be provided by pediatric nephrologists. Strategies to introduce the broad complement of PPC options and maintain open lines of communication between families and nephrology colleagues will be reviewed by PPC experts with experience caring for patients with ESRD. Finally, presenters will discuss challenges to implementing and maintaining palliative care principles, including those beyond end-of-life discussions, within the context of ESRD care. In this concurrent session, participants will have an opportunity to learn about ESRD care options and hear our centers’ experiences caring for these complex patients, highlighting the various roles of PPC, some challenges and ethical concerns we have encountered, and strategies to introduce palliative care within the pediatric ESRD population.

Evaluating Quality of Pain Treatment Among the Seriously-Ill Populations (TH367)

Amy Kelley, MD MS, Icahn School of Medicine at Mount Sinai, New York, NY. Laura Hanson, MD MPH FAAHPM, University of North Carolina, Chapel Hill, NC. Christine Ritchie, MD MSPH FAAHPM, University of California, San Francisco, CA. Katherine Ast, MSW LCSW, AAHPM, Chicago, IL.

Objectives
- Understand the benefits and challenges of broadening the eligible population for hospice and palliative care quality measures to include those with serious-illness.
- Identify suggested ideas for implementation of the measure using real-world case examples
- Apply and translate this measure to other work that’s been done and to be able to replicate it in future work

Quality measurement for palliative care is limited by the “denominator problem,” or the inability to identify distinct populations of patients with serious illness in large health data sources, thus limiting the potential for broad system-based measurement of quality. Using claims and clinical data in the OptumLabs Data Warehouse, our goal was to identify seriously ill populations and evaluate the feasibility of assessing a pain-related quality measure in these populations.

We accomplished this through the following aims:
1. Develop claims-based technical specifications for patients with serious-illness, and two population subsets with:
   a. Dementia
   b. Multiple chronic conditions (MCC)
2. Assess the validity/reliability of the AAHPM’s Measuring What Matters (MWM) Pain Treatment quality measure in each of the eligible (sub) populations above.
Beyond the Horizon: Providing Palliative and End-of-Life Care for Undocumented Immigrants in the United States (TH368)

Ahima Lal, MD, Emory University, Atlanta, GA. Sean O'Mahony, MD, Rush University, Chicago, IL. Vijeyanthi Periyakoil, MD, Stanford University, Stanford, CA. Nicky Quinlan, MBChBAO, Santa Clara Valley Medical Center, San Jose, CA. Christopher Metchnikoff, MD, Olive View-UCLA Medical Center, Los Angeles, CA. Anne Kinderman, MD, University of California at San Francisco, San Francisco, CA. Mona Patel, DO, MJHS Hospice and Palliative Care, New York, NY. Sarah Stroe, MSW, Zuckerberg San Francisco General Hospital, San Francisco, CA.

Objectives

- Investigate factors that complicate caring for seriously ill undocumented immigrants.
- Discuss options for quality end-of-life care for undocumented immigrants.
- Design or revise institutional policies to protect undocumented patients/families and healthcare providers.

Approximately 11 million undocumented immigrants (UI), accounting for 14.6% of the uninsured population living in the United States are not eligible for insurance under the Affordable Care Act, limiting options for palliative and end-of-life (EOL) care. Though the Universal Declaration of Human Rights includes the right to dignity-conserving care for all, access to quality EOL care eludes UI, with limited access to charity hospice care. UI experience many challenges when seeking healthcare including language/cultural barriers, limited social support, financial stressors, lack of access to care and insurance, discrimination and general mistrust in the healthcare system. Some mistrust can be mitigated through developing institutional policies to protect UI and their families when ICE officers are present in health care settings. UI rely on hospitals, including safety-net institutions for healthcare; unfortunately, they often present with advanced illness due to limited access (with delayed diagnosis, fragmented care and lack of advance care planning). While some barriers can be overcome through development of institutional policies to protect UI and their families, palliative providers are confronted with challenges in providing continued symptom management with limited charity care and resources available to this vulnerable patient population.

Using case-based presentations, experts from different states will provide insight into the current plight of the seriously ill UI and the healthcare personnel caring for them. We will identify strategies and outline ways to advocate for access to medical and hospice services. Through an interactive immersive learning structure we will identify best practices in different geographical regions of the US as a collaborating practice to protect the basic human rights of the seriously ill and their families including approaches to medical repatriation.

Expanding Palliative Care Accessibility: Models for Palliative Care delivery in Primary Care and Hospital-Based Settings (TH369)

Jennifer Dulin, MD, Medical University of South Carolina, Charleston, SC. Shana Semmens, MD, Medical University of South Carolina, Charleston, SC. Claire Ankuda, MD MPH, Icahn School of Medicine at Mount Sinai, New York, NY. David Nowels, MD MPH, University of Colorado School of Medicine, Aurora, CO. Kate Lally, MD FACP, Care New England Health System, Providence, RI. Susan Enguidanos, PhD MPH, Davis School of Gerontology at the University of Southern California, Los Angeles, CA. Joshua Lakin, MD, Dana-Farber Cancer Institute and Brigham & Women’s Hospital, Boston, MA.

Objectives

- Compare and contrast primary palliative care and consult based care delivery.
- Describe interdisciplinary peer education strategies.
- Describe longitudinal support system from academic center to rural community hospital to improve palliative care access for patients in rural communities.
- Evaluate successes and barriers in supporting palliative care planning and implementation in rural ICU setting.

Primary palliative care is a model to deliver palliative care that can be used by treatment teams without access to full palliative care consult teams. This includes primary care offices which are the center of care for many patients with serious illness, especially those in rural and underserved regions. Ensuring excellent palliative care delivery within these models is critical to improving quality of care across the trajectory of serious illness.

Primary palliative care benefits patients and families by decreasing symptom burden, suffering, conflict and non-beneficial treatments while increasing quality of life, comprehension and satisfaction. It similarly benefits clinicians and health systems by decreasing conflict, costs, length of stay and delivery of non-beneficial therapies. Primary palliative care can use triggers, guidelines and decision support tools to aid...
primary providers in palliative interventions and communication. This is increasingly recognized in value-based payment models such as Accountable Care Organizations (ACOs) and the Comprehensive Primary Care Plus program, thus creating an opportunity for palliative care clinicians. This concurrent session will present unique, multidisciplinary approaches to enhance primary palliative care delivery. These models vary from providing training for hospital-based and primary care clinicians to integrating palliative specialists in primary care. They include:

1. Focused geriatrics and palliative care skills training for primary care physicians within an ACO.
2. A trial of home-based palliative care embedded within a primary care practice vs. usual office-based care enriched with palliative care training for primary care clinicians.
3. A systematic intervention to improve serious illness communication in primary care.
4. A curriculum on best practice approaches to delivering primary palliative care for hospital-based teams with community education and outreach.

Both primary care and palliative care needs and resources vary widely by region and practice. Each model presented will emphasize the process of needs assessment and stakeholder engagement preceding program design and implementation. This will equip attendees to return to their own communities and begin to engage with primary care practices around developing models of care.

The Epidemiology of Community-Based Pediatric Palliative Care: A Descriptive Study (TH370A)
Rachel Diamond, MD MS, University of Rochester, Rochester, NY. David Korones, MD FAAHPM, University of Rochester Medical Center, Rochester, NY. Susan Ladwig, MPH, University of Rochester, Rochester, NY. Philene Cromwell, MS RN PNP, Lifetime Care—CompassionNet, Rochester, NY. Alyssa Gupton, MSW LCSW, Lifetime Care—CompassionNet, Rochester, NY.

Objectives
- Describe the demographics of the pediatric population served by a community-based palliative care program.
- Recognize survival data of the pediatric population served by a community-based palliative care program and its implications on the care needs and support for these children and their families.

Original Research Background. Pediatric Palliative Care (PPC) is a rapidly-growing pediatric subspecialty. While there is ample literature characterizing children receiving inpatient palliative care services, little is known about the children enrolled in community-based pediatric palliative care programs.

Research Objectives. To characterize a large cohort of children in upstate NY cared for by CompassionNet, a community-based pediatric palliative care program.

Methods. Children were identified by reviewing the CompassionNet database from 2008-14. Children were eligible for the program if they were <22 years old and had an illness that put them at risk of dying before age 21. Demographic data, time on the program, disease categories, overall survival, and date of death were extracted from the database. Disease type was defined by ICD9 codes for complex chronic conditions (CCC).

Results. 713 children were enrolled and followed during the study period. The median time children were on the program was 3.5 years (range 0-15 years). Median age at time of enrollment was 6.5 years (0-24). 379 (53%) were male. 426 (60%) were white, 102 (14%) black, 38 (5%) were Hispanic and 49 (7%) were other. The most common CCC’s were malignancies 265 (37%), cardiovascular disease 81 (11%), and neonatal disease 58 (8%). 546 (77%) of children enrolled in the program are alive. At 1 and 2 years, 82% and 56% of children are still being served by the program, respectively.

Conclusion. These data suggest there is a role for community-based pediatric palliative care programs in caring for children with CCC’s and that with many of these children surviving a long time, that role can continue over many years.

Implications for Research, Policy, or Practice. Children with complex chronic conditions live a long time and spend much of that time in the community. Broader support for community-based programs is needed to provide these children and their families support at home, not just in the hospital.

Improving Moral Distress and Provider Perceptions with an Integrated Palliative Care Conference in the Neonatal Intensive Care Unit (NICU) (TH370B)
Riddhi Shukla, MD MPH, Indiana University School of Medicine, Indianapolis, IN. Rebecca Baker, MPH, Indiana University, Indianapolis, IN. Karen Moody, MD MS, MD Anderson Cancer Center, Houston, TX.
Jayne Allen, MD, Indiana University School of Medicine, Indianapolis, IN.

**Objectives**

- Describe how domains of palliative care can be integrated into the care of high-risk infants in the Neonatal Intensive Care Unit (NICU).
- Delineate the effects of an integrated palliative and neonatal interdisciplinary conference on staff moral distress and neonatal providers’ perceptions towards palliative care.

**Original Research Background.** Despite national recommendations to incorporate palliative care (PC) into the Neonatal Intensive Care Unit (NICU), providers’ (MD and APN) perceptions may prevent optimal PC delivery in this setting, leading to moral distress in staff.

**Research Objectives.** Objectives were to investigate the efficacy of a weekly case-conference to improve moral distress and perceptions of PC in the NICU and to increase consultation rate to specialty PC for newborns at high risk for mortality and/or morbidity.

**Methods.** An interdisciplinary PC/NICU case-conference served as a platform for educating providers on incorporating palliative care domains into the care of high-risk NICU infants. NICU providers’ PC perceptions were measured at baseline and after 12 months of implementation (follow-up) using a published survey. Providers and multidisciplinary NICU staff completed the Moral Distress Scale-Revised at baseline and follow-up. NICU consultation rate to PC at follow-up was compared to baseline.

**Results.** Surveys were completed by 57 MDs/APNs and 176 NICU staff, mostly RNs. Compared to baseline, providers were significantly more likely to endorse that they provide families with PC options (84% v. 95%; p<.03); are comfortable with PC (84% v. 97%; p=.03); are satisfied with EOL care (65% v. 79%; p<.02); have time to provide PC (42% v 72%; p<.02); and perceive parents are involved in PC decisions (81% v. 95%; p<.01). Additionally, moral distress among NICU staff was significantly reduced (p=.005) and the number of PC consultations increased by 56%.

**Conclusion.** Moral distress, provider perceptions of PC, and PC consultation rate can be improved by a weekly case-based interdisciplinary conference that includes PC and NICU stakeholders.

**Implications for Research, Policy, or Practice.** This study provides direction for overcoming some PC implementation barriers in the NICU. Future studies should assess the effect of improved utilization of PC services on parental perceptions and newborn outcomes.

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**Availability of Bereavement Support Services for Those Affected by a Pediatric Death: A Literature Review (TH370C)**

Tanner Hoke, BS, Northwestern University Feinberg School of Medicine, Chicago, IL. Patrick Murday, BS, Northwestern University Feinberg School of Medicine, Chicago, IL. Patricia Smith, MLIS, Northwestern University, Chicago, IL. Kristin James, LCPC, Pediatric Palliative Care, Chicago, IL. Kelly Michelson, MD MPH, Lurie Children’s Hospital, Chicago, IL.

**Objectives**

- Describe the importance of providing bereavement support services to families impacted by the death of a child.
- Describe how to conduct a scoping literature review.
- Discuss the limits of existing research related to the availability of bereavement support services for families impacted by the death of a child.

**Research Background.** Bereavement support is an essential component of palliative care. Yet little is known about the availability of bereavement support services offered to those affected by a pediatric death.

**Research Objectives.** To review existing literature related to the availability of bereavement support services for families affected by the death of a child (including pre-natal deaths) in the United States (US).

**Methods.** We searched five databases (PubMed, Embase, PsycINFO, CINAHL, and Cochrane Library) using terms related to three concepts: “child death,” “bereavement,” and “support.” We included articles discussing availability of bereavement support services based in the community, hospital, clinic, or a palliative care organization. We excluded articles that focused on bereavement education, case studies or series, specific program descriptions, healthcare provider support, the impact of a child’s death on parents or healthcare providers, adult death, efficacy of bereavement services, activities during the dying period, and programs outside the US. Two people screened articles for those that met our inclusion/exclusion criteria. A third team member resolved discrepancies. Resultant articles were reviewed by two people for content.

**Results.** Our database search identified 2,067 articles, of which 7 met our inclusion/exclusion criteria. Three articles addressed services for all pediatric populations, 3 focused on pregnancy loss, and 1 focused on cancer patients. 4 articles described the types of services available, two of which highlighted variability in the breadth and depth of services offered. 3 articles described service use and noted that minorities are underrepresented.

**Conclusions and Implications for Research, Policy, or Practice.** The literature on availability of US bereavement support services for families affected
by pediatric death is sparse. Existing literature raises concerns that certain services might be unavailable to some populations. More research is needed to understand why bereavement support services are not uniformly available and to develop programs for underserved populations.

**Embedded Specialty Palliative Care Is Feasible, Acceptable, and Perceived to Be Effective in Cystic Fibrosis: Results of a Pilot Randomized Clinical Trial (TH371A)**

Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Laura Moreines, RN NPCRNP, Yale, New Haven, CT. Zachariah Hoydich, BS, University of Pittsburgh, Pittsburgh, PA. Dara Ikejiani, BS, University of Pittsburgh, Pittsburgh, PA. Jonathan Yabes, PhD, University of Pittsburgh, Pittsburgh, PA. Elisabeth Potts Dellon, MD, The University of North Carolina School of Medicine, Chapel Hill, NC. Connie Richless, MN RN, University of Pittsburgh Medical Center, Pittsburgh, PA. Robert Arnold, MD FACP FAHHPM, University of Pittsburgh, Pittsburgh, PA. Joseph Pilewski, MD, University of Pittsburgh, Pittsburgh, PA.

**Objectives**

- Appraise the challenges in conducting palliative care interventions among individuals with genetic disorders, such as cystic fibrosis (CF).
- Interpret the results of a pilot feasibility trial of an embedded specialty palliative care intervention in cystic fibrosis.

**Original Research Background.** People with CF experience myriad physical and emotional burdens, all of which degrade quality of life (QoL). Although specialty palliative care (PC) reduces suffering for individuals with serious illness, no evidence exists for its impact in CF.

**Research Objectives.** Conduct the first randomized pilot trial to evaluate the feasibility, acceptability, and perceived effectiveness of embedded specialty PC for patients with CF.

**Methods.** Following a needs assessment, we developed a protocolized, patient-centered PC intervention embedding a PC clinician within an adult CF center. Patients receive ≥4 in-person visits (and follow-up calls as needed) with a PC nurse practitioner, addressing: symptom management, emotional support, advance care planning, and coping. We measured feasibility via enrollment and assessment rates. We conducted semi-structured interviews evaluating acceptability and perceived effectiveness.

**Results.** We randomized 50 adults to intervention plus usual care, or usual care alone (approach-to-randomize rate, 79%). Fifty-six percent of our sample was male, with a median age of 32 (range: 18-67), and median FEV1 of 41% predicted (range: 20-82% predicted) at enrollment. Of 50 randomized, two died and one was lost to follow-up. Sixty-seven percent of participants reported the intervention was not burdensome and 100% agreed/strongly agreed that they were satisfied with the PC clinician's care. Sixty-seven percent of participants agreed/strongly agreed that the intervention improved their physical symptoms, 62% their QoL, and 100% felt that all patients with CF should receive specialty PC. Interview themes include: 1) appreciation that PC focuses on more than physical symptoms; 2) appreciation that PC was seamlessly integrated within usual CF care, longer clinic appointments notwithstanding; and 3) a desire to have been exposed to specialty PC earlier in their disease.

**Conclusion.** Embedded specialty PC is feasible, acceptable, and perceived to be effective among individuals living with CF.

**Implications for Research, Policy, or Practice.** Given these promising findings, further clinical trials are warranted to establish the efficacy of PC in CF.

**Early Palliative Care Consultation in the Medical Intensive Care Unit—A Clustered Randomized Crossover Trial (TH371B)**

Jessica Ma, MD, Duke University Hospital, Durham, NC. Stephen Chi, MD, Washington University in Saint Louis, Saint Louis, MO. Benjamin Buettner, MD, Barnes Jewish Hospital/Washington University, Saint Louis, MO. Katherine Pollard, MD, Indiana University School of Medicine, Indianapolis, IN. Monica Muir, DO, Mercy Hospital, Saint Louis, MO. Charu Kolekar, MD, Southern Illinois Medical Services, Carbondale, IL. Marin Kollef, MD, Washington University School of Medicine, Saint Louis, MO. Maria Dans, MD, Washington University School of Medicine, Saint Louis, MO.

**Objectives**

- Describe patient outcomes with early palliative care consultation in the medical ICU for patients with advanced disease.
- Describe impact of PC utilization on ICU and hospital resource utilization.

**Original Research Background.** Patients with advanced disease present to intensive care units (ICUs) for management; however, palliative care (PC) consultation is often delayed or not utilized.

**Research Objectives.** To study the impact of early PC consultation in the medical ICU on patients with advanced disease.

**Methods.** A PC screening tool was used to identify patients at risk for poor outcomes due to the
presence of chronic organ dysfunction or malignancy admitted to two medical ICUs (MICU) in a single center from August 2017 to May 2018. One MICU had PC consultation within 48 hours of ICU admission and the other had standard of care. The units were crossed over after 100 patients were enrolled. Multivariate logistic regression analysis was utilized.

**Results.** A total of 199 patients were enrolled, 97 in the intervention arm and 102 in the control arm; 49.3% were Caucasian and 52.3% were male, with mean age 64. The average APACHE II scores were 17.0 ± 5.2 and 17.0 ± 6.4 for the intervention and control arms respectively. There was no significant difference between MICU and hospital length of stay. Patients in the intervention arm were significantly more likely to transition to do-not-resuscitate and do-not-intubate (50.5% vs 23.5%, OR 3.32, p<0.01) and discharge to hospice (18.6% vs 4.9%, OR 4.42, p<0.01). Patients in the intervention arm also had significantly fewer ventilator days, tracheostomies performed, and post-discharge emergency room visits and readmissions (p < 0.05). There was no significant difference in death in hospital and death within 30 days of discharge.

**Conclusion.** There is a benefit in early PC consultation for qualifying patients in the medical ICU reflected by change in resuscitation preferences and hospice utilization.

**Implications for Research, Policy, or Practice.** Early palliative care involvement in the ICU may encourage increased goals-of-care discussion in patients with advanced disease and improve ICU and post-discharge care utilization.

**Provider Perspectives on Palliative Care in End-Stage Liver Disease: A Qualitative Study (TH371C)**

Macy Stockdill, RN, University of Alabama at Birmingham, Birmingham, AL. Sandhya Mudumbai, MD, University of Alabama at Birmingham, Birmingham, AL. Nicholas Hoppmann, MD, University of Alabama Birmingham, Birmingham, AL. James Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham, Birmingham, AL. Brendan McGuire, MD, University of Alabama at Birmingham, Birmingham, AL. Cynthia Brown, MD MSPH, University of Alabama at Birmingham, Birmingham, AL. Marie Bakitas, DNSc NP-C FAAN, University of Alabama at Birmingham School of Nursing, Birmingham, AL.

**Objectives**
- Identify specific challenges, needs, barriers, and facilitators to implementing palliative care in end-stage liver disease from the perspectives of clinicians.
- Identify future implications for the integration of palliative care into end-stage liver disease.

**Original Research Background.** End-stage liver disease (ESLD) patients with high symptom burden and mortality may benefit from palliative care (PC). However, PC is underutilized in ESLD patients. Few studies explore clinicians’ perspectives on the role of PC in ESLD management.

**Research Objectives.** To identify clinicians’ perspectives on patient challenges, needs, barriers, and facilitators for PC referral in ESLD.

**Methods.** Semi-structured, one-on-one interviews were conducted with 13 purposively sampled hepatology and PC clinicians at an academic medical center. Clinicians were asked about: 1) challenges in caring for persons with ESLD and their family caregivers, 2) their perceptions of PC and hospice, and 3) PC referral and access barriers and facilitators. Interviews were audio recorded, transcribed, and analyzed using thematic analysis in NVivo software.

**Results.** Clinicians (n=13) were majority female (n=8) and from hepatology/gastrointestinal disciplines (n=9). Physicians (n=6) and nurses practitioners/coordinators (n=7) were equally represented. ESLD challenges included: non-adherence to treatment, substance abuse, communicating serious news, and patient medical complexity. Needs included addressing psychological symptoms and social needs, advanced care planning, and interdisciplinary care. Most clinicians experienced PC late in disease course and were open to early integration of PC. PC Barriers included a lack of understanding of PC, difficulty introducing PC to patients with concern of “giving up”, and patient/family refusal. PC facilitators included its convenience for patients (location, same day visit), availability of interdisciplinary services, and hepatology provider education regarding PC.

**Conclusion.** Findings suggest that ESLD patient needs are potentially amendable to PC from clinician perspectives with facilitators for early integration being convenience for patients, utilizing interdisciplinary services, and education of Hepatology clinicians regarding PC.

**Implications for Research, Policy, or Practice.** Future research is needed to develop an early PC intervention that addresses the most appropriate PC referral timing, patient population, and mode of delivery based on identified needs and barriers/facilitators.
Effect of an Early Introduction to Palliative Care on Palliative Care Perceptions Among Hematologic Oncology Patients and Their Caregivers (TH371D)

Anjali Desai, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Virginia Klimek, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Peter Wan, MA, Touro College of Osteopathic Medicine, New York, NY. Aileen Heinberg, PhD, Memorial Sloan Kettering Cancer Center, New York, NY. Kelley Anderson, RN, Memorial Sloan Kettering Cancer Center, New York, NY. Camila Bernal, MPH, Memorial Sloan Kettering Cancer Center, New York, NY. Judith Nelson, MD JD, Memorial Sloan Kettering Cancer Center, New York, NY.

Objectives

- Understand how patients beginning outpatient care for hematologic malignancies and their primary informal caregivers perceive the role and value of palliative care in relation to their cancer care.
- Understand how patients and their primary informal caregivers perceive the role and value of palliative care after it is introduced and provided (at a primary level) by their oncology team, with specialist palliative care support as needed, from the beginning of their outpatient cancer care.

Original Research Background. Palliative care is beneficial throughout the serious illness trajectory and is mandated by the National Comprehensive Cancer Network as part of comprehensive cancer care. However, palliative care remains underutilized, particularly among patients with hematologic malignancies.

Research Objectives. Our institution piloted the “One-Two-Three” Program, which incorporates palliative care into the treatment approach for patients with myelodysplastic syndrome (MDS) starting at the time of diagnosis. “One-Two-Three” supports primary palliative care by the oncology team, while expanding access to Palliative Care specialists, in assessing and responding to palliative care needs. We aimed to understand how patients and their caregivers perceive palliative care when it is introduced by the oncologist as a routine part of comprehensive cancer care.

Methods. Using a written guide, a trained interviewer conducted face-to-face interviews with adult MDS patients establishing care at our institution and their informal caregivers. Questions explored participants’ perceptions of palliative care before it was introduced by the oncologist, and 5 visits later, following exposure to the “One-Two-Three” intervention. Interviews were audio-recorded, transcribed, and qualitatively analyzed by an interdisciplinary team, using Grounded Theory and ATLAS.ti software.

Results. Patients (N=21) and caregivers (N=14) initially expressed concerns with the term “palliative care,” which they associated with “end-of-life care,” whereas they had more positive impressions of “supportive care.” At follow-up, patients (N=10) and caregivers (N=4) believed that palliative care was a valuable part of their cancer care, although some participants still preferred the term “supportive care.”

Conclusion. Patients with hematologic malignancy and caregivers understand the value of palliative care in their cancer care following exposure to an early, integrated palliative care program. At our institution, the term “supportive care” may have more positive associations for patients than “palliative care.”

Implications for Research, Policy, or Practice. Early integration of primary and specialist palliative care may favorably influence patient and caregiver perceptions of the role of palliative care in comprehensive cancer care.
Friday, March 15

7–8 am

Concurrent Sessions

Embers of Hope: A Palliative Care/Burn Unit Collaboration Story (FR400)
Kristin Edwards, MD FACP CPE, YNHHS—Bridgeport Hospital, Bridgeport, CT. Kimberly Wills-Rinaldi, LCSW, Center for Geriatrics, Bridgeport, CT. Alisa Savetamal, MD FACS, Connecticut Burn Center, Bridgeport, CT.

Objectives
- Describe Unique Clinical Features of Burn Care which impact a Palliative Care approach.
- Describe key mental health aspects involved in the care of patients with burn injury.
- Identify challenges and successful elements in the development of Burn/Palliative Collaboration at a Regional Burn Center.

According to current statistics, approximately 30,000 people will be hospitalized at one of the 128 U.S. Burn Centers this year, with over 3000 patients succumbing to death from fire or inhalation injury. Yet there is little description in the literature of successful Palliative Care/Burn Unit integrated collaborations. Burn patients are unique, representing the most severe model of trauma for many of the disciplines involved. For example, patients with severe burn injury have 40-45% pre-burn psychiatric morbidity, including substance abuse, depression, anxiety, PTSD, and psychosis, and many develop post-burn PTSD and depression. Primary and specialty level palliative care integration in burn units can lead to improved pain and symptom management, clearer prognostic discussions, earlier establishment of goals of care, and assessment and treatment of mental health comorbidities.

Since 2011, the Palliative Care Team at Bridgeport has been providing consultative services, but initial Burn Service integration was sporadic and minimal. In 2016, following a successful index case, BH developed a strong PC/Burn collaboration, resulting in an average of over 20 consults per year. Average time to consult also shows earlier consultation and consultation for those with a greater chance of survival. The Bridgeport Hospital Palliative Care/Burn Service Collaboration was recognized by ACS Surveyors as an exemplary integration of the two programs to relieve distress in patients with burn injury and their families. Through case discussions, brief didactic sections, and subsequent discussion, presenters will share the core aspects of Palliative/Burn care, including challenges, successes, and lessons learned in developing a Burn/Palliative Care Partnership. Burn Unit specific issues that will be discussed are prognostication, assessment and treatment of mental health issues, pain management, and collaborative/coaching relationships with referring clinicians. These lessons, while specific to the Burn Unit, are applicable to additional settings in the development of collaborative partnerships.

Begin with the End in Mind: Interprofessional Primary Palliative Care (FR401)
Timothy Short, MD FAAFP FAAHPM, University of Virginia, Charlottesville, VA. Kenneth White, PhD ACNP ACHPN FAAN, University of Virginia, Charlottesville, VA. Elizabeth Patterson, MEd, University of Virginia School of Medicine, Charlottesville, VA.

Objectives
- Describe how an effective interprofessional (IP) primary palliative care curriculum is designed, refined and pilot tested.
- Understand how educational initiatives, when promoted by a champion or change agent, will positively shift culture in a sustainable fashion.
- Describe why primary palliative care is best practiced and taught in an interprofessional manner.

While the demand for palliative care is rapidly expanding in the United States, there is a critical shortage of palliative care specialty providers, and that shortage is compounded annually. Contributing to the urgency of this shortage is the increasing focus on end of life care, as 25% of the health care dollar in the US is spent in the last six months of life. Due to limited fellowship training programs, there is a need for widespread training of primary and specialty providers in the principles of palliative care.

Given the scope and urgency of the need, an interprofessional approach will be most effective. Palliative care was conceived and has been practiced as an interdisciplinary specialty, yet it continues to be taught in separate curricula among health care professionals. The challenges of merging nursing and medical curricula led to the development of this portable, flexible, collaborative curriculum.

While educational initiatives are important in shifting culture in a health system, they are limited. Identifying and supporting champions as change agents to embed the principles of palliative care in the healthcare system is essential and thus a “train the trainer” element was designed in the curriculum.

This workshop will describe how an IP curriculum was designed by a multidisciplinary team and refined after expert panel review and feedback from a pilot teaching program. The course, entitled “Advanced Disease Life Support” (ADLS) is composed of two parts: didactic sessions addressing core elements of the eight domains...
of palliative care and a communication component focusing on leading code status discussions and family meetings about goals of care. AAHPM workshop participants will have an opportunity to experience some of the curriculum elements in an interactive fashion. Outcomes data will be shared about the curriculum content, effectiveness of the IP curriculum and instructional design, and the impact on IP attitudes.

**Can You See Me Now? Exploring Telehealth in Palliative and Supportive Care (FR402)**

Rodney Tucker, MD MMM FAAHPM, University of Alabama at Birmingham Center for Palliative and Supportive, Birmingham, AL. Marie Bakitas, DNSc CRNP, University of Alabama at Birmingham School of Nursing, Birmingham, AL. Jennifer Hicks, MS, University of Alabama at Birmingham, Birmingham, AL. James Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham School of Nursing, Birmingham, AL. Eric Wallace, MD, University of Alabama at Birmingham, Birmingham, AL.

**Objectives**

- Explore the current evidence base for benefits of telehealth interventions in various palliative and supportive care settings.
- Summarize the potential benefits and barriers to implementing a telehealth program within palliative and supportive care.
- Develop an operational checklist of items to consider when starting a telehealth program.

Community-based Palliative Care focuses on delivering the elements of Palliative Care where people with serious illnesses spend the majority of their time – at home. This support is provided through a variety of models of care designed to meet the needs of seriously ill individuals. With increasing focus on eliminating unnecessary emergency room visits and hospitalizations while increasing quality of life and satisfaction with healthcare services, the current U.S. Health System is driving healthcare delivery models outside of the traditional hospital/clinic settings. This is encouraging healthcare providers to develop new and innovative models to provide care for seriously ill people and their families including telehealth and innovative strategies. In the emerging field of telehealth and palliative care programs.

Can You See Me Now? Exploring Telehealth in Palliative and Supportive Care

**Build It and They Will Come: Outcomes of Developing a Palliative Care Identification and Machine Learning Algorithm (FR403)**

April Krutka, DO, Intermountain Healthcare, Salt Lake City, UT. Hannah Luettek-Nahl, MPA, Cerner Corporation, Kansas City, MO. Sarah Hill, PhD, Ascension Health, St. Louis, MO.

**Objectives**

- Discuss how development of a software tool can drive development of inpatient and outpatient palliative care programs.
- Discuss Algorithms 101.
- Discuss ‘lessons learned’ and results of going live with a Palliative Care Algorithm in the acute care setting.

One of the largest barriers for seriously ill patients, is timely identification of Palliative Care needs. In the acute care setting, many admitting and consulting physicians struggle with identification of appropriate patients. Intermountain Healthcare and Ascension Health, in collaboration with an electronic medical record company, developed an electronic Palliative Care identification algorithm, or trigger, which leverages historical and near real-time data to identify patients that would benefit from Palliative Care services. This project allowed several iterations of the algorithm, which ran in a silent mode in the electronic medical record. Over time, accuracy has improved with a current positive predictive value of 80%. It has identified nearly 26% of this 310 bed hospital’s adult population as appropriate for Palliative Care services. This algorithm led to accurate data for program development and resource allocation at Intermountain Healthcare. Ascension’s St. John Providence Hospital has utilized this same Palliative Care identification algorithm in a live clinical setting since April 2017. Many lessons were learned at both the algorithm development and the deployment state which can benefit others hoping to utilize similar methods. Due to the high volume of patients and staffing capacity of most palliative care programs, risk stratification for identified patients will be necessary. Therefore, development is underway for a machine
learning algorithm to help assign a risk score to each patient identified as appropriate for palliative care services. This stratification will allow for appropriate resource allocation, identification and education about primary Palliative Care, and further adjustments to the electronic solution to help embed Palliative Care throughout the healthcare continuum. This presentation reviews the current state of an ongoing collaborative project between a major electronic medical record company and multiple large healthcare systems, as well as the lessons learned in the technology and healthcare delivery industries.

**Palliative Radiation Therapy for Palliative Care Providers: What You Need to Know and How You Can Best Advocate for Your Patients (FR404)**

Emily Martin, MD, University of California, Los Angeles, Los Angeles, CA. Shayna Rich, MD PhD MA, Haven Hospice, Gainesville, FL. Joshua Jones, MD MA, University of Pennsylvania Health System, Philadelphia, PA. Candice Johnstone, MD MPH, Medical College of Wisconsin, Milwaukee, WI.

**Objectives**
- Describe the process of palliative radiation therapy delivery and how to best support patients through the process.
- Define appropriate indications for palliative radiation therapy based on current evidence.
- Describe the most common adverse effects of palliative radiation therapy and interventions to prevent or treat them.

Radiation therapy is a highly effective intervention in the palliative management of patients with advanced cancer. Patients may have rapid and durable relief of pain, bleeding, or obstructive symptoms; reduced risk of seizures or paralysis; and improved quality of life. Unfortunately, radiation therapy can also add physical, financial, and psychosocial burdens. It is important for hospice and palliative medicine (HPM) providers to understand how to best integrate radiation therapy into a patient’s treatment plan. Patients may look to their HPM providers to clarify whether palliative radiation aligns with their goals of care, to provide reassurance during the treatment process, and to offer psychosocial support. HPM providers may need to advocate for their patients to ensure appropriate use of palliative radiation, including shorter treatment schedules, technologies with rapid turnaround times, or omission of radiation therapy altogether. HPM providers may also need to manage the adverse effects of radiation therapy and to identify patients likely to benefit from re-irradiation, as follow-up with radiation oncologists may be limited in the palliative setting.

Insufficient education in palliative radiation among HPM providers has been identified as one reason palliative radiation remains underused. In this session, we will discuss the key aspects of palliative radiation that we believe all HPM providers should know. We will explain basic terminology, provide an overview of the treatment process, and define the indications for and expected outcomes of palliative radiation. Using case examples, we will review common early and late toxicities and give recommendations about side effect prevention and management. We will also discuss how to provide support for patients throughout the radiation process. Our session’s goal is to increase HPM providers’ knowledge of palliative radiation so that they can advocate for the radiation regimen that is most suited for their patient.

**Let All Flowers Bloom: Encouraging Innovation in Kidney Supportive Care through Partnerships with ESCOs—The Pathways Project (FR405)**

Dale Lupu, PhD MPH, George Washington University, Washington, DC. Alvin Moss, MD FACP FAAHPM, West Virginia University School of Medicine, Morgantown, WV. Andrea Moore, MSW LSW, Quality Insights, Richmond, VA.

**Objectives**
- Describe the fourteen best practices for supportive kidney care developed for the Pathways Project change package.
- Discuss the opportunity that the ESCO accountable care model provides for innovating and integrating palliative care into the continuum of kidney care.
- Assess the potential for leveraging value-based purchasing arrangements to foster integration of supportive care practices in your own community.

The current care of patients with advanced chronic kidney disease (CKD) and end stage renal disease (ESRD) in the U.S. is not patient-centered, nor does it utilize palliative care approaches to optimize patients’ quality of life. In several recent studies, patients with ESRD compared to patients with other chronic diseases have received the most intensive treatments at the end of life including cardiopulmonary resuscitation, intensive care unit admission, mechanical ventilation, and feeding tube insertion. The Pathways Project, which originates from Quality Insights’ Coalition for Supportive Care of Kidney Patients, seeks to address this deficit through the implementation of an 18-month national Collaborative funded by the Gordon and Betty Moore Foundation. Fourteen teams consisting of nephrology and palliative care staff from ESRD Seamless Care Organizations (ESCOs) are participating (ESCOs are an
Implementing a Bereaved Family Survey to Improve Palliative and End of Life Care at Academic Medical Centers (FR406)

Jessica Kaltman, MD MSHS, UCLA; David Geffen School of Medicine, Los Angeles, CA. Karl Lorenz, MD MS MSHS, Stanford—VAPAHCs, Palo Alto, CA. David Casarett, MD MA FAAHPM, Duke University, Durham, NC. Stephanie Harman, MD, Stanford University School of Medicine, Stanford, CA.

**Objectives**
- Describe the process needed to implement the Bereaved Family Survey (BFS) at academic health systems.
- Explain the importance of the BFS and how it can be used to improve the quality of palliative and end of life care provided by medical systems.

With the growth of value-based payment and alternative payment models, health systems have an interest in addressing the significant deficiencies in the care of serious illness including the quality of palliative and end of life care (PEOLC). A key obstacle to improvement is difficulty in measuring care processes and outcomes at the end of life. The patient and caregiver’s experience with PEOLC is an important domain of quality inaccessible using administrative data and requires direct patient and family feedback. The Bereaved Family Survey (BFS) is endorsed by the National Quality Forum and has been used nationally by the Department of Veteran’s Affairs (VA) since 2010 to assess PEOLC at inpatient facilities. However, it has not been broadly used outside the VA or in the outpatient setting. BFS results can identify systematic problems in relation to communication, pain and symptom management, and care of the dying patient as well as patient characteristics associated with a poor end-of-life experience.

This concurrent session will help participants to assess whether the BFS is appropriate for their institutions and will provide guidance about implementation in the inpatient and ambulatory care setting. We will discuss the steps needed to execute the BFS in a large health system as well as strategies for automating the process. The presentation will review research and experiences with the BFS, address challenges in the implementation process including recent efforts in our own health systems, and provide potential solutions to these barriers, and discuss opportunities for collaboration in using it for quality improvement. The BFS collects valuable information regarding gaps in care quality vital to improve the quality of PEOLC.

Transcending Emotional Labor in Palliative Care: How Best Practices from Organizational Psychology Can Enhance Workplace Well-Being (FR407)

Erin Stevens, DO, Massachusetts General Hospital, Boston, MA. Keri Brenner, MD MPA, Stanford University, Palo Alto, CA. Gregory Stevens, PhD, Workhuman Research Institute, Globoforce, Framingham, MA.

**Objectives**
- Describe emotional labor and understand its significance within palliative care.
- Demonstrate best practices for emotion management from research within service industries and discuss the relevance within palliative care.
- Outline tips that palliative care providers can use to strategize their day to mitigate emotional labor at work.

Emotional labor, often referred to as emotional management, is an underrecognized area of research within palliative care. Emotional labor is the process by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions. Given the highly emotional nature of this work, palliative care providers are frequently attending to others’ emotions as well as those within oneself. Often, providers are able to display their true emotions, but at other times may experience emotional discrepancy and engage in emotional management. It is this emotional labor...
within palliative care that can make one especially vulnerable to feelings of inauthenticity. Studies have shown that emotional labor influences job satisfaction, burnout, and organizational well-being. In this case-based discussion led by an industrial organizational psychologist and dual trained palliative care-psychiatry and palliative care-geriatric clinicians, we will discuss emotional labor, highlighting the many areas from clinical interaction to collegial engagement where there is the potential to experience emotional labor. We will review literature from business management and organizational psychology, illustrating strategies at the organizational, team, and individual level that may help mitigate the long-term consequences of emotional labor and draw from the most recent research of the employee experience to emphasize the importance of bringing the “whole self” to work.

**Pediatric Concurrent Care: Where Are We Today? (FR408)**

Khaliah Johnson, MD HMDC, Children’s Healthcare of Atlanta, Atlanta, GA. Nancy Hutton, MD FAAP FAAHPM, Johns Hopkins School of Medicine, Baltimore, MD. Kimberly Bower, MD DC HMDC FAAHPM, Rady Children’s Hospital, San Diego, CA. Mary Tiso, RN, Gilchrist, Baltimore, MD. Judi Lund Person, MPH CHC, National Hospice & Palliative Care Organization, Alexandria, VA.

**Objectives**
- Describe the CCCR legislation and options available for its implementation.
- Identify barriers to implementing concurrent care in one’s state and strategic approaches to overcoming these barriers.
- Cite additional steps that may be taken to advocate for improved access to pediatric palliative care for Medicaid patients.

In 2010, the concurrent care for children requirement (CCCR, Section 2302) was signed into effect as part of the Patient Protection and Affordable Care Act, in order to improve pediatric patients’ access to hospice care while simultaneously receiving disease modifying treatments. This talk will provide an overview of the progress that has been made in nearly ten years since the implementation of CCCR, highlighting successes and common challenges experienced across states. Georgia, Maryland, and California will be used as case examples to demonstrate how local pediatric clinicians and stake-holders worked with state-based Medicaid programs to identify barriers to CCCR implantation and formulate a strategic plan for addressing those barriers. Finally, we will engage the audience in discussion on the impact of section 2302 on improving care for children with life-limiting illnesses, and what additional advocacy efforts can be taken to optimize its impact.

**Standing Tall: Advancing Your Career as an Academic Clinician and Educator in Hospice and Palliative Medicine (FR410)**

Sangeeta Lamba, MD FAAHPM, Rutgers New Jersey Medical School, Newark, NJ. Jane deLima Thomas, MD FAAHPM, Harvard Medical School, Harvard Interprofessional Palliative Care, Fellowship, Dana-Farber Cancer Institute/Brigham and Women’s Hospital, Boston, MA. Vicki A. Jackson, MD MPH FAAHPM, Massachusetts General Hospital, Boston, MA. Steven M. Radwany, MD FACP FAAHPM, Ohio State University Wexner Medical Center, Akron, OH.

**Objectives**
- Identify and engage in steps to start a professional development plan for academic advancement and success.
- Define the broadened scope of scholarship for academic advancement to include education, clinical practice, and leadership.
- List strategies for building a clinical and/or educational portfolio from work that you already do.

The majority of academic interdisciplinary clinicians in hospice and palliative medicine such as the physicians, nurses and social work faculty spend a large proportion of their time in clinical practice and teaching, and therefore may face unique struggles related to academic/career advancement. Faculty working in the areas of clinical innovation and education have important scholarly contributions that should be shared with the field to advance our knowledge. Many faculty erroneously believe that only rigorously designed research projects are worthy of dissemination or feel unsure about how to share their clinical innovation, quality improvement, and education work in a scholarly way. Building a portfolio of scholarly work is important when seeking advancement and/or promotion. There exists a lack of local mentors who can guide clinicians and educators on how to develop and successfully submit a portfolio since senior leadership such as Chairs have traditionally advanced on research tracks themselves. We plan to use a panel with expertise both in academic palliative medicine and faculty affairs to assist attendees in identifying how to develop a professional development plan including options for scholarship such as case reports, thought pieces, quality improvement, clinical innovation, and education projects. The goal will be for faculty to identify and document their work with a broadened scope of scholarship as contributions to the field and for their academic advancement.
8:15—10 am

Plenary Session

Defining Hope: What Makes Life Worth Living (102)
Carolyn Jones, Award-winning photographer and filmmaker.

Objectives
- Provide an outsider-looking-in perspective, and show what patients and families experience when receiving care.
- Remind healthcare professionals why it’s critical to have in-depth conversations with patients and families that cover all of the choices they will need to make when faced with a life-threatening illness.
- Explore the general public’s misconceptions about end-of-life care and hospice, and consider how, as a healthcare professional, you have an opportunity to dispel people’s fears.

In this session, filmmaker and ethnographer Carolyn Jones will bring an outsider-looking-in perspective, describing her journey into the world of healthcare as a journalist, a patient, and a family member. Having collected countless stories for her book and documentary film projects, Jones exposes some of the public’s biggest misconceptions about hospice and palliative care, and examines what it’s like to be on the receiving end of that care. Jones will share clips from Defining Hope, her latest film, which follows patients with life-threatening illness as they make choices about how they want to live, how much medical technology they can accept, what they hope for and how that hope evolves when life is threatened. It is about optimism and reminds us that we have choices in how we die.

In this session, among other stories, Jones will also delve into her own personal experience with loss, which took place unexpectedly in the midst of filming Defining Hope. Empowered with the knowledge and tools from years of interviewing healthcare professionals about end-of-life choices, she was able to navigate the impossible decisions she and her family were forced to make. Her goal is to jumpstart critical conversations and help people define what truly makes life worth living.

10:45—11:45 am

Concurrent Sessions

Advancing Legal and Medical Collaboration in Advance Care Planning (FR411)

Objectives
- Describe the barriers to collaborating and communicating people’s medical wishes between the medical and legal professions,
- Evaluate solutions to medical-legal collaboration concerning advance care planning,
- Describe the new advance care planning guide for lawyers, and
- Employ three or more tools to improve communication between lawyers and health care providers on advance care planning.

While health systems are increasingly engaged in advance care planning, patients are still more likely to complete formal planning with lawyers than with medical or other professionals. Yet the medical and legal professions view advance care planning through different lenses and without much interprofessional dialogue. Opportunities to improve the quality and efficacy of ACP practice are too often missed. To address this gap, a diverse group of organizations, lawyers and healthcare professionals helped to identify the most common barriers to effectively communicating individuals’ medical wishes among medical providers, lawyers, and healthcare systems. Working groups helped to determine solutions culminating in a new guide for lawyers called “Advance Directives: Counseling Guide for Lawyers,” by the American Bar Association Commission on Law and Aging. The guide provides detailed information on how to bridge the chasm between lawyers and doctors. This session will discuss the development of this toolkit and best practices in collaborating across the medical and legal fields to ensure patients’ advance care planning wishes are honored. This was a collaborative project funded by the John A. Hartford Foundation that included the American Bar Association Commission on Law and Aging, the American Academy of Hospice and Palliative Medicine, the University of California, San Francisco Medical School and the UCSF/UC Hastings Consortium on Law, Science & Health Policy.

Palliative Care and ACOs: Making the Case for a Match Made in Heaven (FR412)
Allison Silvers, MBA BA, Center to Advance Palliative Care, New York, NY. Robert Saunders, PhD, Duke University, Durham, NC. Laura Patel, MD, Transitions LifeCare, Raleigh, NC.

Objectives
- Describe at least 3 priorities of accountable care organizations (ACOs) in the US, and how they might differ by type of organization.
• Articulate the business case for ACO investment in palliative care services.
• Apply at least 2 additional relationship strategies needed for long-term partnership with ACOs.

Currently, less than one-third of accountable care organizations (ACOs) have formal contracts with palliative care providers, despite the fact that many of the ACO goals can be advanced through palliative care services. At the same time, there are ACOs that have been leaders in starting, growing, and/or driving access to palliative care services for their patients, and many are seeing positive results. This session will cover three things. First, it will explore the state of accountable care in the US, highlighting geographic, ownership and maturity variations that can make a difference in partnership interest levels. Second, drawing on cases of successful palliative care-ACO partnerships, the session will provide attendees with the business case that they can make for investment in palliative care. Lastly, because the path towards financial partnership is rarely straight-forward, this session will also explore what a program might expect even once the business case is successfully made.

Innovative Applications of ELNEC Curriculum: Eighteen Years Equipping Nurses to Deliver Palliative Care in Diverse Care Settings (FR413)

Jennifer Seaman, PhD RN, University of Pittsburgh, School of Nursing, Pittsburgh, PA. Susan DeSanto-Madeya, PhD MSN RN APRN, Boston College, Chestnut Hill, MA. Laura Fennimore, DNP RN, University of Pittsburgh, Pittsburgh, PA. Constance Dahlin, ANP ACHPN FAAN FPCN, Hospice and Palliative Nurses Association, Pittsburgh, PA.

Objectives
• Define primary palliative care and name three reasons why primary palliative care is important for all patients and families.
• Describe the ELNEC program and model for dissemination of primary palliative care education and give three examples of how ELNEC curriculum has been adapted in diverse care delivery settings to provide clinicians with primary palliative care education

Background. The End-of-Life Nursing Education Consortium (ELNEC) was established in 2000 as a national education initiative to expand the capacity of nurses in diverse care settings to integrate palliative care into practice. ELNEC uses a train-the-trainer model and adaptable curriculum materials. ELNEC has expanded to offer multiple specialty courses; and in 2017, the ANA and HPNA recommended that all nurses have ELNEC training as the basis of primary palliative nursing practice.

Methods. We use case examples to demonstrate how ELNEC curriculum has been successfully adapted for diverse learners.

Results. ELNEC curriculum has been implemented to educate acute care nurses, graduate students in a palliative care certificate program, and care managers and social workers within a health plan:
1. A metropolitan medical center administered a needs assessment survey to all inpatient nursing staff. Based on the survey results, multiple 30-minute unit-based educational sessions using portions of ELNEC modules are being piloted to increase nurses’ knowledge of palliative care.
2. Clinical staff at a community hospital wanted to better support families after they had received bad news. ELNEC Core curriculum was used to provide a 3-hour training on communication.
3. Learning strategies from the ELNEC modules are being threaded throughout graduate level interdisciplinary palliative care courses housed within the School of Nursing at a university.
4. An ELNEC Course was offered to more than 250 care managers and social workers for a health plan to increase awareness of the comprehensive needs of members with serious illness and encourage early referral to palliative and community resources.

Conclusions. Across care settings, nurses, care managers, and social workers are ideally positioned to identify and address unmet palliative care needs in the populations they serve. These examples demonstrate how ELNEC curriculum can be adapted to disseminate primary palliative care knowledge, enabling clinicians to improve quality of life for their patients living with serious illness.

General Inpatient Payment and the Office of Inspector General...Can They Live Together in Perfect Harmony? (FR414)

Ruth Thomson, DO MBA HMDC FAAPM FACOI, Jack Byrne Center for Palliative and Hospice Care, Hanover, NH. Terri Gross, BS RN CHPN, Hospice of Dayton, Dayton, OH.

Objectives
• Recognize the issues faced by hospice programs providing, or not providing, the general inpatient (GIP) level of care.
• Examine the Medicare regulations pertaining to the hospice GIP level of care.
• Demonstrate knowledge of clinical criteria for initiating, continuing and terminating the GIP level of care.

Over the past decade, the hospice industry has experienced increasing regulatory scrutiny and change. One area of recent focus is the provision of the general
inpatient (GIP) level of care. The Office of Inspector General (OIG) published a report in 2016 concluding one-third of GIP stays in 2012 were inappropriate, costing Medicare $268 million in unnecessary care. In response, CMS began tracking hospice GIP stays longer than 5 days in the Program for Evaluating Payment Patterns Electronic Report (PEPPER). Conversely, CMS also includes “no GIP” use as a target area in the PEPPER, which has confirmed a number of hospices do not offer any GIP care. A few mainstream media articles have lashed out at the hospice industry for not offering higher levels of care and leaving patients and families without symptom management when they need it most. Interestingly, CMS has given this issue less attention. From the government’s perspective, it seems there is either too much or too little GIP. What is a hospice to do in this no-win situation? First, hospices that do not provide GIP need to address the obstacles that prevent them from offering this required level of care. Second, hospices that offer too much GIP need to review and better understand the Medicare regulations as well as clinical criteria and decision-making related to GIP. This session reviews the risks and challenges hospice programs face in providing, or not providing, the GIP level of care. The discussion then takes a deeper dive into the Medicare regulations and clinical criteria, decision making, and care transitions that need to be considered when offering the GIP level of care. Through didactics, case presentations, and audience participation, learners will be able to navigate GIP care confidently and compliantly… resulting, hopefully, in their hospice programs achieving GIP and OIG harmony.

**Picture My Voice: Harnessing the Power of Comics in Palliative Care (FR415)**
Nathan Gray, MD, Duke University School of Medicine, Durham, NC. Kristen Lakis, LCSW, Duke University Hospital, Durham, NC.

**Objectives**
- Identify ways that palliative providers can use comics to share and process powerful experiences in care.
- Cite examples of how comics can be used to support patients through illness and provide education.
- Participate in creation of a brief comic narrative demonstrating the power of graphic medium in sharing thoughts or experience.

Graphic narratives, often referred to as “comics,” are increasingly recognized as a unique and powerful platform to help both healthcare providers and patients in promote education and exchange of stories in illness and care. For Palliative Care providers who are seeking ways to support clinicians and reduce burnout, graphic narrative can be an accessible and rapid means for processing distressing healthcare experiences, and resultant works can be used to provide support to colleagues. For patients, graphic narrative can be a moving method for sharing their illness with subtleties of emotion or experience that are not easily captured with prose, and comic educational materials may be more approachable for a variety of audiences and literacy levels than simple text. Finally, reviewing the graphic narratives of others helps patients humanize their illness and offers healthcare providers a unique window into what their patients are experiencing.

Many palliative providers may be unfamiliar with the literature that exists on comics in healthcare, unaware of graphic resources available to patients, and uncertain how to utilize graphic narrative in the care of themselves and those they treat. In this conference session, an interdisciplinary duo will open the pages of “graphic medicine” to participants with case examples and visual representations of outstanding health comics that highlight their potential uses in Palliative Care. Providers will develop a toolkit of techniques for using graphic narrative to care for themselves and their patients, and the session will close with an opportunity for participants to create their own brief comic narrative.

**Navigating the Landscape of Increased Cancer Survivorship: When Malignant Pain Transitions from Acute to Chronic (FR416)**
Jennifer Dulin, MD, Medical University of South Carolina, Charleston, SC. Shana Semmens, MD, Banner University Medical Center, Tucson, AZ. Theodore Gourdin MUSC, Charleston, SC. Stephanie Abel, PharmD, The Ohio State University Wexner Medical Center, Columbus, OH.

**Objectives**
- Consider how immunotherapy and prolonged survival are impacting symptom management in patients with incurable malignancies.
- Describe how to assess symptom burden and likelihood of persistence in patients with cancer.
- Identify therapies and conditions which warrant consideration of prophylactic interventions to mitigate development of cancer related pain.

Recent advances in cancer therapies, especially immunotherapy, have drastically impacted cancer treatment and survival. These advances engender earlier diagnosis and longer survival. Increased survivorship and novel therapies bring new challenges including symptom clusters and pain syndromes as well as unknown long-term and late effects of both disease and...
treatment. Assessment of symptoms as well as treatment are challenging as pharmacologic approaches must consider the treatment, interactions with treatment as well as long-term impact on the patient. The benefits of such advances are dramatic, so too are the challenges for palliative care providers. Despite the increased prevalence of cancer survivors and those living with cancer, data regarding pain in this population is lacking but purported to be between 16 and 50%. Chronic pain in this population is often neuropathic; CIPN appears to be on the rise. Cancer pain is complex—due to tumor, anti-neoplastic therapies, associated nerve damage as well as local and generalized inflammation. Tumor related factors and responses such as cachexia, fatigue and nausea often reinforce pain syndromes. Cancer pain does not follow non-malignant trajectories; assessing and treating pain in survivors is similarly unique. There is limited evidence for pain treatment in this population; however, long-term use of opioids and adjuvant analgesics have both known and unknown consequences.

Cancer survivors demand surveillance—a multidisciplinary team and partnerships amongst oncology, palliative care, pain management and rehabilitation specialists are ideal—pain and other symptoms often signal recurrent disease, second malignancy or late onset treatment effects that warrant evaluation, treatment and monitoring. Developing and implementing assessment tools, considering prophylactic therapies prior to treatment and nurturing relationships amongst specialists as well as investigating and utilizing adjuvant, non-opioid therapies is essential in this era of increasing survival.

Substance Use as a Family Disease: Shepherding the Flock Safely Through the End of Life (FR417)
Zachary Sager, MD MA, BIDMC/Boston VA, Boston, MA. Kathleen Faulkner, MD FAAHPM, Good Shepherd Community Care, Newton, MA. Sianna Lieb, MSW, Good Shepherd Community Care, Newton, MA.

Objectives
- Identify the importance of creating structure and a ‘holding environment’ for individuals with substance use disorders (SUDs), in particular during the transition to home hospice.
- Describe how family systems theory can be used to conceptualize and assess the family containing someone with a substance use disorder.
- Describe safety measures used by the hospice team to limit substance misuse and diversion in the home setting.

Opioids have long been a mainstay of symptom management in hospice care, allowing patients with terminal illnesses to have an improved quality of life in the final part of their journeys. Unfortunately, these same medications have contributed to the explosion of the opioid epidemic. As patients with substance use disorders (SUDs) age and develop other life-limiting illnesses, many will be referred to hospice care. For these individuals, opioids used for symptom management can increase suffering due to misuse of medications and addiction. Individuals with SUDs are often dealing with comorbid psychiatric illnesses, coupled with the challenges all individuals face at the end of life, making them particularly vulnerable to chemical coping, escalating misuse, or relapse. Bringing principles of addiction psychiatry and family systems into the home environment can help us safely shepherd individuals through the final part of their lives.

Beyond Charlie Gard: Rights, Responsibilities and Rational Response in the Realm of Parental Requests for Potentially Non-Beneficial Treatment (FR418)
Deena Levine, MD, St Jude Children’s Research Hospital, Memphis, TN. Robert Macauley, MD MFA FAAHPM, OHSU, Portland, OR. Elisha Waldman, MD FAAHPM, Lurie Children’s Hospital of Chicago, Chicago, IL.

Objectives
- Discuss the ethical issues raised by the high-profile case of Charlie Gard, as well as, parental requests for potentially non-beneficial treatment in a broader historical and practical context.
- Discuss multiple perspectives on the complex issues of parental requests for potentially non-beneficial treatment.
- Discuss the potential influence of public opinion and modern media in such cases.

The much-publicized case of Charlie Gard brought the issue of parental requests for potentially non-beneficial treatment (NBT) into the public eye. It is not
hard to understand why parents would advocate fiercely for any treatment that could benefit their child. At what point, though, should clinicians decline such requests based on lack of benefit or disproportionate burden? And what role should institutional policies and public opinion have in determining the proper response to such requests? Using the 2015 ATS/AACN/ACCP/ESICM/SCCM consensus statement on NBT as a framework, this interactive case-based session will examine requests for potentially non-beneficial treatment from clinical, historical, legal, and personal perspectives. After tracing the trajectory of medical decision-making from paternalism to radical autonomy, recent attempts at defining and actualizing the concept of medical futility will be reviewed. Competing notions of burden and benefit will be explored, with specific reference to physicians’ well-documented tendency to underestimate quality of life compared to patients and their families. A multi-disciplinary panel will aid in presenting various perspectives, including that of the parents and families. Clinicians’ engagement with public opinion will be specifically addressed by a palliative care physician who weighed in about the Charlie Gard case, and will explore the degree to which we assume responsibility in presenting these issues to the public evenly and accurately, as well as the potential pitfalls of modern media. Practical steps—including recommendations for specific language, institutional policies, and mediating measures—will be presented.

“My Family Would Be Better Off Without Me”: Managing Suicidal Ideation and Risk in Palliative and Hospice Care (FR419)

David Gruenewald, MD FACP, VA Puget Sound Health Care System, Seattle, WA. Kathleen Bickel, MD MPhil MS, University of Colorado School of Medicine/Rocky Mountain Regional VAMC, Aurora, CO. Jaclyn Schneider, MD, VA WNY Healthcare System, Buffalo, NY. Christopher Parkinson, PhD, Southeast Louisiana Veterans Health Care System, New Orleans, LA. Sumathi Misra, MD MPH CMD FAAHPM, Vanderbilt University Medical Center, Nashville, TN. Lynn Bushor, DNP APRN ACHPN, Veterans Health Administration, Mayfield, KY. Richard Stiles, MSN, Department of Veterans Affairs, New York, NY.

Objectives

- Recognize the high prevalence rate of suicidal ideation, attempts, and completed suicide in Veteran and non-Veteran patients receiving palliative care, and the widespread impact of suicide on survivors including family and professional caregivers.
- Describe validated assessment tools and evidence-based treatments to identify and manage patients at high risk of suicide in palliative care settings.
- Identify actionable strategies to integrate suicide risk assessment and management into clinical practice across various palliative care and hospice settings in Veteran and non-Veteran populations.

People facing serious medical illness often experience significant and debilitating psychological distress in addition to symptoms associated with the underlying disease. While many people are resilient, large epidemiologic studies suggest increased risk of suicide in serious medical illness. For example, in a study of suicide risk and precipitating circumstances in male Veterans >age 65 years, the adjusted odds ratio of suicide was 36-fold higher in those with physical health problems. Suicide in palliative care and hospice patients has not been widely studied, but known suicide risk factors include: older age, history of mental health problems, male gender, social isolation, recent medical hospitalization, poor physical functioning, and access to lethal means including opiates or firearms. Suicidal behavior is more lethal later in life, due to increased frailty, social isolation, greater resolve, and greater likelihood of firearm use.

Despite the high prevalence of these suicide risk factors in palliative care patients, few palliative or hospice programs have routine, standardized screening for suicide risk. Limited data guiding suicide assessment and prevention in palliative care are largely extrapolated from other patient populations. Multiple questions remain, including: should all palliative care and hospice patients be screened routinely for suicide risk? What assessment tools should be used? What warning signs signify especially high risk in this population? What words work best to evaluate risk without detracting from other goals of palliative care encounters? What interventions minimize suicide risk in palliative care patients?

In this concurrent session, our interdisciplinary panel will review current knowledge of suicide risk assessment and prevention across palliative care settings. We will present conceptual frameworks connecting suicidality, interpersonal risk factors, and biopsychosocial-spiritual domains. Then, based on evidence and clinical expertise, we will offer recommendations for assessing and stratifying suicide risk along with suicide risk-reduction strategies adaptable to palliative and hospice care settings.

Palliative Connect: Triggered Palliative Care Consultation Using an EHR Prediction Model (FR420A)

Kate Courtwright, MD MS, University of Pennsylvania, Philadelphia, PA. Corey Chivers, PhD, University of Pennsylvania Health System, Philadelphia, PA. Michael Becker, BS, Penn Medicine, Philadelphia, PA. Susan Regli, PhD, University of Pennsylvania Hospital System, Philadelphia, PA. Michael Draugelis, BS,
Penn Medicine, Philadelphia, PA. Nina O’Connor, MD FAAHPM, University of Pennsylvania, Philadelphia, PA.

**Objectives**
- Describe the general process used to develop and implement an EHR-based mortality risk stratification model.
- Assess the impact and implications of implementation of an EHR-based mortality risk stratification model on clinical, quality, and financial metrics.

**Background.** The frequency and timing of palliative care consultation is highly variable among inpatients with life-limiting illnesses despite evidence of its benefits.

**Objectives.** To develop an EHR-based risk stratification model and evaluate its impact as a trigger for inpatient palliative care consultation.

**Methods.** We performed a retrospective cohort study at three urban hospitals among 63,045 admissions in 2016. Using a randomly split sample and a machine learning approach, we developed and validated an EHR-based model (Palliative Connect) to predict risk of death within six months of admission. We then determined a risk threshold of ≥30% based on expert chart review and prospectively piloted Palliative Connect in a 4-month pre-post study of triggered palliative care consultation on a general medicine service at a large academic hospital. Primary clinicians could decline the consult. We performed an intention-to-treat analysis to evaluate impact on care delivery, quality metrics, and costs.

**Results.** The final prediction model had excellent discrimination (c-statistic 0.84, 95% CI 0.83-0.86). There were no differences in demographics between the pre- (n=142) and post-intervention (n=134) cohorts, with a mean age of 72 years (SD 12.9) and mean risk score of 0.50 (SD 0.16). One in three triggered consults were declined by the primary clinician. In the post-intervention period, there were increased consult orders (63.4% vs 16.2%, p<0.001) and advance care planning notes (26.9% vs 16.9%, p=0.04) in the EHR, and the pre-consult length of stay was lower (1.6 days vs 2.8, p=0.04). Rates of ICU admission, hospital mortality, and 30-day readmission, and mean direct hospital costs were lower post-intervention, and hospice discharges increased, although not statistically significantly.

**Conclusion.** The Palliative Connect model accurately identifies inpatients with high risk of mortality who would not otherwise have received a palliative care consult and shows great promise as a trigger for consultation to improve outcomes.

**Implications for Research, Policy, or Practice.** Innovative predictive analytics may increase palliative care penetration and improve outcomes among patients most in need.

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**Specialty vs. Primary Palliative Care in Randomized Clinical Trials: A Systematic Review (FR420B)**

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**Objectives**
- Describe the state of evidence for palliative care interventions broadly.
- Describe evidence for primary palliative care as one mechanism for potential palliative care delivery.

**Background and Objective.** Evidence shows specialty palliative care (SPC) improves quality of life and reduces symptom burden among seriously-ill patients, yet a shortage of SPC clinicians has prompted primary palliative care (PPC). We compared intervention content, delivery, and outcomes of SPC vs. PPC interventions tested in published RCTs.

**Study Identification.** We updated a 2016 systematic review of palliative care RCTs by reviewing MEDLINE, EMBASE, CINAHL, and Cochrane CENTRAL through December 2017 using National Consensus Project for Quality Palliative Care guidelines.

**Data Extraction and Synthesis.** Three authors classified interventions as SPC or PPC: SPC involved clinicians who were either palliative care board-certified or sub-specialty trained or had extensive clinical experience in palliative care. All other trials were considered PPC. We characterized elements of the interventions, delivery setting, and outcomes.

**Results.** Of 53 palliative care RCTs, 32 were SPC vs. 21 PPC. Most trials incorporated structural palliative care delivery and symptom management. A greater proportion of SPC interventions included ethical and decision-making aspects of care (13/32; 41%) compared to PPC (4/21; 19%). SPC interventions were delivered in inpatient (15/32; 47%) and/or outpatient settings (18/32; 56%) by specialty physicians (16/32; 50%) and nurses (16/32; 50%); PPC interventions were often delivered in the home (8/21; 38%) by nurses (16/21; 76%). In both SPC and PPC trials, most
studies assessed psychological (respectively, n=24/32, 75%; 12/21, 57%) and physical (n=21/32, 66%; 11/21, 52%) symptom burden and patient quality-of-life (n=20/32, 63%; 10/21; 48%) outcomes, of which most favored the intervention arm.

Conclusions and Implications. There were notable differences in intervention content and delivery between SPC and PPC interventions. Both were associated with improvements in outcomes of seriously-ill patients. PPC interventions with different content and delivery mechanisms may be effective to meet some, but not all, palliative care needs of seriously-ill patients and their families.

Evaluating the Impact and Costs of Home-Based Palliative Care at the System Level (FR420C)
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Objectives

- Appreciate home-based palliative care’s potential impact on patients at the end of life.
- Recognize utilization and cost benefits of home-based palliative care and apply economic evaluation to assess the value-for-money of palliative home care.

Original Research Background. While there has been increased investment in palliative care in Ontario, Canada, the evidence remains inconclusive regarding the cost-effectiveness and impact of home-based palliative care at a system level.

Research Objectives. To describe and understand the impact of home-based palliative care on place of death and healthcare cost in the last 3 months of life.

Methods. We conducted a population-based retrospective cohort study using health administrative data from Ontario’s publicly funded home care program. We included adult decedents who died between April 2011 and March 2015. Regression analyses examined the relationship between receipt of home care (including service type, such as nursing), place of death (acute vs. non-acute) and healthcare cost. We calculated the incremental cost-effectiveness ratio (ICER) of palliative care, which is a measure of the added cost per unit of benefit (in this case, death diverted from an acute care facility).

Results. Decedents who received home-based palliative care in the last 3 months of life were less likely to die in acute care (OR = 0.248, p<0.001) and had lower estimated total healthcare cost (OR = 0.935, p<0.001) than those who did not receive home care services. Palliative visits by nurse practitioners demonstrated the largest effect on reducing the risk of acute care deaths (OR=0.948, p<0.001) and healthcare cost (OR= 0.982, p<0.001). Considering costs and benefits together, the ICER indicated that for every $0.25 invested in home-based palliative care, one hospital death is avoided.

Conclusion. Decedents who received home care, specifically care from palliative care nurse practitioners, were less likely to die in acute care and had lower healthcare cost.

Implications for Research, Policy, or Practice. One’s dying experience could be improved by the receipt of home-based palliative supports, which require relatively minimal financial support, given the costs they offset and benefits they provide.

Same or Different? Comparing Cancer and Non-Cancer Patients Referred to Outpatient Palliative Care (FR420D)

Objectives

- Describe key differences between cancer and non-cancer patients referred to clinic-based outpatient palliative care.
- Describe how the outpatient palliative care provided to cancer patients differs from that provided to non-cancer patients.

Original Research Background. While outpatient palliative care (PC) began primarily in cancer centers, outpatient PC increasingly serves patients with a wide range of diagnoses.

Research Objectives. Compare characteristics of patients with cancer and non-cancer diagnoses referred to clinic-based PC, and the care they receive.

Methods. Data were extracted from the Palliative Care Quality Network database regarding 3,569 patients seen by 27 clinic-based PC teams between 01/15/2016 and 07/17/2018.

Results. Overall 79.3% (n=2,766) of all patients referred to outpatient PC had cancer. Compared to patients with non-cancer diagnoses, patients with
cancer were younger (63.9 v 67.9 years; p<0.0001) and had higher Palliative Performance Scale scores (70.9 v. 62.7; p<0.0001).

Patients with cancer were more commonly referred for pain and other symptom management, compared to patients with other diagnoses (83.3% v. 63.9%; p<0.0001). Patients without cancer were more commonly referred for advance care planning (47.1% v. 32.2%; p<0.0001) and support for patient/family (31.3% v. 23.0%; p<0.0001).

Using a 10-point scale (0='none' to 10='worst possible'), patients with cancer reported more pain (4.3 v 3.7; p=0.003) and less depression (2.4 v. 2.9; p<0.001), anxiety (2.7 v. 3.1; p<0.05), and dyspnea (2.2 v. 3.1; p<0.0001).

Patients with cancer identified a surrogate less frequently than non-cancer patients (58.5% v 69.6%; p<0.0001). Fewer cancer patients had a code status of DNR/DNI (35.7% v. 51.9%; p<0.0001) and POLST forms were less commonly completed (19.1% v. 34.6%; p<0.0001).

**Conclusion.** Outpatients with cancer, compared to those with other diagnoses, differ in demographics, reasons for referral, and symptoms. They receive somewhat different care, especially around advance care planning.

**Implications for Research, Policy, or Practice.** As outpatient PC services grow, it will be important to consider the distinct needs of patients with cancer and other diagnoses in order to design and target services optimally.

### The Evaluation of Health Literacy, Spiritual Coping, and Advance Care Planning Following a Culturally Sensitive Intervention for African American Cancer Patients (FR421A)

Ramona Rhodes, MD, UT Southwestern Medical Center, Dallas, TX. Tori Knox-Rice, PHD, UT Southwestern Medical Center, Dallas, TX.

**Objectives**
- Present results of a pilot-intervention designed to increase advance care planning (ACP) engagement within an African American cancer population.
- Describe an investigation into health literacy and religious coping in the context of ACP, with the intention of assessing barriers that impact the completion of advance directives.

**Original Research Background.** Prior investigations into disparities in advance care planning (ACP) among African Americans (AAs) suggest that there is a need to develop interventions to increase engagement in the ACP process.

**Research Objectives.** To test an intervention designed to increase awareness of and intention to complete advance directives (AD) and medical power of attorney (MPOA) among a cohort of AA cancer patients.

**Methods.** AA breast, lung, colon, and prostate cancer patients (Stage II, III, or IV) were randomized to an intervention versus a usual care control group. Intervention participants met with an AA lay health advisor (LHA) who facilitated viewing of a video that addressed barriers to completion of ACP and subsequent discussion. Change in stage of intent to complete AD/MPOA was measured by Transtheoretical Stages of Change Model. Linear regression was conducted to evaluate whether the intervention was associated with a change in stage of intent to complete ACP from baseline to 1-month assessment. Cancer health literacy and religious coping were analyzed as potential moderators.

**Results.** Fifty-six patients were enrolled (28 intervention group, 28 control group). The majority of patients (71%) were found to have high cancer-related health literacy and high religious coping (53%). The intervention was associated with a progression in stage of intent to complete ADs at one month (B = -0.83, t(47) = -2.79, p = 0.007) versus controls. Increased intent to appoint an MPOA at 1 month was not statistically significant. Health literacy and religious coping were not associated with change in intention.

**Conclusion.** This culturally sensitive intervention was associated with progression in stage of intent to complete ADs at 1-month follow-up assessment. Health literacy and religious coping were not considered moderators.

**Implications for Research, Policy, or Practice.** This work highlights the possible utility of a culturally sensitive intervention designed to improve engagement in ACP among African Americans. Future research should continue to address barriers in this area.

### Exploring the Role of Religion and Spirituality in Provider-Patient Communication Among African-Americans with Advanced Heart Failure and Their Family Caregivers (FR421B)

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Partnering with African American Pastors and Healthcare Professionals to Develop Training Videos that Demonstrate Culturally Appropriate Physician Communication Principles and Methods (FR421C)

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Objectives

- Describe how to determine the cultural values and goals of their patients.
- Develop a training video with their partners.

Original Research Background. Culture significantly impacts the way people think of illness, suffering, and dying. Lack of understanding by clinicians of their patients’ unique culture often results in miscommunication, lack of trust, frustration, and patients not receiving goal-concordant care.

Research Objectives. Use Community Based Participatory Research to develop and test the efficacy of training videos highlighting culturally appropriate communication methods for physicians caring for Rural Southern African Americans (RSAA) with serious illness. Phase 1: Determine how RSAA pastors and patients with a serious illness and their families prefer clinician communication. Phase 2: In partnership with RSAA pastors and healthcare providers, develop training videos, each of which demonstrates a culturally appropriate physician communication principle and method(s). Phase 3 (not reported): Following training with the videos, determine physicians’ confidence in communicating with their RSAA patients and family in a culturally appropriate manner.

Methods. Phase 1: Two focus groups were conducted with RSAA: (a) Local pastors and (b) patients and caregivers. Questions focused on how they wanted physicians to communicate with and care for their loved ones. Data was analyzed using thematic analyses. Phase 2: Based on each Phase 1 theme, CAG members developed a scenario that they scripted and in which they acted, that was filmed by a RSAA filmmaker.

Results. Phase 1: Themes included maintaining hope despite life-limiting prognosis; focus on the family, not just the patient; importance of spirituality/religion; and the significant role of pastors. Phase 2: A series of scenarios were developed based on each emergent...
theme. Videos included a cultural explanation of the need for such communication.

**Conclusion.** Partnering with RSAA pastors and healthcare providers resulted in the development of a series of training videos that focus on culturally respectful communication methods for clinicians caring for RSAA patients.

**Implications for Research, Policy, or Practice.** Enhancing clinicians’ knowledge of culturally appropriate communication has the potential to build trust and meet RSAA patients’ goals of care.

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**Engaging Diverse English- and Spanish-Speaking Older Adults in Advance Care Planning: The PREPARE Randomized Clinical Trial (FR421D)**


**Objectives**

- Describe the design and implementation of free, easy-to-use, patient-facing advance care planning tools (www.prepareforyourcare.org), particularly for vulnerable and disenfranchised populations.
- Describe the comparative efficacy of an online advance care planning program called PREPARE (www.prepareforyourcare.org) plus an easy-to-read (5th-grade reading level) advance directive versus an advance directive alone on new advance care planning documentation and self-reported advance care planning engagement without additional clinician or system-level interventions.

**Original Research Background.** Advance care planning (ACP) improves value-aligned care; yet, it remains sub-optimal among diverse patient populations. To mitigate literacy, cultural, and language barriers, we created easy-to-read advance directives (ADs) and a patient-directed, online ACP program called PREPARE in English and Spanish.

**Research Objectives.** To compare the efficacy of PREPARE plus an easy-to-read AD (PREPARE arm) to an AD alone to increase ACP documentation and patient-reported engagement.

**Methods.** We conducted a comparative efficacy randomized trial from February 2014 to November 2017 in four San Francisco, safety-net, primary-care clinics among English- or Spanish-speaking adults age ≥55 years, with ≥2 chronic or serious illnesses. Participants were randomized to the PREPARE arm or the AD alone. There were no clinician/system-level interventions. Staff were blinded for all follow-up assessments. The primary outcome was new ACP (i.e., legal forms and/or documented discussions) at 15 months. Patient-reported outcomes included ACP engagement at baseline; 1 week; and 3, 6, and 12 months using validated surveys. We used intention-to-treat, mixed-effects logistic and linear regression, controlling for time, health literacy and baseline ACP, clustering by physician, and stratifying by language.

**Results.** The mean (SD) age of 986 participants was 63.3 years (± 6.4); 39.7% had limited health literacy; and 45% were Spanish-speaking. No participant characteristic differed between arms; retention was 85.9%. Compared to the AD alone, PREPARE resulted in higher ACP documentation (adjusted 43% vs. 32%; p < 0.001) and higher self-reported increased ACP engagement (98.1% vs. 89.5%; p < 0.001). Results remained significant among English and Spanish speakers.

**Conclusion.** The patient-facing PREPARE program and an easy-to-read AD, without clinician/system-level interventions, increased ACP documentation and patient-reported engagement, with statistically higher gains for PREPARE for both English- and Spanish-speaking older adults.

**Implications for Research, Policy, or Practice.** These tools may mitigate literacy and language barriers to ACP, allow patients to begin planning on their own, and could substantially improve the process for diverse, English- and Spanish-speaking populations.

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**1:30–2:30 pm**

**Concurrent Sessions**

**The Practice of Palliative Medicine in Developing Countries—Part One (FR430)**

Natalia Carafizi, MD MPH, Charity Foundation for Public Health, Chisinau, Moldova. Mohd Khilji, MD, S P Medical College, Bikaner, India. Atif Waqar, MBBS, Aga Khan University Hospital, Karachi, Pakistan.

**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.

**Promoting Resilience and Longevity in Palliative Medicine: A Focus on Being Well While Being Productive (FR432)**

Rita Manfredi, MD FACEP, George Washington University School of Medicine, Washington, DC. Martha Roberts, MSN ACNP PNP, Marymount University, Arlington, VA. Carol Ramsey-Lucas, MDIV, Washington DC VA Medical Center, Washington, DC. Jan Bull, MA, Maryland University of Integrative Health, Laurel, MD. Rebecca Goett, MD FACEP, Rutgers New Jersey Medical School, Newark, NJ.

**Objectives**
- Describe the dimensions of wellness for the palliative clinician and develop strategies to sustain wellbeing.
- Construct a personalized wellness tool box for use in the clinical setting for all members of the palliative team and identify methods of implementation.
- Discuss validated measurement tools to assess wellbeing individually and departmentally.

The high prevalence of burnout in palliative clinicians, 62% in recent studies, suggests that palliative and hospice care practice may be more demanding and stressful than previously thought. The current unmet demand for more palliative providers and services in a setting where patients are increasingly complex contributes to the deficiency of wellness and resiliency in clinicians. It is critical for providers and their departments to recognize the impact of burnout and lack of resilience on patient safety, quality of care, and satisfaction of patient, family, and staff.

The National Academy of Medicine recently launched the Clinician Well-Being Knowledge Hub, a comprehensive resource promoting clinician well-being at the individual and system levels. Such resources provide a framework where being well can be seen as an evolving process through which a provider achieves his or her full potential.

To achieve this goal, how will providers in hospice and palliative medicine tackle the issues surrounding resilience, burnout, and “unwellness”? In this concurrent session, wellness will be represented as a multi-spoked wheel containing all the dimensions necessary for professional wholeness and balance in the specialty. Clinicians from multiple disciplines will discuss a common framework individuals and departments can utilize to build a collegial mental model for being well, building resilience and preventing burnout while being productive clinically.

Review of case examples, didactics, and discussion will illustrate how a palliative clinician can positively impact his or her individual wellness. Validated tools, such as the Professional Quality of Life, which measure compassion, quality of life, and resilience, will be discussed. Since departmental wellness significantly impacts individual wellness, solutions and strategies will be presented which improve wellness at both levels. Exemplary approaches which promote longevity, increase satisfaction, and promote recruitment and retention of palliative providers will be highlighted.

**Effectively Engaging the Faith-Based African-American Community in Advance Care Planning (FR433)**

Valerie Steinmetz, BA, Emory University, Atlanta, GA. Janice Bell, PhD MN MPH, University of California, Davis, Sacramento, CA. Jill Joseph, MD PhD, University of California, Davis, Sacramento, CA. Cynthia Carter Perrilliat, MPA, California State University East Bay, East Bay, CA.

**Objectives**
- Discuss the formation and operation of the Alameda County Care Alliance Advanced Illness Care (ACCA) Programs in the faith-based African-American community.
- Discuss the evolution of the ACCA programs and evaluation for broad community impact.
- Review ACCA strategies, milestones and outcomes toward increasing awareness of advance care planning in the African American community.

Only 1/3 of all Americans and 19% of African-American adults over age 65 have documented their end-of-life care wishes. Similar disparities exist in discussion of values and preferences for end-of-life care, sharing of wishes for health care providers and family and formal completion of advance directives. To address these disparities and increase awareness of advanced care planning (ACP), the Alameda County Care Alliance (ACCA) has engaged fourteen denominationally diverse churches, their congregants and pastors using a faith-based community-based participatory approach to: 1) provide lay care navigation support to persons needing advanced illness care and their families/caregivers to meet spiritual, advance care planning, health, social, and caregiving needs; 2) better understand the
Objectives

- Recognize the primary therapeutic principles of expressive therapies and learn how they may be used to deepen the meaning and value of interactions with pediatric and adult populations.
- Describe the evidence supporting the clinical application of therapeutic art for the grieving and bereaved.
- Determine how to facilitate a replicable art-based therapeutic intervention for use with all disciplines working within palliative and hospice care, and for use with patients as appropriate through personal exploration and experience.

As hospice and palliative medicine evolve, an intensified focus emerges on the human experience of death and dying. Meaning making, identity reconstruction, managing negative grief symptoms and facilitating continuing bonds with the deceased are now core competencies in palliative care. Expressive modalities in clinical practice offer a bridge between the medical and the emotional as we strive as a community to meet the psychosocial needs of our patients and their families. The clinical application of therapeutic art with the grieving and bereaved has been widely documented.

In contrast to talk therapy where unresolved issues and interpersonal dilemmas are explored with words, expressive activities such as therapeutic art and play ask participants to use their imagination, and thus subconsciously, as a form of communication. For example, an individual may be asked to draw an image of an idea or feeling. In this way, participants may quickly communicate relevant issues in ways talk therapy simply cannot achieve. When these techniques are applied in the hospice and palliative care setting, clinicians can more fully enhance their patients (or colleagues) ability to communicate effectively and authentically.

This session would afford participants the opportunity to engage in a therapeutic art activity frequently utilized with both patients and trainees, designed to facilitate the emotional exploration of their experience with significant loss. Once complete, members of the group will be invited to share the feelings and insights elucidated by the activity. Facilitators will guide and support as insights into the events that surround personal losses are discovered.

Respecting Patient’s Wishes—How an Electronic POLST Tool Can Drive Goal-aligned Care (FR435)


Objectives

- Describe the key principles to work effectively with your system’s Information Technology specialists to design an electronic POLST tool.
- Discuss applying lessons from the experience of deploying an electronic POLST tool across multiple states.
- Discuss how clinical decision support can help avoid administering unwanted treatments and aid delivery of goal-aligned care.

Honoring a patient’s treatment preferences and priorities are key features of providing goal-aligned care. Having a clear record of a person’s choices related to life-sustaining treatments is particularly valuable. Forty-seven states have developed or are developing a Physician Orders for Life-Sustaining Treatments (POLST) form to unambiguously convey treatment plans that reflect a patient’s wishes to either receive or decline critical interventions. While conceptually straightforward, access to POLST forms and their utility are challenged by the information being static, a “snapshot” of a patient’s preferences, and the lack of interface to the rest of the EHR.

In 2012, we created ePOLST, an integrated EHR-based tool for the electronic completion of POLST forms. In
2016, we improved upon the ePOLST tool leveraging EHR clinical decision support to alert acute care clinicians of potential discrepancies between orders on a patient’s POLST form and inpatient orders. Specifically, we developed a real-time clinical alert for providers of patients with POLST-prescribed ‘Do not attempt CPR’ (DNAR) status. In a Providence-affiliated ED or hospital, if a provider attempts to write a ‘Full Code’ order for a patient with an ePOLST order of DNAR, the provider is alerted to the discrepancy prior to signing the order.

In the first 18 months, 16,570 ePOLST forms were generated across five states; 52% (8,548) included DNAR status, and 14% (2,311) also opted for comfort measures only. In patients with an ePOLST indicating DNAR, the alert was triggered approximately 200 times per month. Fifteen percent of the time, the ordering provider removed the apparently conflicting ‘Full Code’ status order and wrote an alternative code status order instead.

This session will explore the principles and resources necessary to design and implement an ePOLST system. Updated data and detailed outcome analyses of the ePOLST clinical alert will be presented.

If Ketamine Is So Great, Why Won’t My Institution Let Me Use It? (FR436)
Kira Skavinski, DO, University of California at San Diego, La Jolla, CA. Solomon Liao, MD FAAHPM, University of California at Irvine Medical Center, Orange, CA. Jamie Fertal, DO, St. Joseph’s Hospital, Orange, CA. Rosene Pirrello, RPH, University of California UC Irvine Health, Orange, CA.

Objectives
- Implement and titrate ketamine in its various forms (topical, oral, IV, PCA) for pain and depression.
- Weigh the risks and benefits of prescribing ketamine.
- Overcome institutional barriers to prescribing ketamine.

In our current context of a national opioid shortage, Palliative Care teams need to look at alternative options that can provide equal or better analgesia. While there is an emerging evidence base for the use of ketamine in the treatment of refractory depression, the evidence base for the use of ketamine for palliation of pain remains thin, though primarily positive. Ketamine has been used topically, orally and intravenously for the palliation of pain, and orally and intravenously for the treatment of refractory depression, though it is FDA approved only as an anesthetic. For these reasons, many Palliative Care teams wish to add ketamine to their armamentarium. Many, however, encounter institutional barriers in implementing its use.

In this session we will briefly review the available literature regarding the risks, benefits, and questions on ketamine use for palliation of pain and depression. Using case examples, we will examine prescribing and titrating ketamine in various forms including topical, oral, and intravenous (drip, IV push and PCA). We will discuss when ketamine is the most effective and appropriate and discuss practical management of side effects seen. Finally we will explore institutional barriers and engage the audience on how to gain buy-in on various levels to implement ketamine, including sharing our hospital protocols and policies.


Neither Pediatric nor Adult—Unique Care Considerations in the Adolescent and Young Adult (AYA) Patient Population (FR437)
Alexandria Bear, MD, Medical College of Wisconsin, Milwaukee, WI. Melissa Atwood, DO MA, Medical College of Wisconsin, Milwaukee, WI. Suzanne Berg, BS CCLS, Froedtert Hospital, Milwaukee, WI. Heidi Miranda, BS MS CCLS, Froedtert Hospital, Milwaukee, WI. Catherine Van Schylude, MS MSN RN ACHPN NP, Marquette University, Milwaukee, WI.

Objectives
- Discuss defining characteristics of the adolescent and young adult (AYA) population
- Outline unique palliative care considerations for the AYA population
- Delineate proposed palliative care models for AYA patients

Caring for adolescents and young adults (AYA)—patients aged 16-25—who are nearing end-of-life offers unique challenges for both the patients and providers. The young adult population has recently moved out of the pediatric care model but may not yet be a good fit for the adult care model. Existing literature highlights hypotheses that the AYA population is a unique group with special care needs, as these patients are not only entering early phases of independence as adults with ongoing exploration of identity and social and intimate relationships, but they are doing these things...
in the setting of a potentially life-limiting illness. Therefore, a dichotomy exists between this setting of growth and ongoing concerns for loss of self and control. It is important to gain the trust of the AYA patient through the use of appropriate language, encouraging the patient to maintain some control, while offering the AYA time to address “the tough stuff.”

This population creates unique challenges for palliative care providers. As the field of palliative care is rapidly growing, many providers are early in their careers and potentially closer to similar developmental stages as these patients, at times making care emotionally taxing for the provider. This presentation will define the AYA population and outline both unique palliative care considerations and proposed care models for this patient population utilizing exemplary real-life cases. Distinctive provider challenges relating to care for this patient population will also be discussed.

Where Do We Draw the Line? Navigating Personal and Professional Boundary Challenges in Palliative Care (FR438)
Christopher Lawton, MD, Paulist Fathers, Washington, DC. Andrew Lawton, MD, Dana-Farber Cancer Institute, Boston, MA. Erin Stevens, DO, Massachusetts General Hospital, Boston, MA. Sarah Scott Dietz, MD MajUSAF MC, Wright-Patterson AFB Medical center, Dayton, OH. Jo Weis, PhD, Medical College of Wisconsin Palliative Care Center, Milwaukee, WI.

Objectives
- Define the concept of boundaries in the realm of the clinical encounter and describe its importance to medical practice.
- Explain how maintenance of healthy boundaries may be uniquely challenging in palliative care, particularly for those early in their career.
- Identify specific strategies that palliative care professionals can use to maintain healthy boundaries in their work.

Boundaries in clinical medicine are the limitations we place around the emotional and physical relationships between patients and providers and between medical colleagues. Healthy boundaries are critical in fostering a trusting provider-patient relationship, ensuring dignity and equity in care, and maintaining appropriate roles among members of the care team. Despite the importance of this topic, within medical training there has historically been inadequate attention given to boundary setting and maintenance. Palliative care providers are commonly faced with emotionally charged situations while working in a team-based system where appropriate boundaries between the patient and provider or between members of the care team can easily be compromised. Am I spending the appropriate amount of time with this patient? What’s the right balance between emotional availability and professional distance? Does the work I’m doing fall within my role on the team? Boundaries may also become blurred as the provider strives to preserve personal time and relationships in the context of demanding professional work. Palliative care clinicians, especially those early in their practice, may be uniquely vulnerable to such boundary challenges. Not maintaining healthy boundaries may lead to a lack of sustainability and ultimately to burnout. In this session, a panel of early career palliative care professionals and a palliative care psychologist will use case examples to explore the boundary challenges that arise in our field, explain their importance to patient care and provider well-being, and identify specific strategies to address and prevent them. This session seeks to empower attendees with tools for maintaining healthy boundaries with their patients, their colleagues as well as among the various roles the provider plays in their professional and personal life so as to promote greater resilience and sustainability in our work.

Inviting Ourselves to the Party: Cystic Fibrosis as a Model for Implementing Palliative Care Practice, Research, and Policy in “New Diseases” (FR439)
Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Laura Moreines, RN NP CRNP, Yale, New Haven, CT. Elaine Chen, MD, Rush University Medical Center, Chicago, IL. Elisabeth Potts Dellon, MD, UNC School of Medicine, Chapel Hill, NC.

Objectives
- Describe the opportunities and challenges involved in developing an outpatient palliative care clinic for patients with cystic fibrosis.
- Describe a patient-centered model for developing a palliative care intervention in a disease population without much palliative care evidence, as well as the challenges in conducting clinical research in CF palliative care.

Cystic fibrosis is a chronic, progressive, and fatal disease. Individuals living with CF suffer from myriad physical and psychosocial burdens that dramatically degrade patient and caregiver quality of life. Although the evidence base for palliative care in CF is scant, patients living with CF and their caregivers undoubtedly possess palliative needs. Yet, no established model of PC exists for this population of high-need patients. Distinctive characteristics of CF, such as its lifelong nature, unpredictable trajectory, advancing therapies that may alter the course of illness dramatically for some, and the complexities of lung transplantation merit evaluation of how PC should be designed for CF. CF is one of many underrepresented disease
populations with palliative needs, yet without as strong an evidence base or clinical presence as other classic palliative care populations (e.g., oncology). This multidisciplinary, multi-institutional panel of clinicians and researchers in palliative care, pulmonology, and nursing will highlight opportunities and challenges of “breaking into” new disease populations, using CF as an exemplar. First, we will present a multi-pronged approach of identifying palliative needs in CF using qualitative methods and a nationwide survey, to aid in building support for and developing clinical programs. Second, we will describe the process and lessons learned during the development and conduct of the first clinical trial of palliative care in CF. Third, we will share insights on developing an outpatient CF palliative care clinic. Lastly, we will discuss our experiences with developing practice guidelines for palliative care in populations where need and enthusiasm exist, despite little evidence. Lessons learned in this session will be applicable to other fledgling populations with less established research and clinical presence from palliative care. Through shared learning, this forum will nurture future work to level the playing field so that all patients with life-limiting illness benefit from palliative care, regardless of disease.

Examining Relationship Between Post-Traumatic Stress Disorder (PTSD) and Inpatient End-of-Life Care in Veterans Affairs (VA) (FR440A)
Kathleen Bickel, MD MPhil MS, University of Colorado School of Medicine Aurora, CO. F Amos Bailey, MD FACP FAAHPM, University of Colorado Hospital, Aurora, CO. Richard Kennedy, MD PhD, University of Alabama at Birmingham, Birmingham, AL. Kathryn Burgio, PhD, Birmingham VA Medical Center, Birmingham, AL.

Objectives
- Describe potential differences between patients with and without PTSD at the end of life.
- Consider how these findings may relate to caring for patients with PTSD at end of life.

Original Research Background. The effects of PTSD on the end of life are not well studied. PTSD is a symptomatic illness, affecting pain sensation, anxiety, and sleep. High symptom burden, reliance on avoidant coping strategies, and high comorbid substance use in PTSD, all suggest that these patients may have a more complicated end-of-life trajectory.

Research Objectives. To conduct an exploratory descriptive analysis of end-of-life care for veterans with and without PTSD dying in VA hospitals.

Methods. This was a secondary analysis of a multiple-baseline, stepped-wedge design implementation trial to improve end-of-life care processes for VA inpatients. Variables were collected via direct chart review, using a chart abstraction form. Inter-rater reliability was good to excellent. Analysis included descriptive statistics and chi-square analyses with Bonferroni correction.

Results. PTSD was present in 8.76% of the sample (468/5341). The PTSD population was 98.7% male and 36.5% Black (171/468), with a younger mean age at death than those without PTSD (PTSD 65.4, no PTSD 70.5, p<0.0001). Patients with PTSD had higher mean VA hospital admissions and emergency room (ER) visits in the last 12 months of life (admissions: PTSD 2.8, No PTSD 2.4, p<0.0001; ER visits: 3.2, 2.5, p<0.0001). During the final hospitalization, patients with PTSD had higher rates of intensive care unit (ICU) use (49.6%, 42.7%, p=0.0041) and higher rates of advanced directives (48.1%, 37.9%, p<0.0001), trending toward lower rates of do-not-resuscitate status (66.5%, 71.0%, p=0.037). In the last 7 days of life, patients with PTSD had higher rates of receiving benzodiazepines (47.4%, 39.7%, p=0.0012) and antipsychotics (26.3%, 15.7%, p<0.001), trending toward higher receipt of opiates (73.3%, 68.3%, p=0.026).

Conclusion. Veterans with PTSD dying in VA hospitals appear to experience differences in end-of-life care, compared to those without PTSD.

Implications for Research, Policy, or Practice. Further analysis is needed to confirm this finding, to evaluate contributing factors, and to determine applicability outside of the VA population.

The Opioid Epidemic and Opioid Prescribing Regulations: A Survey Exploring Potential Barriers to Adequate Pain Management in Adults with Cancer (FR440B)
Sarah Verga, DO, University of Virginia, Charlottesville, VA. Joshua Barclay, MD MS MSC FACP, University of Virginia, Charlottesville, VA. Leslie Blackhall, MD MTS, University of Virginia School of Medicine, Charlottesville, VA. Ambereen Mehta, MD MPH, University of Virginia, Charlottesville, VA.

Objectives
- Identify current opioid prescribing regulations and describe their perceived impact on adult cancer patients in an outpatient palliative care clinic.
- Identify factors that impact adult cancer patients' experience of pain and pain management in the current climate of the “opioid crisis.”
- Identify future areas of needed research to lessen the adverse impact of the “opioid crisis” and prescribing regulations on palliative care patients.

Original Research Background. In the United States, there has been an increase in opioid misuse
leading to increased monitoring. Although many guidelines exclude treatment of palliative patients, it remains important to evaluate all patients receiving opioids for substance misuse to ensure safety.

**Research Objectives.** The primary objective was to determine if current opioid prescribing regulations are perceived by adult cancer patients as a barrier to adequate pain management.

**Methods.** Following a review of the literature and discussion with palliative experts, we identified potential concerns for patients with prescribing guidelines and developed a 21-item survey. We used a convenience sample of patients receiving opioids in the University of Virginia Palliative Care clinic during the period from February to April 2018. We used chi-square and t-tests to evaluate the correlation between patient perceptions that regulations made pain management difficult and demographic variables, pain and physical function scores, and the opioid risk tool (ORT).

**Results.** Ninety patients completed the survey. The majority (88.9%) were aware of opioid prescribing laws and 83.2% agreed that opioid abuse is a problem. One-third reported increased regulations made it difficult to manage pain (37.1%) or that insurance issues were a barrier to getting pain medications (32.6%). 38.9% of patients reported their doctor is less likely to prescribe strong pain medications due to the opioid crisis and 24% stated family or friends have told them not to take opiates. In univariate analyses, patients with higher ORT scores (p=0.025) and those with higher pain scores (p=0.0058) were more likely to report difficulty obtaining pain medications due to prescribing regulations.

**Conclusion.** This initial survey suggests many palliative care patients feel the increase in opioid prescribing regulations is a barrier to adequate pain management.

**Implications for Research, Policy, or Practice.** Further research is needed to explore the impact of the current opioid crisis and prescribing regulations on patients receiving adequate pain management.

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**What’s the Risk? Naloxone Co-Prescribing in an Outpatient Palliative Care Clinic (FR440C)**

Lorin Fisher, PharmD, University of Iowa Hospitals and Clinics, Iowa City, IA. James Ray, PharmD, University of Iowa College of Pharmacy, Iowa City, IA. Kashelle Lockman, PharmD MA, University of Iowa College of Pharmacy, Iowa City, IA.

**Objectives**

- List the three most prevalent risk factors for opioid-induced respiratory depression in patients receiving palliative care.
- Discuss the potential benefits and burdens of naloxone co-prescribing in palliative care.

**Original Research Background.** Centers for Disease Control and Prevention (CDC) guidelines on opioid prescribing for chronic pain recommend co-prescribing naloxone for patients with risk factors for Overdose or Serious Opioid-induced Respiratory Depression (OSORD). While palliative care is excluded from this guideline overall, many patients receiving palliative care need chronic opioid therapy; prevalence of OSORD risk factors in this population is unexplored.

**Research Objectives.** This study aims to 1) describe prevalence and patterns of risk factors for OSORD among ambulatory palliative care patients at an academic medical center and 2) identify frequency of naloxone co-prescribing in a pilot initiative using an integrative risk tool, the Risk Index for OSORD (RIOSORD).

**Methods.** Patients taking opioids and followed in outpatient palliative care in March–June 2017 were included in this retrospective chart review. Demographics, published risk factors for OSORD, RIOSORD score, and naloxone prescription were extracted. RIOSORD score ≥ 18 was designated as indication for naloxone co-prescription. Descriptive statistics were used to evaluate data.

**Results.** Risk factors of note among 91 included patients were prescription of ER/LA opioid formulation(s) (54.9%), benzodiazepine(s) (29.7%), MEDD > 100 mg (49.5%), and MEDD > 50 mg (74.7%). Sixty-one patients (67.0%) had an indication for naloxone, and 28 of these patients (45.9%) were co-prescribed naloxone. Naloxone may have been appropriate for an additional 18 patients if single AMA or CDC recommendations were applied. Twenty-one patients had RIOSORD scores in the highest risk class. Sixty-seven percent of patients had active cancer; 14% were in survivorship.

**Conclusion.** Patients receiving palliative care have similar risk factors for OSORD versus patients without serious illness and may benefit from naloxone co-prescription, when consistent with their goals of care.

**Implications for Research, Policy, or Practice.** An integrative risk tool may be useful to stratify patients for naloxone co-prescribing. Future studies should determine the most predictive risk factors of OSORD and the impact of naloxone co-prescribing on quality of life in this population.

**Impact of Parenteral Opioid Shortage on Opioid Prescriptions Among Patients Seen by the Palliative Care Team of a Comprehensive Cancer Center (FR440D)**

Ali Haider, MD, MD Anderson Cancer Hospital, Houston, TX. Yu Qian, MD, MD Anderson Cancer Center at University of Texas, Houston, TX. Zhanni Lu,
After POS, parenteral opioids (patient-controlled analgesia, and intravenous breakthrough) were less used by the referring oncology teams [before POS 159/338 (47%) vs. 96/338 (29%) (P < .001); non-parenteral opioids 179/338 (53%) and 240/228 (71%)]. At first PC follow-up, significantly less proportion of patients achieved better pain control after POS [119/193 (62%) vs. 144/193 (75%) (P = .006)]. However, at the second PC follow-up, the proportion of pain improvement was similar in both cohorts.

**Conclusion.** There is a significant change in opioid routes associated with POS. POS was associated with worse analgesia.

**Implications for Research, Policy, or Practice.** More research is needed to better understand the impact of POS.

**Family Caregiver Practices to Support Self-Management Among Adults with Serious, Chronic Illness (FR441A)**

Dena Schulman-Green, PhD, Yale University School of Nursing, West Haven, CT. Shelli Feder, PhD APRN FNP ACHPN, Yale University, New Haven, CT. James Diomne-Odom, PhD RN ACHPN, University of Alabama at Birmingham, Birmingham, AL. Janene Batten, MLS, Yale University School of Nursing, New Haven, CT. Victoria Long, MPH, Duke-NUS Medical School, Singapore. Yolanda Harris, PhD CRNP CPNP-AC, University of Alabama at Birmingham School of Nursing, Birmingham, AL. Abigail Wilpers, MSN, Yale University, New Haven, CT. Tiffany Wong, MSC RN, Yale School of Nursing, Orange, CT. Robin Whittemore, PhD APRN FAAN, Yale School of Nursing, West Haven, CT.

**Objectives**
- Identify at least three practices of family caregivers to support patient self-management of serious, chronic illness.
- Identify at least three factors that may help or hinder family caregivers in supporting patient self-management.
- Describe how data inform self- and family management of serious, chronic illness.

**Original Research Background.** Self-management refers to the daily activities of patients and their family caregivers to co-manage illness. While family caregivers have an integral role in self-management, what they actually do in this role remains unclear.

**Research Objectives.** We sought to identify family caregivers’ practices to support patients’ self-management of serious, chronic illness, including facilitators and barriers.

**Methods.** For this qualitative metasynthesis of published research containing family caregivers’ reports of their experiences supporting patient self-management of serious, chronic illness, we searched Ovid-MEDLINE, OVIDPsycINFO, OvidEMBASE, and CINAHL databases. After reviewing articles for eligibility and using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) standards for reporting, we extracted practices, facilitators, and barriers from each article and coded them. We then categorized similar practices, facilitators, and barriers.
**Results.** The final sample (n=30 articles) had publication dates from 2000 to 2017 and represented international family caregivers aged 18–89 caring for patients with cancer (20%), heart disease (20%), progressive neurological disease (10%), diabetes (7%), chronic obstructive pulmonary disease (3%), and other serious, chronic conditions (40%). Self-management practices grouped into the areas of focusing on the patient’s illness needs (e.g., managing symptoms), activating resources to support oneself as the family caregiver (e.g., using technology for information and support), and living with a patient with a serious, chronic illness (e.g., managing caregiver emotions). We categorized facilitators and barriers into the areas of Personal/Lifestyle Characteristics (e.g., patient empowerment), Health Status (e.g., caregiver stress), Resources (e.g., assistive devices), Environmental Characteristics (e.g., stigma), and the Health Care System (e.g., access to care).

**Conclusion.** Across health conditions, the family caregiver role is complex and makes considerable demands that challenge support of patient self-management.

**Implications for Research, Policy, or Practice.** Data indicate areas for assessment and potential intervention to support and sustain family caregivers’ role in managing serious, chronic illness.

**The Power of Human Connection (FR441B)**

Amy An, MD, University of Rochester Medical Center, Rochester, NY. Susan Ladwig, MPH, University of Rochester, Rochester, NY. Ronald Epstein, MD FAAHPM, University of Rochester, Rochester, NY. Holly Prigerson, PhD, Weill Cornell Medicine, New York, NY. Paul Duberstein, PhD, University of Rochester, Rochester, NY.

**Objectives**
- Recognize the importance of therapeutic alliance between caregivers and oncologists in the care of cancer patients.
- Describe the relationship between caregiver-oncologist therapeutic alliance and the caregiver bereavement experience.

**Original Research Background.** The therapeutic alliance (TA) between oncologists and patients with cancer has been associated with an array of end-of-life (EOL) outcomes, but we are aware of no studies on TA between oncologists and cancer caregivers.

**Research Objectives.** To examine the associations between caregiver-oncologist TA and cancer caregiver bereavement outcomes.

**Methods.** We conducted secondary analyses of data collected in the Values and Options in Cancer Care (VOICE) study, a randomized clinical trial aimed at improving quality of communications between oncologists and patients with advanced cancer and their caregivers. Having previously reported the intervention’s effects on patient outcomes, we now report secondary analyses, focusing on the effects of caregiver-oncologist TA on bereavement outcomes in 102 caregivers. Shortly after study entry, we assessed TA using the Human Connection Scale. Two months after death of the patient, we assessed caregiver-reported experiences of EOL care using the Quality of Death scale (QOD), Caregiver Evaluation of the Quality of End-Of-Life Care (CEQUEL) and the Modified Decision Regret Scale. Seven months after death of the patient, we assessed for Prolonged Grief symptoms (PG-13) and Purpose in Life (PIL). We conducted multivariable regressions examining associations between TA and outcomes after adjusting for study design variables (e.g., intervention arm, study site) as well as caregiver age, patient gender, patient education, and whether patients lived with their caregivers.

**Results.** TA was significantly associated with higher QOD (p=0.01), CEQUEL (p<0.005), and less decisional regret (p<0.01). The relationships between TA and PG-13 (p=0.60) and PIL (p<0.1) were not statistically significant.

**Conclusion.** A stronger TA between caregivers and oncologists was associated with better caregiver perceptions of the quality of the patient’s EOL care, and serves an important role in helping caregivers navigate the complicated environment of cancer treatment.

**Implications for Research, Policy, or Practice.** Improving TA between physicians and caregivers in the care of cancer patients may have widespread effects on caregivers’ bereavement experiences.

**Social Support and Relationship Quality as Moderators in the Association Between Heart Failure Patient Illness Severity and Caregiver Outcomes (FR441C)**

Teresa Cooney, PhD, University of Colorado Denver, Denver, CO. Christine Proulx, PhD, University of Missouri, Columbia, MO. David Bekelman, MD MPH, University of Colorado, Denver, CO.

**Objectives**
- List two ways that caregiver burden from heart failure patient illness severity can be moderated.
- Describe the stress process model as a theory that explains the connection between heart failure patient illness severity and caregiver well-being, and the potential for social support to moderate that association.

**Original Research Background.** Heart failure, a leading cause of hospitalization and death, can present severe challenges for patients and their...
caregivers. Caregivers who feel supported by relationships with the patient they care for, family or friends may be buffered from the stress from patient heart failure.

**Research Objectives.** Test the moderating role of social support and caregiver-patient relationship quality on the longitudinal association between baseline heart failure patient illness severity and subsequent caregiver outcomes.

**Methods.** Longitudinal data were analyzed for 100 heart failure patient-primary caregiver dyads, a subset of participants in a randomized clinical trial of a symptom management and psychosocial care intervention. Key patient-reported predictors were symptom severity and level of disability. Moderating variables, measured at baseline, included caregiver-perceived social support and relationship quality. Caregiver outcomes included depression and caregiver burden at 12 months. Separate multiple regression analyses were used to examine the moderating role of social support and relationship quality. Regression models were adjusted for baseline demographics and baseline caregiver burden.

**Results.** Significant moderation effects were found on the caregiver burden outcome only. The association between baseline patient symptom severity and subsequent caregiver burden was mitigated by caregiver reports of higher relationship quality with the patient (β = -0.30, p < 0.05 for interaction, model r² = 0.50). Similarly, social support moderated the association between patients’ reports of disability and caregivers’ later burden. Lower levels of perceived social support magnified the longitudinal association between baseline patient disability and caregiver burden 12 months later (β = -0.24, p < 0.05 for interaction, model r² = 0.54).

**Conclusion.** Caregivers’ relationships with their care recipient and perceptions of their social network can shape how they respond to and interpret the demands of caregiving from patient illness severity.

**Implications for Research, Policy, or Practice.** Promoting and cultivating positive social relationships within and outside the caregiver-patient dyad is a promising avenue for interventions aimed at reducing the burden experienced by caregivers for patients with heart failure.

**Palliative Care Needs and Perspectives on Early Palliative Care from Individuals with COPD and their Family Caregivers: A Mixed Methods Study (FR441D)**

Anand Iyer, MD, University of Alabama at Birmingham, Birmingham, AL. James Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham, Birmingham, AL. Lanier O’Hare, MSN, University of Alabama at Birmingham, Birmingham, AL. Sandhya Mudumbi, MD, University of Alabama at Birmingham, Birmingham, AL. deNay Kirkpatrick, DNP, University of Alabama at Birmingham, Birmingham, AL. Nataliya Ivanova, PhD MPH, University of Alabama at Birmingham, Birmingham, AL. Rodney Tucker, MD MMM FAHPM, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL. Mark Dransfield, MD, University of Alabama at Birmingham, Birmingham, AL. Cynthiana Brown, MD MSPH, University of Alabama at Birmingham, Birmingham, AL. Marie Bakitas, DNSc NP-C FAAN, UAB School of Nursing, Birmingham, AL.

**Objectives**
- Identify chronic obstructive pulmonary disease (COPD) patient and caregiver palliative care needs.
- Describe COPD patient and caregiver perspectives on early palliative care.
- Synthesize qualitative perspectives and quantitative measures of palliative care needs.

**Original Research Background.** Little direction exists on how to integrate early palliative care (EPC) in COPD.

**Research Objectives.** To identify patient and family caregiver palliative care needs and to explore their perspectives on EPC in COPD.

**Methods.** We conducted a concurrent (quantitative + qualitative) mixed methods study of purposively sampled patients with moderate-to-very-severe COPD (FEV1/FVC < 0.70 and FEV1 < 0.80) and their family caregivers. We measured patient quality of life using the COPD Assessment Test (CAT), with scores > 20 defining poor quality of life. We conducted semi-structured in-depth interviews of patients and their family caregivers on palliative care needs and EPC, which were transcribed, coded, and examined for recurring themes. Results from quantitative and qualitative analyses were integrated to compare themes on palliative care needs by CAT <= 20 and > 20.

**Results.** Ten patients were on average 60 years old, 50% were African American, 30% female, and 40% had very severe COPD (FEV1 < 0.35); 10 family caregivers were on average 58 years old, 40% were African-American, and 90% female. The 70% of dyads with a patient who had poor quality of life (CAT > 20) reported greater palliative care needs including challenging respiratory and emotional symptoms, difficulty coping with COPD and defining caregiver roles, and concerns about outlook planning. Only 35% of participants had awareness of palliative care, and only 5% had an advanced directive. After we described EPC, patients and their family caregivers unanimously wanted EPC for: 1) Comprehensive supportive care; 2) Outlook planning; and 3) Illness education.
Conclusions. Patients with moderate-to-very severe COPD and their family caregivers had several unmet palliative care needs and limited awareness of palliative care; however, dyads unanimously found EPC acceptable after being given a description.

Implications for Research, Policy, and Practice. These data will guide development of interventions to integrate EPC in COPD.

3–4 pm

Concurrent Sessions

AAHPM Collaborations in the Field: Mapping Community Palliative Care and Modernizing the EDRS System (FR450)

Cordt T. Kassner, PhD, CEO, Hospice Analytics, Colorado Springs, CO. Maggie Rogers, MPH, Center to Advance Palliative Care, New York, NY. Rachael Heitner, MA, Center to Advance Palliative Care, New York, NY.

Objectives

- Describe the current status of the Mapping Community Palliative Care project goals.
- Understand how to register a new program on the Mapping Community Palliative Care website.
- Summarize key goals and progress of the Next Generation Electronic Death Registration System (EDRS).

AAHPM collaborates with multiple partners across the country, and this session will review two such collaborations. First, the Academy works with the Center to Advance Palliative Care (CAPC) and the Mapping Community Palliative Care project. Currently over 2,000 community palliative care providers are included—is yours one of them? Presenters will review current status of this project, how information being collected is being used, and answer your questions. Second, the Academy works with the Centers for Disease Control and Prevention to update the Next Gen Electronic Death Registry System (EDRS). Presenters will review goals and current status of this project, and answer any questions.

Making Meaning of Metrics: Utilizing Data in Home- and Community-Based Palliative Care in Large Healthcare Systems (FR451)

Sarina Isenberg, PhD MA, Sinai Health System, Toronto, ON, Canada. Bonnie Chen, MD, Kaiser Permanente, Oakland, CA. Laura Cantino, MD, Kaiser Permanente East Bay and Oakland Medical Center, Oakland, CA. Steve Lai, MD FAAHPM, Palo Alto Medical Foundation, Palo Alto, CA. Amy Hsu, PhD, Ottawa Hospital Research Institute, Ottawa, ON, Canada. Peter Tanuseputro, MD MHSc CCFP FRCPC, University of Ottawa, Ottawa, ON, Canada. Dana Benton, MS RN CNS, Kaiser Permanente Northern California, Sonoma, CA. Kuljeet Multani, MD HMDC, Palo Alto Medical Foundation, Freemont, CA.

Objectives

- State common potential benefits and challenges of collecting data about home and community-based palliative care (HCPC) in a variety of health systems.
- Compare approaches about how to best leverage this data to assess the impact of HCPC and to inform program growth.

Our international, multi-disciplinary panel will discuss both opportunities and lessons learned in leveraging data collection to support the growth of home and community-based palliative care (HCPC) programs within large health care systems. Our presentation showcases three case studies:

- The single payer healthcare system in Ontario, Canada has allowed for large health administrative datasets. We will provide an overview of the data, and present two studies demonstrating the datasets use for research, policy and practice. Our 2011-2015 study (n=277,128) examined the relationship between receipt of HCPC in the last 90 days of life and subsequent health utilization/outcomes. This research has informed the Ontario government’s investments into HCPC.
- Palo Alto Medical Foundation/Sutter Health is a large, multispecialty group serving about 1 million patients in Northern California at 4 clinical sites, with each providing a community-based palliative care program. We will discuss our efforts to leverage data to plan for sustainable growth for the program, including measurement to capture the work of each discipline, processes to utilize resources on interdisciplinary team effectively, and standardization of clinical assessments.
- Kaiser Permanente Northern California is an integrated health care system serving 4.2 million members at 15 clinical sites and 21 hospitals, with ambulatory palliative care available at all sites. We will present on efforts to standardize care across our system, including provision of process measures to allow sites to standardize clinical assessments, unifying documentation, and proactive patient identification using a regional registry.

By the end of this presentation, participants will be familiar with approaches to collecting data in HCPC, including challenges of doing so in diverse practice settings. Lessons learned in this session will assist participants in thinking through how to use this data for research and clinical applications.
Compassionate Design: Applying Design Thinking Principles to Pediatric End-of-Life Care (FR452)

Rachel Thienprayoon, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH. Joseph Lane, BFA, Live Well Collaborative, Cincinnati, OH. Daniel Grossoehme, DMin MS, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH.

Objectives

• Discuss bereaved parent and staff perspectives regarding limitations for end-of-life care for children who die in intensive care units.
• Explain the process of co-creation sessions, and identify opportunity concepts for improving end of life care in pediatric intensive care units.
• Discuss multiple interventions to improve end-of-life care for children who die in intensive care units and their families.

Approximately 70% of pediatric deaths at Cincinnati Children’s (CCHMC) occur in an intensive care unit (ICU). Memories of the child’s death critically impact the grieving process. Yet, ICU rooms are not designed for end-of-life (EOL) care. Space and privacy are limited; families may feel pressured to leave quickly after the child dies. Visitation policies limit family presence. Ritual bathing is difficult to accommodate. Some families desire to accompany the child through the basement to the morgue, a walk described as “unceremonious” and “stark”.

The Objectives of this study were to (i) understand EOL and post-mortem (PM) experiences of bereaved parents, how they relate to grief/mourning, (ii) understand EOL and PM experiences of staff, how they relate to job satisfaction/moral injury (iii) design new patient-centered, culturally sensitive processes and dedicated space for EOL and PM care.

This project was a collaboration between CCHMC and a University of Cincinnati College of Design, Architecture, Art and Planning student design team, united through the Live Well Collaborative (LWC), a non-profit utilizing a design-thinking process to co-create innovations to improve health outcomes.

LWC utilized human centered design in three phases: research, ideation and refinement. Research: LWC drew insights from a literature review and interviews with bereaved families and staff. The team designed an experience/journey map visually representing stakeholders’ thoughts, experiences, and emotions throughout the EOL process. A feasibility/influence chart focused them on 3 improvement areas: privacy, transition from intensive care to legacy building, and parental control. Ideation: the team’s co-creation sessions with parents and staff led to 7 opportunity concepts. Refinement: Concepts were tested and refined: room privacy lights, a comfort quilt, little reminders, announcement and spiritual lighting en route to the morgue, a remembrance garden and other spatial considerations. These were presented to the CCHMC team and other stakeholders for implementation.

“IT’s not Magic, IT’s Intentional Communication”—Using the Primary Palliative Care Communication Toolkit to Teach Communication to Interdisciplinary Learners at Different Levels of Training (FR453)

Maie El-Sourady, MD, Vanderbilt University Medical Center, Nashville, TN. Juan Iregui, MD MA FAAHPM, CHI Franciscan Hospice and Palliative Care, Tacoma, WA. Jill Nelson, RN ACHPN APRN, Vanderbilt University Hospital, Nashville, TN. Mohana Karlekar, MD, Vanderbilt University Medical Center, Nashville, TN. Sumathi Misra, MD MPH CMD FAAHPM, Vanderbilt University Medical Center and Nashville VA, Nashville, TN. Marilyn Pattison, MD, CHI Franciscan, Tacoma, WA.

Objectives

• Incorporate literature-based fundamental conceptual frameworks in communication into a workable toolkit for “just in time” use, for the right learner at the right time at the right place.
• Develop a personalized skill set for Palliative Care teams to recognize teachable moments in everyday care and disseminate timely and concise teaching pearls in communication using the Toolkit.
• Identify techniques to incorporate primary palliative care communication instruction to enhance skill sets in non-palliative care trainees and inter-professional learners.

Primary palliative care (PPC) instruction is gaining prominence as benefits of early palliative care (PC) become clear, as patients live longer with serious illness, and as hospital systems look to improve the care of medically frail patients. With the growth of academic PC, the opportunity to engage learners of many disciplines and levels of training has expanded. Effective PC is based on excellent communication, which can be challenging to teach, especially in busy clinical practices.

We discuss the interdisciplinary PC faculty skills development in utilizing the flexible and adaptable PPC Communication Toolkit. We demonstrate how our current training curriculum for fellows and other learners of various levels and disciplines incorporate this Toolkit to enable learners to build on their personal frame of reference as they see faculty incorporate these principles and techniques into everyday practice. Attendees will apply and practice these core...
elements, methodologies and techniques to engage both teachers and learners during the session. We will showcase four ways the Toolkit has been adapted and incorporated into communication training at a large academic institution and VA hospital. During a real-time consult PC faculty apply the “catch and release” method to coach learners on non-PC rotations when a PC consult is requested. PC faculty use the Toolkit to teach advance care planning to Nephrology fellows, to structure goals of care discussions with Internal Medicine residents on a geriatrics rotation, and to coach ICU nurse practitioners. The Primary Palliative Care Communication Toolkit is a creative, consistent, and adaptable way to incorporate communication training into the day-to-day care of patients living with serious illness and into the education of learners of different disciplines and levels of training. Participants will find tools and ideas that are easy and fun to use as they teach the next generation of clinicians to care for seriously ill patients.

Palliative Care Interdisciplinary Team Effectiveness: Building an Effective Team and Maintaining Team Health (FR454)


Objectives

- Identify and assess the attributes of a healthy palliative care interdisciplinary team.
- Identify and discuss three common threats to individual and team health.
- Identify four practices or processes teams can put in place to improve team effectiveness.

Has your team ever experienced high turnover, seemingly unmanageable consult volumes, tension among team members, role confusion, or less than effective interdisciplinary team (IDT) performance? How did your team maintain clinical quality? How did your team work together to solve problems or issues that were causing stress? Whether due to growth, the ongoing stresses of providing palliative care to seriously ill patients, or diverse personalities, most teams experience these issues at one time or another. Figuring out how to onboard new team members, identify team issues, and collectively work through challenges as a team is critical, particularly when your team stress is at its peak. This interactive session will provide participants with practical tools and tips for building a high-quality, effective interdisciplinary team in and across hospital, home, clinic, and other settings. An interdisciplinary panel will outline the practices and team processes they have put in place that reinforce team health, ensure role clarity, and improve team communication.

'Roid Rage No More: A Review of Corticosteroid Adverse Drug Effects in Palliative Care Patients (FR455)

Thomas O’Neil, MD HMDC, University of Michigan, Arbor Hospice, Ann Arbor, MI. Michael Smith, PharmD BCPS, University of Michigan College of Pharmacy, Ann Arbor, MI. Adam Marks, MD, University of Michigan, Ann Arbor, MI.

Objectives

- Describe the clinical utility of corticosteroids for palliative care patients.
- Compare the differentiating factors of different corticosteroids including pharmacokinetics, potency and relative cost.
- Recognize adverse effect profiles of corticosteroids and summarize their clinical applicability.

Corticosteroids are often utilized in the treatment of many symptoms that arise in palliative care patients including fatigue, dyspnea, pain, anorexia, nausea, and vomiting. However, corticosteroids can produce many adverse drug effects (ADEs) including hyperglycemia, psychosis, hypertension, edema, and osteoporosis. These ADEs can often be significant and treatment-limiting despite clinical improvement of the initial presenting symptom. When ADEs develop and providers still wish to continue corticosteroid use, the question that often arises is: would a different corticosteroid result in a decrease in the ADE of concern or how may the current corticosteroid be managed in light of this ADE? This presentation will review the literature for clinical utility of corticosteroids in palliative care patients as well as present various factors to consider in the choice of different agents. It will include a review of the prevalence, onset, and likelihood of each ADE as well as discuss strategies to mitigate various ADEs when employing corticosteroids for symptom relief.

The Future at Your Fingertips: How Technology Can Help Us Make Better Predictions and Decisions (FR456)

David Hui, MD MS MSC, MD Anderson Cancer Center, Houston, TX. John Maxwell, MD, Virginia Mason Memorial Hospital, Yakima, WA. Eric Prommer, MD HMDC FAAHPM, Greater Los Angeles Healthcare, Los Angeles, CA. Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA.

Objectives

- Apply web-based prognostic tools for patients with cancer and non-cancer diseases.
- Evaluate studies comparing the accuracy of clinician’s prediction and prognostic models.
Caring for the Complex Congenital Heart—Should It Be Palliative from the Start? (FR457)

Objectives
- Identify the current state of congenital heart disease (CHD) and its impact on quality of life for patients and families.

Circle of Trust: How Psychodynamic Themes Such as the ‘Holding Environment’ Optimize Coping with Serious Illness (FR458)
Keri Brenner, MD MPA, Stanford University, Palo Alto, CA. Vicki Jackson, MD MPH FAAHPM, Massachusetts General Hospital, Boston, MA. Linda Emanuel, MD PhD, Northwestern Medicine, Chicago, IL.

Objectives
- Describe the essential aspects of holding presence, holding environment and containment as
they relate to psychological integration and improved prognostic awareness.

- Demonstrate practical techniques and communication strategies to cultivate a holding presence for patients and families.
- Identify key insights from psychodynamic theory that provide a useful framework for optimal psychological coping.

One of the most challenging aspects of hospice and palliative care is encountering a patient’s fear of the dying process, including the common existential worries of dying alone and the losses of physical decline. How does a patient have the psychological strength to go from the security of their previous healthy life to the many phases of loss and uncertainty with life-limiting illness? Recent literature reveals that many patients mitigate these fears by proactively creating a tight-knit circle of trusted people “on the inside.” This “inner circle” generally consists of reliable family, loved ones and clinicians who are emotionally available to the patient, but not overly invasive or intrusive.

The “holding presence” of this inner circle allows patients to better tolerate the possibility of dying by facilitating an environment where patients can smoothly vacillate between comfort and fear as well as more and less realistic hopes. This swinging between such extremes is most successful when a patient has secure attachments to this inner circle of relationships that can witness this back and forth. Moreover, this containing presence allows patients to better communicate their values and goals amidst intense affective experiences. Thus, such a holding environment can facilitate improved prognostic awareness and advance care planning.

In this interdisciplinary concurrent session, three experts in psychodynamic theory and palliative care will highlight how the “holding presence” of an inner circle creates a containing environment for patients to better cope with life-limiting illness. One expert is a psychoanalyst and will reveal how contributions from thinkers such as Winnicott, Bion, Bowlby and Buber illuminate these relational dynamics at the end of life. Presenters will draw upon clinical case material to demonstrate practical techniques utilizing these insights when caring for patients and families.

End of life care in the U.S. has been rooted in values that represent the cultural and religious values of the white middle class. Yet what is perceived and promoted as beneficial for one group may not hold the same value for another groups, with a different frame of reference, value system and life experience. Lack of understanding of, and respect for, the cultural values of others often results in negative consequences for the patient and family. Patients and families whose beliefs and values are not understood or addressed, understandably feel disrespected and devalued, and have to make additional efforts to ensure that the goals of care they wish for themselves/ their loved ones, are followed. Palliative care clinicians often feel frustration when they see a terminally ill patient undergoing “needless” interventions/treatments. In the African-American community the importance of faith, spiritual beliefs and church are key components in understanding and coping with illness, and provide a framework within which treatment decisions are

“God Is Able”: Miracles and Hope in Our African-American Patients: Challenges, Historical Perspective and the Way Forward (FR459)

Ronit Elk, PhD, University of South Carolina, Columbia, SC. Kimberly Johnson, MD MHS, Duke University Medical Center, Durham, NC. Alvin Reaves, MD FACP FAAHPM, MedStar Southern Maryland Hospital, Clinton, MD. Gloria White-Hammond, MD, Harvard Divinity School, Cambridge, MA. Shellie Williams, MD, University of Chicago, Chicago, IL. Leigh Vaughan, MD, Medical University of South Carolina, Charleston, SC.

Objectives

- Recognize potential pitfalls and missed opportunities in responding to family members’ communication about their belief that God will perform a miracle and heal their loved one despite medical team’s belief that patient is at the end of life. Gain understanding of both sides of an interaction in which the clinician encounters a terminally ill African-American patient and family who are expecting a miracle; the clinician who feels frustrated and manipulated by the patient/family who are not facing the reality of impending death; the patient and family who feel their beliefs and culture are being entirely disregarded.
- Describe the ongoing challenges and historical context which inform a belief in miracles and emphasis on hope for African Americans across the lifespan, including at the end of life. Gain insight into the concept of “hope and miracles” in the African-American community, from (1) A historical and cultural context and (2) In terms of how it plays out in serious illness.
- Describe communication strategies which demonstrate respect, build trust, and reduce conflict in responding to family’s expression of a belief in miracles in the face of a patient’s poor prognosis. Gain insight into a communication method in which the patient and family’s values of hope and a miracle are respected by the clinician; and the resulting feelings of (a) the patient/family and (b) the clinician.

Objectives

- Recognize potential pitfalls and missed opportunities in responding to family members’ communication about their belief that God will perform a miracle and heal their loved one despite medical team’s belief that patient is at the end of life. Gain understanding of both sides of an interaction in which the clinician encounters a terminally ill African-American patient and family who are expecting a miracle; the clinician who feels frustrated and manipulated by the patient/family who are not facing the reality of impending death; the patient and family who feel their beliefs and culture are being entirely disregarded.
- Describe the ongoing challenges and historical context which inform a belief in miracles and emphasis on hope for African Americans across the lifespan, including at the end of life. Gain insight into the concept of “hope and miracles” in the African-American community, from (1) A historical and cultural context and (2) In terms of how it plays out in serious illness.
- Describe communication strategies which demonstrate respect, build trust, and reduce conflict in responding to family’s expression of a belief in miracles in the face of a patient’s poor prognosis. Gain insight into a communication method in which the patient and family’s values of hope and a miracle are respected by the clinician; and the resulting feelings of (a) the patient/family and (b) the clinician.

End of life care in the U.S. has been rooted in values that represent the cultural and religious values of the white middle class. Yet what is perceived and promoted as beneficial for one group may not hold the same value for another groups, with a different frame of reference, value system and life experience. Lack of understanding of, and respect for, the cultural values of others often results in negative consequences for the patient and family. Patients and families whose beliefs and values are not understood or addressed, understandably feel disrespected and devalued, and have to make additional efforts to ensure that the goals of care they wish for themselves/ their loved ones, are followed. Palliative care clinicians often feel frustration when they see a terminally ill patient undergoing “needless” interventions/treatments. In the African-American community the importance of faith, spiritual beliefs and church are key components in understanding and coping with illness, and provide a framework within which treatment decisions are
made. African-American families’ deep faith in God’s healing power, and the belief in hope, both of which directly impact goals of care and treatment preferences, are often misunderstood by clinicians. In this session, participants will gain an understanding into the central relevance of “hope and miracles” in the African-American community, from both a historical and cultural context, as well as how it plays out in serious illness. Illustrations will be provided of ineffective clinician-patient/family communication (resulting in the patient/family feeling disrespected and a frustrated clinical team), as well as positive communication. Take-home lessons for effective culturally-based communication and best practices are provided.

**Medical Cannabis in Outpatient Palliative Care: Evidence and Approaches for Integrating Cannabis into Clinical Practice (FR460)**

Ali John Zarrabi, MD, Emory University School of Medicine, Atlanta, GA. Kathleen Broglio, DNP ACHPN ANP-BC CPE FPCN, Dartmouth Hitchcock Medical Center, Lebanon, NH. Drew Rosielle, MD FAAHPM, University of Minnesota Health, Minneapolis, MN. Diana Martins-Welch, MD, Northwell Health, New Hyde Park, NY. Ivan Zama, MD, University of Maryland-Prince George’s Hospital Center, Cheverly, MD. Jeanne-Marie Maher, MD FACP, Catholic Medical Center, Manchester, NH.

**Objectives**

- Discuss the current evidence supporting cannabis as a therapeutic strategy for patients with serious illnesses experiencing symptoms that are unresolved by the standard palliative care toolkit
- Describe strategies for integrating medical cannabis into your palliative care practice.
- Counsel patients on the benefits and harms of cannabis use, cannabis preparations, delivery systems, and state regulations related to its use.

Increasing numbers of patients living with serious illness are requesting access to medical cannabis as well as guidance about its use. Select palliative care clinics have incorporated cannabis into their therapeutic toolkit, and cannabis consultations have become a gateway to a palliative care assessment and advance care planning. In many states healthcare providers are responsible for counseling and registering patients for medical cannabis, although medical decision-making about the benefits and harms of cannabis is challenging given the paucity of clinical guidelines and evidence, and a wide variety of non-standardized cannabis preparations.

In this session, outpatient palliative care providers who have incorporated cannabis as a therapeutic strategy in their clinics will 1) address the existing evidence regarding cannabis for the treatment of pain, nausea, appetite disturbance, insomnia, and mood disturbances, 2) describe how providers are integrating medical cannabis into their palliative care practices, and particularly how providers are using cannabis to reduce opioid and benzodiazepine use, as well as polypharmacy, 3) demonstrate how to counsel patients about the risks and benefits of medical cannabis, obtaining cannabis preparations, using a variety of cannabis delivery systems, and state and federal regulations related to its use.

**Decoding the Code Status: Can a Palliative Care-Led Curriculum Improve Communications Skills in Critical Care and Emergency Department Clinicians? (FR461A)**

Matthew Robinson, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX. Rex Alvin Paulino, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX. Leeling Ong, DO, Kaiser Permanente, Fontana, CA. Jennifer Healy, DO, University of Texas Health Science Center at San Antonio, San Antonio, TX.

**Objectives**

- Recognize the need for Code Status Discussion training for ICU and ED physicians.
- Consider the role of the HPM-practitioner in leading Code Status Discussion training.

**Original Research Background.** Communicating effectively with patients/families is an important skill. Palliative care (PC) specialists are often consulted to help with complex communication. In acute settings like the intensive care unit (ICU) and the emergency department (ED) a PC-specialist may not be immediately available, and Code Status Discussions (CSDs) are often required urgently.

**Research Objectives.** To evaluate the implementation and efficacy of a newly designed CSD curriculum for ED/ICU clinicians.

**Methods.** ED and ICU medical trainees at a single tertiary care center were asked to participate in the CSD curriculum. CSD curriculum featured the NURSE-SPIKES model of delivering bad news and the PULSES model for CSDs. The 2-hour curriculum included lecture, roleplay/feedback, and handouts. Participants were surveyed before, at 30 and 60 days after their CSD comprehension and communication self-efficacy using Bieber’s Questionnaire on the Quality of Physician-Patient Interaction (Cronbach Alpha=.95). Likert scores were analyzed using Pratt’s modified Wilcoxon signed-rank test.

**Results.** Of 38 medical trainees, N=17 completed the pre-survey. Female=35%; Caucasian=53%, Hispanic=24%, Other=24%; ED=65%, ICU=35%.
Of respondents, 82% reported prior contact with PC, and only 47% reported prior PC training. 94% rated CSD-training fairly or extremely important, 35% rated their current training inadequate. N=10 completed 30-/60-day surveys. At 30 days, there was significant improvement in 5/14 self-efficacy metrics (one-tailed, alpha=0.05); at 60 days in 10/14 metrics. Improved areas included: interest in patient’s problems, giving detailed information on illness and options, physician-patient trust, joint decision-making, risks/side effects discussion, understanding patient needs, understanding impact of illness, putting patients at ease, and respecting opinion differences regarding treatment. 83% found the course helpful.

**Conclusion.** A CSD curriculum is a useful tool for developing complex communication skills for ED and ICU physicians.

**Implications for Research, Policy, or Practice.** This study lays the groundwork for curriculum dissemination to a wider audience. It also suggests the PC community could champion the development of complex communications skills to other medical fields.

**What’s That Social Worker Doing? Results of a Nationwide Job Analysis of Hospice and Palliative Social Workers (FR461C)**

Barbara Head, CHPN FPCN, University of Louisville, Louisville, KY. Alyssa Middleton, MSW, University of Louisville, Louisville, KY. Neil Guman, MA, PSI Services, Olathe, KS. Chuck Friedman, PhD, PSI Services, Olathe, KS.

**Objectives**
- Describe the process of developing a job analysis survey.
- Name 4 categories of tasks for the hospice and palliative social worker.
- List three uses of the results of a job analysis.

**Original Research Background.** The role of the hospice and palliative social worker is often ambiguous and misunderstood by colleagues and fellow team members. Job descriptions vary and it is not unusual for social workers to be asked to write their own. One reason for this is the lack of clearly identified skills and tasks employed by these specialty social workers in their daily work. This paper reports the results of the first nationwide job analysis of hospice and palliative social workers.

**Research Objectives.** Develop an evidence-based description of the role of the hospice and palliative social worker.

**Methods.** An Advisory Committee (AC) of experience practitioners was formed to oversee the process. A task list was developed based on a thorough literature review, existing job descriptions, and syllabi and curricula of courses. The AC reviewed and edited the task list and recommended demographic information to be collected. Participants were recruited through multiple websites, databases, and social media.

**Results.** Four-hundred eighty-two respondents submitted usable data. The sample was largely Caucasian (71.4%) and female (93.8%). Forty-six states were represented. The mean number of years in hospice or palliative care practice was 9 and most had Master’s degrees (89.73%). Almost half (47.5) were hospice social workers while the others identified as either palliative (27.7%) or both hospice and palliative (14.4%). One-hundred forty tasks were identified as necessary to the role. The tasks were grouped into four major content areas: Assessment and Reevaluation; Planning and Intervention; Death, Grief and Bereavement; and Professionalism.

**Conclusion.** This job analysis provides a comprehensive list of the tasks required of the hospice and palliative social worker.

**Implications for Research, Policy, or Practice.** The results of this survey can be used to guide educational efforts to prepare social workers for this specialty practice, develop job descriptions, and evaluate competency. Findings will direct the development of the first certification exam for social workers in this specialty practice.

**Online Palliative Nursing Education: The Results of a Creative Strategy to Educate all US Nursing Students in Primary Palliative Care (FR461D)**

Polly Mazanec, PhD ACHPN AOCN CNP FPCN, Case Western Reserve University, Cleveland, OH. Betty Ferrell, MA 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. Rose Virani, MHA RN FPCN, City of Hope National Medical Center, Duarte, CA.

**Objectives**
- Describe the national need for nursing education schools of nursing to prepare their students to provide primary palliative care.
- Describe the results of a 3-year grant-funded initiative to educate undergraduate nursing students.

**Original Research Background.** As the demand for palliative care exceeds the specialty resources, nurses must be educated to provide primary palliative care for those with uncomplicated palliative care needs. However, many schools of nursing are still not providing this education to their undergraduate nursing students.

**Research Objectives.** 1) To develop and implement an online curriculum to meet the 2016 American Association of Colleges of Nursing’s (AACN’s) palliative care
Competencies and Recommendations for Educating undergraduate nursing Students (CARES). 2) To evaluate End-of-Life-Nursing Education Consortium (ELNEC)-Undergraduate Curriculum’s impact on student knowledge, satisfaction, perception of importance of palliative care education to clinical practice, and student preparedness as perceived by faculty.

Methods. In collaboration with Relias Learning, the ELNEC team developed the ELNEC-Undergraduate Curriculum, which is comprised of 6, 1-hour modules and is based on the AACN CARES document and NCP Guidelines for quality palliative care.

Results. During the first 18 months, 6,654 students have successfully mastered the content (scores of 80% or higher). Ninety-eight percent of the students responded “strongly agree” or “agree” to evaluation questions asking about level of satisfaction with the content, the technology and the importance to clinical practice. Six qualitative themes emerged from the open-ended questions and will be presented at the session. Data from 2018 faculty surveys demonstrate that the curriculum is preparing their students for primary palliative care.

Conclusion. Since January 2017, ELNEC has been changing the culture of nursing education by introducing primary palliative care in over 200 undergraduate nursing programs across the country. Evaluation data demonstrates the students’ perceived importance of this palliative care training and faculty’s perception that students are graduating prepared to provide primary palliative care.

Implications for Research, Policy, or Practice. Preparing nursing students to provide primary palliative care, across all clinical settings, to patients with serious illness and their families will help address the shortage of specialty palliative care clinicians and improve quality of care.

4:30–5:30 pm

Concurrent Sessions

The Ripple Effect: The Lasting Impact on a Hospital System After Caring For a Juvenile with ALS at the End of Life in a Tertiary Care Pediatric Hospital (FR471)

Dianna Yip, DO, Dell Children’s Medical Center, Austin, TX. Kahla Gagne, MSN RN PNP, University Hospitals Rainbow Babies and Children’s, Cleveland, OH. Andrea Scioscia, MD, Rainbow Babies and Children’s Hospital, Cleveland, OH.

Objectives

- Discuss an interdisciplinary approach to caring for a hospice patient in an acute care hospital until end of life including an approach to symptom management.
- Describe the emotional impact, needs identified, and lessons learned among an interdisciplinary team as a result of caring for this patient.
- Synthesize the intricacies of an effective comprehensive curriculum for pediatric residents surrounding the end of life and describe the impact this has had on pediatric residents’ and nurses’ comfort at the end of life.

It is not often that one patient goes on to impact an entire hospital system. Lucy was a 16 year old female with Juvenile ALS, ultimately BIPAP dependent. Due to Lucy’s anxiety and her mother’s profession as a nurse, her family wished to remain at the hospital until the end of her life. Her experience required the entire hospital team to care for a hospice patient in a tertiary care inpatient setting.

Lucy was hospitalized for over 7 months where our care team witnessed her progressive decline until end of life. The complex situation required not only intricate symptom management but also long term family and care team support that was less familiar in an acute care setting.

A survey of the residents revealed sixty-four percent of our residents had experienced the death of at least one patient. Fifty-six percent of the residents had participated in an end of life discussion, while 72% rated their comfort level with these discussions as “very uncomfortable” or “somewhat uncomfortable.”

A need was identified to address the logistics of caring for dying patients and facilitating end of life discussions.

Lucy’s case and the results above led to the development of our hospital’s “end of life” curriculum. The six-part series utilized a multi-disciplinary approach to discuss topics related to death and dying. The series was facilitated by an interdisciplinary team and included families of deceased patients.

We will discuss the intricacies of caring for a terminal patient in the hospital, and how the development of and participation in a comprehensive curriculum has increased pediatric residents’ and nurses’ comfort at the end of life. In the data that is currently being collected, we will show how the curriculum is altering resident and nursing comfort in caring for dying children and their families.

Optimizing the Delivery of Home-Based Palliative Care: Experiences from PCORI’s Ongoing Large Multi-Site Clinical Trials (FR472)

Neeraj Arora, PhD, PCORI, Washington, DC. Susan Enguidanos, PhD MPH, University of Southern California, Los Angeles, CA. Huong Nguyen, PhD RN, Kaiser Permanente Southern California, Pasadena, CA.
Objectives

- Discuss different approaches to expanding access to home-based palliative care among diverse patient populations being evaluated in PCORI-funded clinical trials.
- Discuss challenges and examine potential solutions for successfully conducting large scale, complex, multi-site palliative care clinical trials.

Patients with advanced illnesses and their caregivers have been shown to benefit significantly from palliative care services. However, access to comprehensive palliative care remains limited and in many communities is restricted to hospital consults or end-of-life hospice settings. Patients and caregivers report a significant unmet need for receiving palliative care where they live. In response to systematic reviews and priorities identified by a large multi-stakeholder group, the Patient-Centered Outcomes Research Institute (PCORI), in fiscal year 2017, invested over $80 million to fund 9 large, multi-site clinical trials focused on the delivery of community-based palliative care.

In this session we will discuss four of these trials that are evaluating different approaches to delivering palliative care to patients in their homes. These include:

- A trial in 10 Accountable Care Organizations that is comparing the effectiveness of in-person home-based palliative care (HBPC) versus palliative care delivered in clinic by trained primary care providers.
- A trial in 15 clinical sites from an integrated healthcare system that is comparing the effectiveness of an efficient, technology-supported model versus a standard in-person model of HBPC.
- A trial enrolling patients discharged from 9 emergency departments that is comparing the effectiveness of a nurse-led, telephonic case management model of delivering HBPC versus in clinic visits with palliative care specialists.
- A trial in 20 cancer centers that is comparing the effectiveness of delivering HBPC utilizing telemedicine versus in clinic visits with palliative care specialists.

Following an overview of the four trials, we will engage in a moderated panel discussion among the PIs of the studies and with the session attendees on the opportunities for expanding access to HBPC to diverse patient populations and challenges in conducting such large and complex trials that have the potential to generate evidence needed to transform the delivery of palliative care in the US.

Straddling Fee-for-Service and Value-Based Payment: Eight Ways to Keep Your Palliative Care Program Funded and Growing (FR473)

Tom Gualtieri-Reed, MBA BA, Spragens & Associates LLC, Chapel Hill, NC. Donna Stevens, MHA, Lehigh Valley Health Network, Allentown, PA.

Objectives

- Describe common challenges and barriers to funding a palliative care program across different payment models and funding sources.
- Identify four actions that a program can take to improve the likelihood of adequate funding and growth.
- Describe the basic building blocks of the business case for palliative care programs.

Are you struggling to get adequate staffing for your palliative care program? Have you been asked to begin seeing patients in the home or expand into the cancer center? Is your organization considering reducing or eliminating your program? Building the business case for your palliative care program is a continuous process and is particularly challenging during this period of shifts in reimbursement from fee-for-service to value-based payment.

This session will provide participants with practical actions they can take to tell their “value story” and align with organizational, payer, or other funder’s goals. Using a palliative care program’s experience, this interactive session will walk participants through this program’s recent journey in going from being at risk of having their program funding reduced to a place where their organization has recognized its value and is growing its resources.

Through large group facilitated discussion this session will encourage participants to share their own experiences in building the business case for the resources they needed to sustain and grow their program, including what worked and what did not work.

Finally, the presenters will share business planning tools and practical steps for conducting a needs assessment and aligning the program’s goals with their organization’s or other funders’ goals.

Sojourn’s Scholars Present: In the Expert’s Studio (FR474)

Toby Campbell, MD MS MSC, University of Wisconsin, Madison, WI. Abraham Brody, PhD RN ACHPN FAAN FPCN, NYU Rory Meyers College of Nursing, New York, NY. Elizabeth Lindenerberger, MD, Icahn School of Medicine at Mount Sinai, New York, NY. Caroline Hurd, MD, University of Washington, Seattle, WA.
Lynn Reinke, PhD ARNP, Department of Veterans Affairs, Seattle, WA.

Objectives
- Gain insight into the approach to highly skilled communication.
- Skill demonstration in order to demystify the communication process for clinicians.
- Enhanced understanding of the invisible process an expert takes when approaching a complicated situation.

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 rarer is the opportunity to hear about their personal and professional development. Participants will hear the expert comment on their strategies, thought processes, and development.

Our presentation is based upon a “Master’s Class” in which the audience learns from the demonstration of skill by an acknowledged expert and a discussion of their development and approach. We presented this session in 2018 with Dr. Ira Byock and plan to reprise our session in 2019 with another expert, ideally in a larger room with video capability so the audience can better see the expert’s face and body language on screen.

The program is broken into thirds. In the first portion, the interviewer digs deeper into the expert’s personal and professional development into a leader of the field. In the second portion, attendees observe our expert in an uninterrupted simulation such as a family meeting. In the final portion interviewers walk the expert through the simulation to gain insights into their thought process about the communication strategies used and alternatives they considered.

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 engage the audience in the form of submitted questions on paper. This session lends itself to being repeated annually with a different expert participant.

Our group, over time, wants to represent a diverse group of experts. If accepted this year we intend to approach Susan Block, Martha Twaddle, or Diane Meier.

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**Calculating Conversations About Opioid Conversions: Not Your Mama’s Equianalgesic Chart! (FR475)**

Mary Lynn McPherson, PharmD MA MDE BCPS, University of Maryland School of Pharmacy, Baltimore, MD. Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA.

Objectives
- Describe recent data that evaluates including switching from IV hydromorphone to oral hydromorphone, morphine or oxycodone, and other conversions.
- Describe considerations for future opioid switching best practices: equivalency vs. utility.

It is not uncommon for patients to require switching from one opioid to a different opioid to maximize pain control and minimize adverse effects. This may be due to transitions in care (between acute and chronic care), due to lack of an acceptable therapeutic response, or due to opioid-induced toxicity. Practitioners rely on equianalgesic tables to determine an equivalent dose of a different opioid regimen. Much of the data that supports these tables is from single-dose studies, not steady-state clinical trials, and seldom if ever consider patient-specific considerations. In the past 2-3 years, better evidence has emerged in opioid conversions, including data from steady-state clinical practice. In this presentation participants will learn about this emerging data that demonstrates best practices in switching between opioid and dosage formulations. Using a case-based format, the presenters will guide participants through the application of this data, and use of a "new and improved" equianalgesic table. Last, participants will leave about a new concept of "opioid utility" which may be the next concept in opioid conversions. This presentation will share cutting-edge data that provide more accurate guidance than traditional opioid equianalgesic charts have in years past.

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**Managing Scarce Resources: Best Practices in Using Triggers in the Hospital and in the Community (FR476)**

Allison Silvers, MBA BA, Center to Advance Palliative Care, New York, NY. Dana Lustbader, MD FAAHPM, ProHEALTH, New York, NY. Rachel Adams, MD, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives
- List the key data elements used in effective patient identification algorithms, and explain the variation needed between inpatient and outpatient services.
- Describe the key steps in implementing a proactive patient identification program, including ensuring patient engagement.
- Devise strategies to achieve buy-in and support from treating providers, accounting for the needs and culture of their organization.

With limited resources and a specialized skill set, palliative care services must be delivered to the appropriate set of patients to ensure value to the organization. Unfortunately, referrals from treating providers do not always result in palliative care teams seeing the right patients at the right time. As an
alternative, data-driven proactive patient identification (aka “trigger programs”) for palliative care services have been credited with strong improvements in quality, satisfaction, and utilization. In fact, there is a growing industry of vendors creating proprietary data-driven algorithms to identify different subsets of patients, including those most likely to benefit from palliative care.

While some organizations report huge successes with trigger programs, others find that triggers are underutilized, ineffective in achieving targeted outcomes, or generate patient volumes beyond the capacity of the palliative care team. Still others struggle with implementing trigger programs in the first place, due to concerns about HIPAA compliance or objections from other departments and specialties. This session will walk attendees through the details of implementing a data-driven patient identification program. The session first covers the common core data elements in identification algorithms and how they vary from an inpatient to a community-based setting. Next, the session will review the key steps in the process of implementing a proactive patient identification program. Lastly, triggers create a very different relationship with treating clinicians, and will likely identify patients that some may not think to refer. Thus, the session ends with an exploration of how successful trigger programs incorporate treating clinicians, securing buy-in and sustaining those relationships over time.

**Lessons Learned from Engaging Latinos in a Palliative Oncology Research Program (FR477)**

Richard Leiter, MD, Dana-Farber Cancer Institute, Boston, MA. Maria Teresa Bejarano Varas, MD, Boston Medical Center and Boston University, Boston, MA. Yudy Muneton, LCSW, Dana-Farber Cancer Institute, Boston, MA. Laura Hayman, PhD MSN, University of Massachusetts Boston, Boston, MA. Ana Lindsay, DDS MPH DrPH, University of Massachusetts, Boston, MA. Andrea Enzinger, MD, Dana-Farber Cancer Institute, Boston, MA.

**Objectives**

- Recognize disparities in end-of-life care for Latinos with advanced cancer.
- Appraise the existing literature describing the psychosocial, cultural, and communication factors that influence illness understanding, decision-making, and end-of-life care among Latinos with cancer.
- Describe methods for engaging and collaborating with stakeholders and interdisciplinary team members from palliative care and oncology in a research program on minority patients with serious illness.
- Latinos with incurable cancer often receive palliative chemotherapy without understanding that it is unlikely to cure. Such misconceptions are more prevalent among Latinos than Whites, and may contribute to Latino/non-Latino disparities in end-of-life (EOL) care, such as lower rates of advance care planning, underutilization of hospice, and high rates of hospital and ICU death. Latino advanced cancer patients face formidable cultural, linguistic, and structural barriers to accessing critical information about their disease and treatment options. Nevertheless, interventions to enhance Latinos’ understanding and engagement in treatment decision-making are few and underdeveloped. Bolstering communication between oncologists, Latino patients, and caregivers holds promise to improve understanding and quality in advanced cancer and palliative care.

In partnership with Latino community members, investigators, and students, we have developed a multimedia, patient-centered intervention supporting palliative chemotherapy education, tailored to the needs of Latino patients with advanced gastrointestinal malignancies and their caregivers. In an NCI-funded randomized controlled trial (RCT) we seek to determine its impact on Latino patients’ and caregivers’ understanding of chemotherapy risks and benefits, communication satisfaction, treatment choices, and EOL planning. In this concurrent session we will present our systematic literature reviews and focus groups with Latino patients and caregivers to contextualize disparities in end-of-life outcomes for Latinos with advanced cancers. Audience members will be asked to list challenges they face performing cross-cultural palliative oncology research. We will then present our work on this project as an example of how to overcome these barriers. Focusing on the creation of our intervention, the development of tools to measure outcomes, and the design of an RCT, we will review critical topics, challenges, and lessons learned in research involving minority patients with advanced illness: the engagement of stakeholders, the translation of educational and research materials into another language, and the exploration of explanatory models and decision-making frameworks.

**Integrative Pain Management for Hospice and Palliative Care (FR478)**

Ann Marie Chiasson, MD DC HMDC, University of Arizona, Tucson, AZ. Lucille Marchand, MD BSN FAAHPM, University of Washington, Seattle, WA.

**Objectives**

- Discuss the role of Integrative Therapies in the management of pain in palliative care and hospice patients.
- Understand the evidence for acupuncture in pain for palliative care and hospice patients.
• Understand the evidence for dietary supplements in pain management for palliative care and hospice patients.

Pain is a complex multidimensional issue compromised of physical, biochemical, neurological, nutritional, and psychosocial-spiritual components. Primary medical treatments to date habitually treat pain with pharmacologic management as first line of care, yet chronic pain management metrics have not improved. As opioid medications have recently come under intense scrutiny, certain integrative therapies such as acupuncture are now being recognized as effective for many chronic non-malignant pain syndromes, such as chronic headache and chronic low back pain. Palliative and hospice patients often have co-morbid chronic non-malignant pain secondary their palliative diagnosis. Further, as up to half of cancer patients report undertreated pain, an integrative comprehensive pain strategy can provide superior pain management in cancer patients. This presentation will address the evidence and role for integrative therapies, including acupuncture, dietary supplements, mind-body therapies, massage, music, and cannabinoids in the management of chronic and cancer pain.

Vigil Volunteers—The Power of Presence at the Bedside (FR479)
Rebecca Hixson Vanderbilt University Medical Center, Nashville, TN. Mohana Karlekar, MD, Vanderbilt University Medical Center, Nashville, TN. Andrew Peterson, MDiv MMHC, Vanderbilt University Medical Center, Nashville, TN. Cody Case, MDIV, Vanderbilt Medical Center, Nashville, TN.

Objectives
• Outline the key steps in developing a self-sustaining Vigil Volunteer Program from inception to institution-wide roll out.
• Describe a framework to recruit, orient and provide ongoing training for volunteers with little to no experience in caring for patients at the end of life that is both that time and cost efficient.
• List both the benefits and barriers in establishing a model a Vigil Volunteer Program to patients, families and clinical staff.

Many of us have imagined what we want at the end of life (EOL). Most all of us wish to be surrounded by loved ones. Studies show that patients fear abandonment. The reality, however, is that a significant portion of patients die alone. Death creates angst. Dying alone exacerbates this angst.

In our institution, a quaternary care center that routinely accepts patients from hundreds of miles away, a great many patients find themselves alone at the EOL despite having family. The moral distress of dying alone is unimaginable. To address this concern, we developed a Vigil Volunteer program available to any patient who finds themselves alone at the EOL regardless of whether they had family.

In this session, we will describe the structure and operations of our Vigil Volunteer Program including the iterative process that led to this self-sustaining program. We will use our experience as an example to show how other institutions can develop their own vigil program to suit their individual needs without adding additional staffing.

We will describe the impetus in developing our program, and how we scaled our pilot from a single inpatient unit to the entirety of the institution.

We will discuss the nuts and bolts of the program emphasizing staffing, specifically volunteer recruitment, orientation, and ongoing training and resilience. Finally, we will highlight the benefits to patients, families and health care providers, as well as share the perspective of an actual volunteer’s personal experience.

Each member of our team will discuss how our institution has created a therapeutic presence for our hospitalized patients nearing the end of life. We will describe and account for the effect of human, mindful presence positively impacts the care and comfort of those individuals who would otherwise have gone through the journey alone.

The Evolution from Futility to Non-Beneficial Treatment: Updates for the Palliative Care Clinician (FR480)
Adam Marks, MD, University of Michigan, Ann Arbor, MI. Phillip Rodgers, MD FAAHCP, University of Michigan, Ann Arbor, MI. Gregg VandeKieft, MD MA FAAHCP, Providence Health and Services, Olympia, WA. Denise Hess, MDIV, Providence St. Joseph Health, Hillsboro, OR. Steven Radwany, MD FACP FAAHCP, Summa Health System, Akron, OH.

Objectives
• Understand the definition and history of the ethical concepts of medical futility and non-beneficial treatment as it pertains to hospice and palliative medicine.
• Discuss the ethical and legal scope and limitations of these concepts in withdrawing/withholding life-sustaining therapies.
• Review the experiences of three hospital systems’ implementation of non-beneficial treatment policies, including impact on ethics consults.

Not infrequently, palliative medicine clinicians encounter a patient or family who requests treatment at the end of life that is of little or no clinical benefit. In the majority of instances, these cases can be resolved with thoughtful, value-based communication and shared decision making. However, in some cases, conflict can arise when the patient or family insists on
medical treatment, often for religious reasons, that is felt by the clinician to be either of little benefit or carries significant risk without expectation of improvement.

In the past, the concept of “futility” has been used to discuss such cases, and many hospitals have crafted policies defending the clinicians right to not provide care deemed medically futile. However, as an ethical construct the concept of futility has long been known to be difficult to invoke in individual circumstances and thus can be unevenly or inappropriately applied. Recently, increased attention has been paid to the concept of “non-beneficial treatment” (NBT) as a term that more accurately captures medical treatments that either have little or no chance of benefit or for which the risks outweigh the benefits.

This concurrent session will provide a review of these terms, the impact they have on clinical care, their scope and limitations, and provide perspectives from three institutions that have implemented a hospital policy on non-beneficial treatment. Participants will be engaged to share their own experiences with futility and/or NBT policy development, implementation, and application in practice, in service of identifying best practices and strategies for success.

**Palliative Care for Inmates in the Hospital Setting (FR481A)**

Stephanie Stephens, DO, Virginia Commonwealth University Health, Richmond, VA. Brian Cassel, PhD, Virginia Commonwealth University, Richmond, VA. Danielle Noreika, MD, Stephens Medical Center, Richmond, VA. Egidio Del Fabbro, MD, Richmond, VA.

**Objectives**
- Identify illness and symptom burdens unique to the inmate population.
- Describe the need for palliative care in the hospitalized prison population.

**Original Research Background.** The US population of inmates is growing at a rate 11 times faster than the general population. Along with this growth there is rapid increase in the number of elderly prisoners with an accelerated ageing phenomenon. Previous studies have demonstrated multiple barriers to providing palliative care for seriously ill inmates.

**Research Objectives.** The aim of this study was to assess the frequency of palliative care consultation and nature of consultation requests for inmates who died while hospitalized at a large tertiary care hospital.

**Methods.** A retrospective chart review of all inmate decedents over a 10-year time period was conducted. The reason and timing of consultation was noted in addition to symptoms identified and interventions recommended by the palliative care team. Characteristics of patients who were transferred to the inpatient palliative care unit were also recorded.

**Results.** Two hundred ninety-nine inmates died over the 10 years, with 45% of inmate decedents being seen by palliative care. Timing of consultations was short, with median time of consultation being 3 days prior to death. Inmates with cancer were significantly more likely to have a palliative care consultation prior to death (p<0.000). Older inmates were also significantly more likely to have palliative care consultations (p<0.026). The most frequent intervention recommended, in 82% of patients, was opiates for pain or dyspnea. Delirium was often missed by the primary team but was identified by the palliative care team in 37% of patients.

**Conclusion.** The inmate population has both a high rate of comorbid conditions with associated symptom distress. There is a demonstrated need for palliative care interventions, much like free-living patients.

**Implications for Research, Policy, or Practice.** Nearly 5,000 prisoners die each year, most in community hospitals. There is a need for inmates to have access to palliative care and further research should be done to determine how to best deliver care for this underserved population.

**Shifts in the Adoption of Hospital-Based Palliative Care Programs (FR481B)**

Maggie Rogers, MPH, Center to Advance Palliative Care, New York, NY. R. Sean Morrison, MD FAAHPM, Icahn School of Medicine Mount Sinai, New York, NY. Amy Kelley, MD MSHS, Icahn School of Medicine at Mount Sinai, New York, NY. Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY. Melissa Aldridge, PhD MBA BA, Icahn School of Medicine at Mount Sinai, New York, NY.

**Objectives**
- Explain the prevalence of palliative care programs in US hospitals and how this has changed over time.
- Discuss the characteristics of hospitals that implemented palliative care programs during the period and the characteristics of those that closed programs during the period.

**Original Research Background.** Cross-sectional studies have identified hospital size, tax status, and region as predictors of palliative care presence in hospitals. However, little is known regarding longitudinal changes in palliative care program adoption and closure and whether characteristics of hospitals newly establishing palliative care programs differ from historical adopters.

**Research Objectives.** Identify the organizational and regional characteristics associated with hospitals
with newly established palliative care programs and those that closed programs between 2013 and 2016.

**Methods.** We linked the American Hospital Association Annual Survey to the National Palliative Care Registry for 2013 and 2016. We categorized hospitals as newly establishing a palliative care program, closing a program, or no change. We used 3 multivariate logistic regressions to identify factors associated with each category.

**Results.** Nationally, the proportion of hospitals with 50 or more beds with a palliative care program increased from 67% in 2013 to 78% in 2016. A total of 278 hospitals established palliative care programs and 61 hospitals closed programs during this period. The proportion of for-profit hospitals with palliative care increased from 23% to 45% compared with nonprofit hospital increase from 78% to 88%. Hospitals with new vs established programs were more likely to be smaller (AOR 8.41, 95% CI 5.49-12.89 for 50-149 vs >300 beds; AOR 3.75, 95% CI 2.43-5.79 for 150-300 vs >300 beds), for-profit (AOR 7.45, 95% CI 4.95-11.19), sole community providers (AOR 3.36, 95% CI 1.97-5.73), and in the South Atlantic. Hospitals that closed palliative care programs had similar characteristics to hospitals that newly established programs.

**Conclusion.** Palliative care program implementation is volatile among for-profit and smaller hospitals and varies by region. The impact of these changes on access to palliative care remains a critical area for future research.

**Implications for Research, Policy, or Practice.** Understanding longitudinal patterns in palliative care program implementation and closure will enable development of technical assistance and resources to maximize access to palliative care.

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**Development of a Social Work-Led Primary Palliative Care Model in Hospital Medicine (FR481C)**

Keisha Berglund, LCSW, Mount Sinai Hospital, New York, NY. Emily Chai, MD, Mount Sinai Health System, New York, NY. Jaison Moreno, MA, Mount Sinai Health System, New York, NY. Maria Anaizza Reyna, MD, Mount Sinai Hospital, New York, NY. Laura Gelfman, MD MPH, Icahn School of Medicine at Mount Sinai, New York, NY.

**Objectives**
- Describe what is involved in an embedded primary palliative care program.
- Describe how an embedded primary palliative care program model can improve patient outcomes.

**Original Research Background.** Due to palliative clinician workforce shortages and the growing number of patients with serious illness in need of palliative care, innovative primary palliative care models are essential to meet this population’s needs using the existing resources.

**Research Objectives.** To increase palliative care delivery, enhance appropriate hospice referral and decrease readmissions of seriously ill patients admitted to the hospitalist service.

**Methods.** To meet unmet palliative care needs of patients admitted to the hospitalist service at Mount Sinai Medical Center, a social worker-led embedded primary palliative care model was developed. The social worker facilitated goals of care discussions, delivery of prognosis, discharge planning, and completion of advance directive documentation.

**Results.** In 2017, 184 patients received a primary palliative care consultation; those patients seen had an average age of 70 years, 43% were female and the median Karnofsky performance status of 40%, as compared to 20% for those seen by specialty palliative care. Overall, 51% of the patients seen met palliative care solid tumor oncology trigger criteria, 20% were triaged from the specialty palliative care team and 15% were direct referrals from hospitalists. Of those evaluated, 5% had documented goals of care in the electronic medical record before the consultation and 92% after the consultation. The hospice referral rate was 25% and the specialty palliative care referral rate was 25%. Reasons for referral to specialty palliative care were transfer to the palliative care unit (51%) and complex symptom management (49%). Of those who received the consultation, 30-day readmission rate was 5.3%, as compared to those who did not (16%).

**Conclusion.** Patients seen by the social worker-led primary palliative care team were more functional, suggesting they were seen earlier in their disease course, and had fewer readmissions.

**Implications for Research, Policy, or Practice.** Primary Palliative Care Models broaden the reach of Palliative Care to patients who are seriously ill.

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**Promoting Resilience in Stress Management (PRISM): A Prevention Model for Palliative Care (FR481D)**

Nancy Lau, PhD, University of Washington/Seattle Children’s, Seattle, WA. Miranda Bradford, MS, Seattle Children’s Research Institute, Seattle, WA. Angela Steineck, MD, Seattle Children’s Hospital, Seattle, WA. Claire Wharton, BS, Seattle Children’s Hospital, Seattle, WA. Samantha Scott, BA, Seattle Children’s Research Institute, Seattle, WA. Courtney Junkins, PsyD, Seattle Children’s Research Institute, Seattle, WA. Joyce Yi-Frazier, PhD, Seattle Children’s Research Institute, Seattle, WA.
Institute, Seattle, WA. Abby Rosenberg, MD MA MS, Seattle Children's Hospital, Seattle, WA.

Objectives
- Evaluate Promoting Resilience in Stress Management (PRISM) as a prevention model for pediatric palliative care.
- Translate research findings to clinical practice working with patients with serious medical illnesses, emphasizing the importance of real world implementation.

Research Background. Adolescents and young adults (AYAs) with cancer are at high risk of poor quality of life and negative psychosocial outcomes. Promoting Resilience in Stress Management (PRISM), a brief, 1:1, skills-based intervention, has demonstrated efficacy in improving quality of life and alleviating distress for AYAs. In this secondary analysis of data from a recent randomized trial, we examined PRISM’s role in preventing the development of negative psychosocial outcomes.

Methods. One hundred English-speaking AYAs (ages 12-25 years) with cancer were randomized to receive PRISM vs Usual Care (UC). At enrollment and 6 months later, AYAs completed validated Patient Reported Outcomes (PROs) measuring resilience (CDRISC-10), hope (Snyder hope scale), quality of life (PedsQL), and distress (Kessler-6). Individual patient response trajectories from baseline to 6-month follow-up were categorized as “improved” (>10% increase in PRO scores), “stable” (+/- 10% change), or “deteriorated” (>10% decrease in PRO scores) for each PRO.

Results. Seventy-four patients (36 PRISM, 38 UC) completed baseline and 6-month PROs assessments. A positive response to PRISM persisted even after AYAs were stratified by demographics of gender, age, and race. Individual patient trajectories across all PROs measured suggested PRISM recipients generally experienced either symptom improvement or remained stable over time, whereas UC participants tended to deteriorate over time. The cancer-specific PedsQL provides an illustrative example of group-wide categorical trends such that fewer PRISM recipients “deteriorated” compared to UC (5.6% vs 15.8%, respectively), and more PRISM recipients “improved” compared to UC (33.3% vs 13.2%, respectively).

Conclusions and Implications. PRISM seemed to work equally well across demographic groups. Individual trajectories and group-trends suggested that PRISM may prevent deterioration in resilience, hope, quality of life, and distress. Thus, PRISM may serve as a viable prevention model for pediatric palliative care. Future research will explore the implementation of PRISM as “entry level” psychosocial standard of care for all AYAs with cancer.

Interactive Educational Exchange

Using Simulation to Teach Interprofessional Communication in Palliative Care (FR482A)

Barbara Jones, PhD MSW, University of Texas, Austin, TX. Clarissa Johnston, MD, Dell Medical School University of Texas, Austin, TX. Elizabeth Kvale, MD FAAHPM, University of Texas Dell Medical School, Austin, TX. Molly Curran, PharmD, BCPS BCCCP, University of Texas, Austin, TX. John Luk, MD, University of Texas Dell Medical School, Austin, TX. Gayle Timmerman, PhD RN CNS, University of Texas, Austin, TX. Veronica Young, PharmD MPH, University of Texas, Austin, TX. Richard Bottner, PA, Seton and Dell Medical School, Austin, TX.

Objectives
- Compare and contrast different types of palliative care simulation described in the literature.
- Identify opportunities within one’s own institution to develop similar coursework.
- Create learning outcomes for the use of simulation in palliative care education.

Background. Simulation has become a common education modality across most health professions but is not widely adopted in palliative care education. In a recent review, Smith et al. (2018) found several examples in the literature of end-of-life communication training for nurses and nursing students. However, less than 25% of the thirty articles reviewed included team-based simulation encompassing nursing, social work, and medical students. Simulation provides students a tangible experience in interprofessional palliative care prior to workforce entry.

Audience. The Foundation for Interprofessional Collaborative Practice course incorporates learners from the UT Austin Schools of Pharmacy, Medicine, Nursing, and Social Work and would be appropriate for additional disciplines including psychology and chaplaincy.

Approach. This two-semester experience places students in small interprofessional teams which meet monthly. In the first part of the palliative care module, learners participate in a three-hour large group session with small group breakout sessions based on materials adapted from the iCOPE curriculum (Head, et al. 2014).
In the second part of the module, the focus of our Interactive Educational Exchange, students participate in a twenty-minute goals-of-care conversation in a standardized patient lab utilizing trained patient actors. The group facilitator observes the interaction remotely and then provides direct feedback. This portion of the module is based on original content created by our steering committee.

**Results.** Over 500 learners have participated and report increased comfort with palliative care communication and interprofessional teamwork.

**Impact.** Introduction to palliative care is an important opportunity for interprofessional learners. Many students have little previous knowledge of palliative care and end-of-life issues. This course allows students to explore these concepts in a safe environment while being positively exposed to the field.

**Critique/Next Steps.** We plan to evaluate whether interprofessional communication training influences learner comfort with difficult conversations in future clinical practice.

### Simulation to Teach the Art of Difficult Conversations: A Curriculum Adaptable for All Learners (FR482B)

Cassandra Hirsh, DO, Akron Children’s Hospital, Akron, OH.

**Objectives**
- Identify the key components necessary to create a successful conversation simulation curriculum.
- Create a difficult conversation simulation curriculum that is applicable to learners in your respective program.

**Background/Context.** Simulation is an effective way to educate learners in practical medical skills. A program implemented within our pediatric residency and palliative care fellowship program allows each learner to have an opportunity to participate in two unique simulated conversations during their training. This allows our learners to try different techniques and have these conversations in a safe place.

**Audience.** The target audience is anyone responsible for teaching others to have difficult conversations.

**Approach.** Each learner is presented with a scenario and observed having a difficult conversation with a bereaved parent. Then a debriefing occurs to discuss the encounter and provide education about conversation techniques that may make the conversation easier. The learner repeats the simulation and another debriefing occurs.

**Results/Outcomes.** We have had this program in place for the past six years and there have been more than one-hundred simulated experiences. Using both qualitative and quantitative outcome measures, we have seen specific improvements in learners.

**Impact.** This educational experience allows the learner to have a difficult conversation in a safe environment where the stakes are not as high. The perspective of a bereaved parent makes the situation more genuine. Incorporating simulated difficult conversation training into the curriculum of any learner (resident, fellow, nurse, nurse practitioner, chaplain, social worker) allows this skill to be taught to learners in a way that leaves room for error and learning without causing harm to a patient. This technique has also been adapted to perform in a group setting.

**To Poop or Not to Poop: A Multi-Sensory Learning Experience in Constipation Management (FR482D)**

Ashley Nichols, MD, UAB Hospital, Children’s of Alabama, Birmingham, AL.

**Objectives**
- Define constipation and list the underlying causes that contribute.
- Formulate best constipation treatment based on mechanism of action, drug formulation, taste, cost, and contraindications.

**Background/Context.** Constipation is a prevalent symptom that plagues patients across the disease spectrum, contributing to morbidity and mortality. This innovative educational experience engages learners with multi-sensory experiences to help them remember how to appropriately prevent and manage constipation.

**Audience.** All palliative clinicians (physicians and nurses) as well as generalists to enhance primary palliative care skillset.

**Approach.** A multisensory teaching curriculum for constipation, including a matching game to place constipation treatments into their therapeutic categories (to understand mechanism of action, pearls/pitfalls) as well as markers for formulation of meds (liquids, tabs vs rectal administration), pill samples to show size/shape/cost of commonly-prescribed medications, and taste-testing station for liquid formulations.

**Results/Outcomes.** I teach this curriculum on a monthly basis in our palliative didactic series, so all of our Internal Medicine residents as well as any medical students on elective get to participate (>50-60 learners annually); in addition, I teach this to both Palliative and Oncology fellows (4-8 learners annually). Over the 5 years I’ve taught this curriculum,
I’ve added more sensory experiences (pills, formulations, taste tests, costs) to improve engagement and add more empathy-driven teaching pearls for providers. This didactic consistently gets very high praise/feedback including noted change in clinical practice behaviors.

**Impact.** Example of adult-based learning and multi-sensory teaching technique to engage learners and teach primary palliative care across the field.

**Critique/Next Steps.** This innovation’s strengths include a fun, multi-sensory way to teach a primary palliative skill that can be applied to other teaching curricula as well as experiential learning that helps provide clinicians with patient-guided, empathic prescribing practices that take into account effectiveness, cost, and pill burden. This teaching method is low cost and easily replicable as well as conducive to all clinician learners across the learning spectrum. Next steps include formally evaluating learner knowledge and comfort via pre- and post-tests; data collection pending.

The Use of E-Learning, Narrative, and Personal Reflection in a Medical School Ethics and Palliative Care Course (FR482E)

C Christian Paine, MD, University of Mississippi Medical Center, Jackson, MS. Angelle Klar, MD, University of Mississippi Medical Center, Jackson, MS. Andrew Hayslett, MD, University of Mississippi Medical Center, Jackson, MS. Angelle Klar, MD, University of Mississippi Medical Center, Madison, MS.

**Objectives**

- Describe the opportunities and challenges inherent in teaching Palliative Care over e-learning platforms.
- Utilize narrative to engage learners as well as engender empathy and emotional awareness.
- Identify methods for encouraging personal reflection and meaning building in medicine.

**Background/Context.** The growth of E-Learning and Adult Learning Theory have presented new challenges and opportunities for medical education. This course combines the accessibility and adaptability of online tools with the interactive and collaborative nature of in-person participation. It leverages the studied benefits of narrative, group discussion, reflection and asynchronous learning to introduce learners to Palliative Care and Medical Ethics.

**Audience.** The target audience is anyone involved in medical education seeking new ways to effectively use online learning in Hospice and Palliative Care. The targets of the course are learners at any level of medical training. It could also be utilized by other disciplines by adapting the narratives.

**Approach.** The course is online and discussion based. Each week students are presented with a line of the Hippocratic Oath, a short unit discussing the relevant ethical and palliative principles, a section of the course narrative representing both patient and provider perspectives, suggested readings, and a discussion question. Students then post both an original response as well as participate in message-board based discussion with classmates and instructors. After several units, participants post a personal reflection as a self-addressed letter stating what they intend to take away from their collaboration.

**Results/Outcomes.** The course is in its third year, and each year approximately 125 students take part. Outcomes are measured both by observation of students’ participation as well as post-course surveys. Comments have been positive with suggestions including introduction of some in-person video modules with discussion.

**Impact.** This innovation integrates e-learning, narrative and discussion to improve palliative and ethical competence, increase self-awareness and empathy, and grow interest in Hospice and Palliative Care.

**Critique/Next Steps.** Comments have identified the course’s narrative, discussion, and reflection as effective tools for engaging with palliative principles. In the future, in-person video modules and group reflection will be added.
Saturday, March 16

7–8 am

**Cambia Leadership Lecture Breakfast**

**Women in Leadership: Pathways for Empowerment, Leadership, Action and Culture Change (CAMBIA)**

Rachelle Bernacki, MD MS FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Patricia Davidson, PhD MEd RN FAAN, Johns Hopkins School of Nursing, Baltimore, MD. Stephanie Harman, MD, Stanford Palliative Care, Stanford, CA. Jean S. Kutner, MD MSPH FAAHPM, University of Colorado School of Medicine, Aurora, CO. Deborah Lafond, DNP PPCNP-BC CPON CHPPN, Children’s National Health System, Washington DC. Peggy Maguire, JD, Cambia Health Foundation, Portland, OR. Christine Ritchie, MD MSPH FAAHPM FACP, University of California San Francisco, San Francisco, CA.

**Objectives**

- Describe the challenges, prospects and strategies to increase the number of women in palliative care leadership positions.
- Discuss how to mentor, support and encourage more women to assume leadership positions.
- Identify best practices and leadership styles for ‘managing up’ in an organization, supervising those who report to you, and gaining support from men and other women in the organization.

Participants who register for the session will be surveyed prior to the session for questions they may have about women leaders and how to attain and sustain leadership. The moderator, Dr. Kutner will select questions from the survey results and encourage questions from participants for the panel discussion which will also include big picture issues pertaining to women leaders.

Some possible themes and questions are as follows:

1. How have women and men in the palliative care movement been affected by the Me-Too movement?
2. What planned or random experiences helped you become a leader? (e.g., programs, mentors, colleagues, coaches)
3. Did you find road blocks at any time in your career because you are a woman? How did you overcome them?
4. What are the work-life balance issues you face as a leader? How do you support others on your team? (Do men and women come to you with different issues?)
5. How do you stay in tune with your highest and best use with many demands on your time?
6. What was the best piece of career advice you received on your path to leadership?
7. How did you find a unique voice as a women leader?
8. What are the challenges and opportunities faced by you in leading your own organization and having an impact nationally?

8:15–10 am

**Plenary Session**

**State of the Science (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**

**The Practice of Palliative Medicine in Developing Countries—Part One (SA500)**

Kayode Olafimihan, BSc. MBBS FWACP, Dip. Pall Med. University of Ilorin Teaching Hospital, Ilorin, Nigeria. Mohja Marhoom, MBBS, Khartoum Oncology Hospital, Khartoum, Sudan. Zohora Jameela Khan, DCH MD, Dhaka Medical College Hospital, 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.

**Transgender Health Literacy 101: Providing Whole-Person Care Without Assumption (SA501)**

Ruth Thomson, DO MBA HMDC FAAHPM FACOI
Jack Byrne Center for Palliative and Hospice Care, Hanover, NH. Pat Starke, BSN RN CHPN, Over the Rainbow, Dover, DE. Denise Morris, EDD, Wesley College, Dover, DE.

**Objectives**

• Formulate transgender health literacy by understanding the physical, psychological, and social aspects of caring for transgender patients.
• Demonstrate respectful communication and care for transgender patients.
• Employ skills that foster moving past assumptions and bias to provide whole-person care for transgender patients.

Best available data estimates 0.6-0.7 percent of the U.S. population identify as transgender. Transgender people have not only faced societal discrimination, they have also endured discrimination in health care settings. A 2011 survey of 6,500 transgender individuals showed that 19% of respondents reported refusal of medical care, 28% experienced harassment in a medical setting, and 50% interacted with providers who had a complete lack of understanding of the care they needed. As a result of discrimination and other psychosocial challenges, transgender individuals experience high levels of postponing health care and suffer much higher rates of HIV infection, substance abuse, and suicide than the national average. Discrimination affects access to the continuum of healthcare, including serious illness and end-of-life care, for transgender people.

Most hospice and palliative care teams pride themselves on being inclusive to the needs of the wide variety of people they serve. While a robust body of evidence in our field supports culturally competent care, there is still a paucity of literature addressing the nuances of caring for the LGBTQ population, especially transgender people. Many clinicians lack basic knowledge about transgender medicine and hold false assumptions. To be true to our intentions of whole-person care, we need commit to developing transgender health literacy across our interdisciplinary teams. Once this is achieved, hospice and palliative care teams can hopefully move past biases and provide care without assumption to their transgender patients. This session will provide a platform for all members of the interdisciplinary team to develop transgender health literacy. The session will also explore false assumptions and implicit bias, so we can transcend these to build trust with our transgender patients and provide whole-person care. Through didactics, case presentations, and audience participation, the learner will develop a skill set to provide inclusive, respectful care for their transgender patients.

**Beyond The Device: Exploring the Psychosocial and Spiritual Aspects of the LVAD (SA502)**

Peter Baenziger, MD MS, Indiana University School of Medicine, Indianapolis, IN. Shivani Martin, MD, Indiana University School of Medicine, Indianapolis, IN. Helen McClain, MSW, Indiana University Health Physicians, Indianapolis, IN.

**Objectives**

• Recognize the common psychosocial themes for patients living with serious illnesses and how these apply specifically to patients and their families who are considering left ventricular assist devices.
• Describe the sacred space of hardware treatments on the heart and how spirituality may play a role in decision-making.
• Demonstrate strategies to incorporate palliative care into the management of advanced heart failure patients by teaming with the heart failure specialists and support groups.

Heart transplantations are declining worldwide due to a lack of donors; however, the use of the left ventricular assist device (LVAD) is increasing in patients with advanced heart failure. As mechanical circulatory assist devices grow popular, it is imperative that clinicians are able to recognize not only the medical aspect of the LVAD but the psychological and social stressors that impact a patient and their caregiver. Accepting or denying an LVAD is a major decision for the patient as they may have it for the rest of their life (destination therapy) rather than a temporary measure (bridging therapy).

In this concurrent session, clinicians will discuss the common psychosocial themes in patients living with
serious illnesses and how it may pertain to patients with LVADs including loss of control, self-image, dependency, social stigma, anger, abandonment, isolation and thinking about death. Tools to manage psychosocial stressors such as local support groups and the implementation of therapeutic metaphors (the Labyrinth and Butterfly Release Life Transformation Celebration for LVAD patients) will be described in detail. We will discuss the incorporation of our palliative care team in assisting with management of LVAD patients in collaboration with the advanced heart failure team including advanced care planning and assessing psychosocial factors prior to implantation. Through brief case examples from our experience, we will discuss how spirituality has played a role in decision-making for patients as they view their heart as a sacred entity.

Project ECHO: A Disruptive Innovation to Expand Palliative Care (SA503)
Elizabeth Burpee, MD, Four Seasons, Asheville, NC. Sriram Yennu, MD FAAHPM, MD Anderson Cancer Center, Houston, TX. Christopher Piromalli, DO MPH, Alaska Native Tribal Health Consortium, Anchorage, AK. Michelle Mikus, PharmD, Delta Care Rx, Pittsburgh, PA. Vickie Leff, MSW LCSW ACHPN, Four Seasons Compassion for Life, Flat Rock, NC.

Objectives
- Describe the needs within the larger palliative care community, including workforce shortage, that could be addressed with the use of Project ECHO and other innovative practices.
- Explain the concept and practice of Project ECHO around the world and its role in disseminating specialty medical knowledge to medically underserved populations.
- Discuss the value of interdisciplinary input and multi-site collaboration in palliative care.

Project ECHO uses teleconferencing to link specialist medical teams with community medical care providers who are seeking expertise in a specific field. The specialist teams hold regular “teleECHO” sessions, essentially virtual grand rounds, combining teaching, mentoring and patient case presentations. Over the past few years palliative care programs internationally have begun to utilize this method to expand palliative care knowledge and services in communities. As workforce shortages continue, Project ECHO is an innovative way to increase the capacity of providers by offering education, resources and skills.

We will conduct a teleECHO session, using ZOOM videoconferencing. The purposes of the session are to explain and model Project ECHO, facilitate a discussion of how it and other innovative programs can be used in palliative care, to encourage group input and to model interdisciplinary and international collaboration.

People can participate in several different ways through attending the session in person or by logging into the session from anywhere. The interdisciplinary specialist team will facilitate the discussion from the concurrent session room.

We will follow a typical ECHO session agenda:
1. Didactic presentation: The didactic topic will be “Project ECHO: A Revolutionary Model for Expanding Access to Care”. The presenter will be a Project ECHO leader/expert. The goal is to familiarize audience/participants with the ECHO model.
2. Case presentation and discussion: The “case” will involve a palliative care provider presenting to the session participants some obstacles their organization and providers face. Main question for interdisciplinary specialist team and session participants will be “what innovative solutions have other groups used to address needs/deficiencies in their palliative practice communities?” We will have some of our international ECHO colleagues participating. We will encourage audience to share their own innovative ideas. Interdisciplinary expert panel will share with the audience how Project ECHO has been used to address needs in the PC community.

Beyond Meditation and Deep Breathing: Programmatic Strategies for Clinician Wellness and Team Resilience (SA504)
Arif Kamal, MD MBA MHS FAAHPM, Duke Cancer Institute, Durham, NC. Kristin Edwards, MD FACP CPE, YNHHS–Bridgeport Hospital, Bridgeport, CT. Katy Hyman, MDiv, MemorialCare Long Beach Medical Center, Long Beach, CA. Sumathi Misra, MD MPH CMD FAAHPM, Vanderbilt University Medical Center, Nashville, TN. Ashley Albers, DO HMDC, Four Seasons Compassion for Life, Flat Rock, NC.

Objectives
- Describe the intrinsic framework and core features of five diverse wellness programs across the spectrum of hospice and palliative medicine practices.
- Identify organizational, programmatic and team related challenges and strategies to overcome them when developing, implementing and sustaining wellness programs in diverse settings.
- Adapt and apply at least three strategies/tools that could be implemented in attendees’ own practice environments.
Clinician Wellness, including resilience and burnout, has been gaining recognition as a critical area within health care quality in recent years. In the palliative care community, it has long been recognized that the intensity of the emotional work required in palliative care can contribute to burnout (marked by emotional exhaustion, cynicism, and decrease personal efficacy). Until recently, however, much of the efforts for clinician wellness, such as mindfulness and mind-body techniques, have been targeted at personal resilience strategies. Though important, personal strategies are only half the story. There is growing recognition that promoting clinician wellness and thriving at work requires both personal strategies and organizational support.

During this presentation, we will review five geographically and organizationally diverse programs and their innovative efforts to provide programmatic approaches clinician wellness. The multidisciplinary panel has been chosen from a variety of practice settings to demonstrate the range of programs that are possible, including a tertiary academic center, two community hospital settings with different leadership perspectives, a tertiary teaching program with strong VA affiliations, and one hospice setting. Each clinical environment presents unique challenges and opportunities for implementing programs, including resource limitations, parent institution culture, geographic challenges including rural and urban settings within one larger program, and program size with associated growth related challenges.

We will begin with a brief overview of current research in general clinician wellness, and then progress on to Palliative Care specific content. We will identify organizational, programmatic and team related challenges and strategies to overcome them when developing, implementing and sustaining wellness programs. We will host an interactive discussion to allow personalization and adaptation of strategies and tools that could be implemented in attendees’ own practice environments.

**New Drugs and Drug News: The 411 and Implications for Palliative Care (SA505)**

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

**Objectives**

- List new drugs approved by the FDA in 2018. For each drug the participant will be able to describe the approved indication, unapproved uses of the medication, common adverse effects and drug interactions.

- For each new relevant medication approved in 2018, describe the burden-to-benefit ratio and the role of the medication in caring for patients with advanced illness.

- Analyze important drug alerts and their relevance to drug therapies commonly used in hospice and palliative care patients.

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 the previous year’s very popular update on new drugs. For relevant drugs approved in 2018, 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” (e.g., new molecular entity, formulation, manufacture, 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 for 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 health care professional needs to attend!

**Not Just for Neonatologists Anymore—The Blueprint for the Perinatal Palliative Care Consult (SA506)**

Jonathan Mullin, MD, Washington University School of Medicine, Saint Louis, MO. Christopher Collura, MD, Mayo Clinic, Rochester, MN. Joan Rosenbaum, MD FAAHPM, Division of Newborn Medicine, Saint Louis, MO.

**Objectives**

- Recognize trends in the growth of perinatal palliative care and the evolution in characteristics of
patients who receive perinatal palliative care consults.

- Discuss areas of expertise and challenges of perinatal palliative consultation for both non-neonatologists and non-palliative medicine trained clinicians.
- Construct a framework for perinatal palliative care consultation based on patient characteristics and background of consulting providers.

Nearly 30 percent of infant deaths in the United States result from congenital anomalies. Treatment options now exist for conditions that were once considered lethal. Parents may face challenging decisions regarding anticipated newborn care, which impact themselves and their families perinatal palliative care (PPC) supports families navigating these decisions through a family-centered, shared decision-making model of care. PPC occurs concomitantly with expectant obstetrical care, providing intensive psychosocial support during and after pregnancy, including at end-of-life.

Currently there is no standard practice for PPC. Perinatal palliative care programs differ in terms of interdisciplinary structure and training. Historically, consults were performed by neonatologists, many of whom have no formal training in palliative care. NICU survivors often have complex medical and palliative care needs that include pain and symptom management, evolving goals of care, and need for psychosocial support. Thus, many contend that PPC consults should be performed by palliative care-trained clinicians.

Challenges exist for palliative care-trained providers including unfamiliarity with delivery room care, evolving standards around resuscitation at the limits of viability, and nuanced understanding of neonatal physiology. Neonatologists may face challenges performing PPC consultations, including a nuanced understanding of options for palliative care, palliative transportation and hospice. Additionally, neonatologists are limited in their clinical capacity for long-term continuity that many children receiving PPC consults will require.

A one-size fits all model is unlikely to meet the palliative care needs every patient. In this interactive session, two neonatologists, board certified in hospice and palliative medicine, will present key considerations and education for non-neonatologists performing palliative care consultation. A palliative care physician will review the data on PPC programs, and present data and experiences from a single institution that has transitioned to having non-neonatologists perform palliative care consults including discussions of early involvement, transitions of care, and continuity.

**Finding Strengths in Our Differences: How Interprofessional Training Prepares Clinicians for Collaborative Practice (SA507)**

Elliot Rabinowitz, MD, Boston Children’s Hospital, Boston, MA. Katharine Brock, MD MS, Emory University, Children’s Healthcare of Atlanta, Atlanta, GA. Jenna Freitas, MSN RN CPNP, Boston Children’s Hospital, Boston, MA. Caitlin Scanlon, MSW, Riley Hospital for Children, Indianapolis, IN. Shih-Ning Liaw, MD FAAP, Dana-Farber Cancer Institute, Boston, MA. Jane deLima Thomas, MD FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

**Objectives**

- Describe the unique aspects of an interprofessional training model from the perspectives of fellowship directors and social work, nurse practitioners, and physician trainees.
- Identify the benefits and challenges of an interprofessional training model in providing patient care and promoting self-care.
- Devise strategies to develop interprofessional training experiences that attendees can implement in their own palliative care and hospice programs.

Clinical practice guidelines for quality palliative care highlight the interprofessional nature of palliative care, recognizing that clinicians in each discipline must understand the unique perspectives and strengths of their colleagues in order to provide comprehensive collaborative care. Despite this, finding clinicians proficient in interprofessional collaborative practice proves difficult due to the lack of interprofessional training programs. Instead, palliative care clinicians often resort to learning to work with team members of different disciplines in the course of delivering complex clinical care to seriously ill patients and their families.

One innovative solution to this problem is interprofessional palliative care training programs. Training physicians, nurses, psychosocial clinicians, and other disciplines in an interprofessional fellowship affords professionals insight into the distinct and shared roles of each discipline while allowing trainees dual roles as learner and teacher for their co-fellows. This model includes cross-training experiences, a shared didactic and experiential curriculum, and respectful appreciation of one another’s value.

In this concurrent session, attendees will explore this interprofessional educational model through the lens of interprofessional trainees and fellowship directors. Presenters will summarize the literature of interprofessional education, highlight the benefits and challenges of each discipline’s role through case-based clinical scenarios, and examine how this model minimizes compassion fatigue and clinician burnout.
Finally, presenters and attendees will explore financial, system, and staff limitations and generate strategies to implement interprofessional training experiences into their own programs. Interprofessional training provides unique benefits to patients, families, trainees, and clinical systems, and should be considered by programs nationwide.

**Analog Care in a Digital World: Telemedicine in Outpatient Palliative Care (SA508)**

Reggie Saldivar, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Youngho Kim, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Emma Allen, BSN RN, Memorial Sloan Kettering Cancer Center, New York, NY.

**Objectives**

- Compare between an ambulatory in-person palliative care visit and a telemedicine palliative care visit conducted between two clinical sites.
- Describe how clinicians can promote a therapeutic alliance within a telemedicine visit.
- Deepen knowledge of oncology patient's perception of telemedicine visits.

Interest in telemedicine continues to rise in conjunction with advancements in technology, improving reimbursement, and growing demands by patients and families. For patients with life limiting illnesses, additional clinician visits separated in time and location can represent a significant burden to quality of life. The use of telemedicine in outpatient palliative care holds the promise of improving access to palliative care while allowing patients to stay closer to home. Understanding patient’s perceptions regarding satisfaction and acceptability are the first steps for meaningful expansion of telemedicine.

While prior work in telemedicine has focused on deploying this technology to patients in rural or remote areas, patients within an urban metropolitan area can experience difficulty in accessing palliative care specialists. Memorial Sloan Kettering Cancer Center has an expansive regional network in Westchester County, Long Island, and New Jersey. Patients who live in these regions are required to travel into Manhattan to receive ambulatory palliative care. In this concurrent session, we will share how we created an outpatient telemedicine palliative care program within our regional network that complements our current in-person ambulatory practice. Our physicians and nursing staff will share their perspectives on providing empathetic care within a digital space. We will describe the fundamental differences between telemedicine and in-person ambulatory visits from both a patient and clinician perspective. Utilizing data from patient surveys we will also examine whether these differences affect the patient’s overall experience with telemedicine. Understanding patient’s acceptability and satisfaction with telemedicine visits was key in the development of our current program and we will share our most up to date patient data. Lastly, we will consider the feasibility factors that should be kept in mind when thinking about expansion of telemedicine within your own institution.

**Specialty Palliative APRN Practice Through State-of-the-Art Graduate Education: Report of the HPNA Graduate Faculty Council (SA509)**

Constance Dahlin, MSN ANP-BC ACHPN FPCN FAAN, Hospice and Palliative Nurses Association, Pittsburgh, PA. Mary Ersek, PhD RN FPCN, University of Pennsylvania School of Nursing, Philadelphia, PA. Dorothy Wholihan, DNP AGPCNP-BC ACHPN FPCN, NYU College of Nursing, New York, NY. Clareen Wiencek, PhD ACNP-BC, University of Virginia School of Nursing, Charlottesville, VA.

**Objectives**

- Define specialty palliative care practice for APRNs.
- Summarize the essential components and characteristics for master’s programs for specialty APRN entry into practice.
- Discuss recommendations for graduate level APRN education.

As palliative care continues to move beyond hospital walls into office, clinics, homes, and long term care settings, more advance practice registered nurses (APRNs) will be needed to assure access to high quality palliative care. Sound educational preparation of APRNs is critical to meet this workforce need. However, little is known about the content and teaching-learning approaches of existing Masters, DNP, and post-Masters certificate programs. Furthermore, there appears to be little standardization among these educational programs. This session will describe recommendations for preparing entry-level APRNs for specialty palliative care practice within graduate education.

**Setting Trends in the Preoperative Care Setting: Advance Care Planning (SA510A)**

Roma Patel, MD MPH, Indiana University, Indianapolis, IN. Shilpee Sinha, MD FACP, Indiana University Health Physicians, Indianapolis, IN. Rachel Gruber, MS, Regenstrief Institute, Indianapolis, IN. Barbara Nation, BSN, Indiana University Health, Indianapolis, IN. Kathleen Lane, MS, Indiana University School of Medicine, Indianapolis, IN. Na Bo, MSPH, Indiana University, Indianapolis, IN.

**Objectives**

- Examine the prevalence of Advance Directives in patients undergoing elective surgery.
Original Research Background. High-risk patients undergoing elective surgery have an increased likelihood of life-threatening complications. Most lack capacity during their procedure, yet completion of Advance Directives (ADs) is not required.

Research Objectives. The Objectives of this project were: 1) identify the prevalence of ADs (living will or surrogate decision maker) and 2) assess for relationship between ADs, preoperative risk factors, readmissions, and mortality.

Methods. This was a retrospective chart review of patients undergoing preoperative evaluation for elective surgery. Demographic, comorbidities, Charlson Index Reviewed, Revised Cardiac Risk Index, and functional status were obtained from the preoperative evaluation. The Electronic Medical Record (EMR) was reviewed for the presence of AD’s prior to surgery and at 1-year follow-up, 1-year mortality, and readmissions. Statistical methods included chi-square, Fisher’s exact, and multiple logistic regression.

Results. Four hundred charts were reviewed. Thirty-five percent of patients were ≥65 years old and 29% reported having an AD; however, only 12.5% had an AD in the EMR prior to surgery. In the regression model, age ≥65, male gender, congestive heart failure, and HIV/AIDS were associated with having an AD on file (p-values <0.05). Of 386 records at 1-year follow-up, 18 were deceased, of which 3 (17%) had completed an AD prior to surgery. One-hundred two patients were readmitted at least once. Readmissions were not related with having an AD on file at 1 year (p-value 0.42).

Conclusion. Less than 15% of patients undergoing elective surgery had ADs on file. Patients who were readmitted were not more likely to have an AD. Preoperative clinics provide an opportunity to identify and assist with advance care planning.

Implications for Research, Policy, or Practice. This project affirms that few high-risk surgical patients have ADs completed prior to surgery and presents an opportunity for patient education, dissemination of results to preoperative clinics, and implementation of a quality improvement project aimed at AD counseling in this setting.

Effect of FAmily CEntered (FACE) Advance Care Planning (ACP) on Families’ Appraisals of caregiving for their Teens with Cancer (SA510B)

Jessica Gaines, BSN RN CPN, Children’s National Health System, Washington, DC. Sarah Friebert, MD FAAP FAAHPM, Akron Children’s Hospital, Akron, OH. Justin Baker, MD FAAP FAAHPM, St. Jude Children’s Hospital, Memphis, TN. Jennifer Needle, MD MPH, University of Minnesota, Minneapolis, MN. Yao Cheng, MS, Children’s National Health System, Washington, DC. Maureen Lyon, PhD, Children’s National Health System, Washington, DC.

Objectives

- Describe the effect of FACE ACP on families’ appraisals of caregiving for their teens with cancer.
- Describe communication approaches in advance care planning.

Original Research Background. Little not much is known about how well family caregivers respond to participating in advance care planning with their adolescents with cancer.

Research Objectives. To identify the effect of the FAmily CEntered (FACE) pediatric advance care planning (pACP) on family caregivers’ appraisal of their caregiving for their child with cancer.

Methods. Eighty-four adolescent/family dyads were randomized to either FACE-TC intervention or treatment as usual control. FACE-TC is 3 weekly, 60-minute pACP sessions with a trained/certified facilitator. Controls and intervention participants received an information booklet on ACP. Family Appraisal of Caregiving Questionnaire subscales assessed outcomes. The GEE model tested the effect of intervention on family caregiver appraisals subscales at 3-month postintervention.

Results. We enrolled 84 adolescent/family dyads. In this interim analysis 60 dyads have completed 3-month assessment. Demographics of adolescents: mean age of 16 years (range 14-20); cohort is 39.3% male; 80.9% Caucasian. Family participants’ demographics: mean age of 45 (range 19-63); cohort is 80.9% female; 80.9% Caucasian. Positive caregiving subscale items are “Caring for ___ is satisfying; It is a privilege to care for ___; Caring for ___ has made me feel closer to him/her; I am able to comfort ___ when he/she needs it; I feel confident I can handle most problems in caring for ___; I feel useful in my relationship with ___; I am committed to caring for ___.” FACE pACP significantly increased positive caregiving appraisals at 3 months postintervention, compared to controls, (β=0.225, Confidence Interval=0.0016-0.448, p=0.0484). No significant differences were
found between groups for burden, distress, or family well-being.

**Conclusion.** FACE pACP significantly increased positive caregiver appraisals compared to controls.

**Implications for Research, Policy, or Practice.** The family caregiver’s role is critical for the well-being of teens with cancer. Findings indicate positive aspects of caregiving in the context of ACP for family caregivers without increasing caregiver burden or distress.

**From “Beat Cancer” to “Apply to Graduate School”: How Goals Evolve During a 12-Month Period for Adolescents and Young Adults (AYAs) with a Cancer Diagnosis (SA510C)**

Krysta Barton, PhD MPH, Seattle Children’s Research Institute, Seattle, WA. Nicole Etsekson, MPH, Seattle Children’s Hospital, Seattle, WA. Claire Wharton, BS, Seattle Children’s Hospital, Seattle, WA. Miranda Bradford, MS, Seattle Children’s Research Institute, Seattle, WA. Joyce Yi-Frazier, PhD, Seattle Children’s Research Institute, Seattle, WA. Abby Rosenberg, MD MA MS, Seattle Children’s Hospital, Seattle, WA.

**Objectives**
- Identify 5 categories of goals that adolescents and young adults (AYAs) defined in short- and long-term goals.
- Discuss how the AYAs goals evolve over a 12-month period.

**Original Research Background.** The experience of serious illness may impact patients’ short- and long-term goals.

**Research Objectives.** To characterize the evolution of adolescent and young adult (AYA) short-term (1-month) and long-term (1-year) goals over a 12-month period during cancer treatment.

**Methods.** In the Promoting Resilience in Stress Management (PRISM) RCT, AYAs receiving cancer treatment reported short- and long-term goals at enrollment 6 and 12 months later. Three blinded reviewers assigned each goal to 1 of 5 thematic categories: life milestone, physical health, mental health, cancer-specific, and hobbies. Goals were summarized using frequencies and percentages individually, for the full cohort, and by study arm and cancer status (newly diagnosed vs advanced cancer).

**Results.** The frequency of categories was similar across study arms (N=92: 48 PRISM, 44 usual care); data for the full cohort are reported here. Seventy-three percent of participants were 13-17 years, 57% male, 62% Caucasian, and 23% had advanced cancer. At baseline (n=92), 6 months (n=70), and 12 months (n=64), AYAs reported 169, 139, and 127 unique goals, respectively. The distribution of categories changed over time in all groups. At baseline, the most common were cancer-specific (35% of short- and 33% of long-term goals). By 6 months, only 12% and 10%, respectively, were cancer-specific, decreasing to 5% and 6% by 12 months. Physical goals increased from 23% and 12% at baseline to 38% and 23% at 6 months. Long-term milestone goals grew steadily (40%, 49%, and 64%) among newly diagnosed patients, while those with advanced cancer reported a high proportion of long-term milestone goals at all 3 time points (62%, 57%, and 61%).

**Conclusion.** AYA goals evolve over their cancer experience. Many endorse cancer specific goals early and life milestone goals later, which may be due to evolving priorities.

**Implications for Research, Policy, or Practice.** Understanding how the timeline of illness impacts these goals will enable better patient-centered care.

**Sign-Off Rounds: A Workflow Innovation to Manage Census and Volume for an Inpatient Palliative Care Consult Service (SA511A)**


**Objectives**
- Describe the workflow innovation, Sign-Off Rounds (SOR).
- Assess the impact of SOR and implications.

**Background.** Although palliative care (PC) programs continue to grow rapidly, growth in PC staffing often lags behind demand, resulting in unmet demand for consults and a large census of patients to follow. The PC team at a large academic hospital sought to improve efficiency by establishing weekly SOR to systematically evaluate the need for ongoing specialist palliative care involvement and promote timely sign-offs, thereby increasing the ability of the team to accept new consults.

**Aim Statement.** To assess the impact of SOR on team- and patient-level outcomes.

**Methods.** We performed a retrospective study of all patients who received a PC consult for 6 months pre-SOR and 6 months post-SOR implementation (with a 6-month lead-in period) using an institutional palliative care registry. The primary outcome was the proportion of consults signed-off among total
consults seen, with secondary outcomes including re-consultation during the same hospitalization, duration of consult follow-up, and hospice discharges. Analyses were done at the patient level. We used T tests for continuous data and chi-square tests for proportions.

**Results.** During the pre-SOR (January-June 2016) and post-SOR (January-June 2017) periods, the PC team completed 955 and 975 unique patient consults, respectively. There were no sociodemographic differences between the two cohorts. The team signed off a greater proportion of consults in the post-SOR period (28.7% vs 21.4%, p<0.001). The mean follow-up duration was significantly reduced post-SOR (6.4 vs 10.1 days, p<0.001). While there was a trend towards more re-consultation rates, it was not statistically significant (13.9% vs 16.7%, p=0.41) Hospice discharges increased after implementation of SORs (15.0% vs 6.9%, p=0.002).

**Conclusions and Implications.** Sign Off Rounds is a scalable, innovative workflow intervention that may allow a busy inpatient PC team to sign off follow-up consults earlier and see more new patients, without causing harm. Future work should evaluate additional PC quality metrics and the impact on PC clinicians’ job satisfaction and burnout.

**The Integrated Care Service: Impact of a Multidisciplinary Supportive Care Service on Hospice Discharge Rates for Medical Oncology Patients in a NCI-Designated Cancer Center (SA511B)**

Finly Zachariah, MD FAAFP, City of Hope National Medical Center, Duarte, CA. Denise Morse, MBA, City of Hope National Medical Center, Duarte, CA. Lucia Kinsey, MSW, City of Hope National Medical Center, Duarte, CA. Matthew Loscalzo, LCSW, City of Hope National Medical Center, Duarte, CA. William Dale, MD PhD, City of Hope National Medical Center, Duarte, CA.

**Objectives**
- Comprehend various models of inpatient palliative care.
- Analyze why the integrated care service did not demonstrate decreases in length of stay and readmission rate as seen by other co-rounding oncology and palliative care teams.

**Background.** Palliative care (PC) has shown benefits to inpatient length of stay (LOS), symptom burden reduction, decreased utilization, and time on hospice. It has shown less impact on the rate of hospice referrals.

**Aim Statement.** We assessed the impact of an integrated care model on quality end of life metrics.

**Methods.** From January to July 2018, the Department of Supportive Care Medicine collaborated with medical oncology, nursing and administration to create the integrated care service (ICS). The ICS was designed to have geographic colocation, morning PC and medical oncology rounds, multidisciplinary rounds, and postacute management. Multidisciplinary rounds include medical oncology, PC, social work, spiritual care, psychiatry, psychology, hospice liaison, nursing, case management, nutrition, and physical and occupational therapy. Admission criteria include: 1) later-stage disease, 2) noncurative intent therapy, 3) high-distress burden, and 4) poor prognosis. The ICS was compared with other medical oncology patients (non-ICS) and Mantel-Haenszel Chi-Square statistical significance (p<0.05) was calculated using Epi Info StatCalc.

**Results.** In 6 months, 190 medical oncology patients (pts) were admitted to ICS vs 537 non-ICS pts. Compared with non-ICS, the ICS pts had a higher Case Mix Index (1.81 vs 1.56) and metastatic disease incidence (95% vs 78%, p=0.008). Discharge to hospice was higher from the ICS service vs non-ICS (23% vs 7%, p<0.001), and average hospice LOS increased from 9 to 15 days. No ICS patient received chemotherapy in the last two weeks of life (0 vs 6 non-ICS pts). Length of stay (LOS) was higher on ICS as compared to non-ICS (8.45 vs 5.26 days) and readmission rates were similar (12% vs 13%).

**Conclusions and Implications.** For medical oncology inpatients, the ICS significantly improved discharge rates to and LOS on hospice, avoided patients receiving chemotherapy, and maintained similar readmission rates. Based on this pilot, the ICS is planning for expansion to include hematology and surgical services.

**Dancing the WOLST: A Quality Improvement Project on Withdrawal of Life Sustaining Therapies (WOLST) (SA511C)**

Alana Carpenter, MD, Baylor College of Medicine at Texas Children’s Hospital, Houston, TX. Jessica Casas, MD MPH, Baylor College of Medicine at Texas Children’s Hospital, Houston, TX. Kimberly Sawyer, MD, University of Washington, Seattle, WA. Jared Rubenstein, MD, Baylor College of Medicine at Texas Children’s Hospital, Houston, TX. Tammy Kang, MD, Baylor College of Medicine at Texas Children’s Hospital, Houston, TX.

**Objectives**
- Design a systematic approach to the WOLST process.
- Integrate the systematic approach to WOLST into the EMR.
• Maximize interdisciplinary team communication during a WOLST procedure.

**Background.** Literature demonstrates many patients with life threatening complex chronic conditions die in the intensive care unit (ICU), with nearly half of these patients dying after withdrawal or withholding of life sustaining therapies.1-7 There is considerable variation in how WOLST occurs and whether formal training is provided.2 No prior research has established the best practices for this procedure.1,2

**Aim Statement.** In patients undergoing WOLST, we will use a best practice guideline and electronic medical record (EMR) templated note to increase provider confidence and quality of death by 10% in 12 months.

**Methods.** We created a best practice WOLST guideline through literature review and expert consensus. This guideline included a pre-WOLST huddle template and a templated EMR note. Care team members involved in a WOLST received a survey to assess their confidence with the process and evaluate their perception of quality of death in their patient. Participants included clinicians involved in a patient’s WOLST. The setting included all ICUs at a quaternary children’s hospital.

**Results.** Baseline data was collected following 35 WOLST procedures, 250 surveys were sent with 116 responses, resulting in a survey response rate of 46%. Physicians and nurses reported a mean score of 84 and 82 out of 100 respectively for confidence in preparing families for the dying process. Data revealed marked variability when evaluating clinicians perception of death, with scores ranging 0-100; mean=81. Thematic analysis identified key processes on which to focus PDSA cycles including: anticipatory guidance to team and family, provider role clarity, and earlier involvement of interdisciplinary team members.

**Conclusions and Implications.** Little has been published regarding a specific methodology for teaching the process of WOLST to care teams, thus development of a systematic approach is critical to providing the best care at the end of life. Identifying key drivers to WOLST procedures has enabled creation of a practice guideline and EMR template for continued PDSA cycles.

**Training Nonpalliative Care Clinicians in Serious Illness Communication: Results of a Train-the-Trainer Model in Three Health Systems (SA511D)**

Joanna Paladino, MD, Ariadne Labs, Boston, MA. Anna Kennedy, BA, Ariadne Labs, Boston, MA. Nina O’Connor, MD FAAHPM, University of Pennsylvania, Philadelphia, PA. Laurel Kilpatrick, MD, Baylor Scott & White Health, Temple, TX. Ramya Prabhakar, MD, Lowell General Hospital, Lowell, MA. Erik Fromme, MD MSCR FAAHPM, Ariadne Labs, Boston, MA.

**Objectives**

- List the steps of a structured approach to training clinicians in serious illness communication using the Serious Illness Conversation Guide.
- Evaluate clinician-reported outcomes of serious illness communication training, including self-assessment of change in skills.
- Categorize and reflect on clinician takeaways from training that they will apply in practice as well as trainer perceptions of common barriers.

**Background.** Failure to initiate discussions about values and goals in serious illness (‘serious illness communication’) remains a common problem. Insufficient training leaves clinicians unsure of what to say or how/when to approach these conversations. Given the shortage of palliative care clinicians, evidence is needed to guide the development and implementation of consistent high-quality communication training for all clinicians.

**Aim Statement.** Evaluate the impact of clinician training as part of an organization-wide initiative and train-the-trainer program in three health systems.

**Methods.** In partnership with the Serious Illness Care Program at Ariadne Labs (AL), 3 health systems identified champions to complete a novel train-the-trainer program. Subsequently, these trainers delivered skills-based trainings on the Serious Illness Conversation Guide (SICG) to nonpalliative-care clinicians in their own systems. After each training, clinician participants completed a survey, including self-assessment of change in skills and self-reported learnings.

**Results.** From 2016-2018, AL trained 22 trainers (18/22 were palliative care MDs) in three systems, who then trained 331 clinicians (48% MD; 32% APP; 20% RN, SW) in 53 sessions spanning subspecialties (67%); primary care (25%); other (8%). Upon completion, participants reported improvement in each of the communication tasks (e.g. assessing illness understanding, sharing prognosis, exploring goals/values); improvements between self-rating scores pre- and posttraining were all significant (p<0.0001). Participants rated the quality of the training highly (98% mostly/extremely effective) and shared a diverse array of personalized takeaways to apply in practice, including core skills learned (e.g. reflective listening) and the usefulness of a structure.

**Conclusions and Implications.** Serious Illness Conversation Guide training, delivered through a train-the-trainer model and system-level program, was highly acceptable and resulted in significant
measurable improvements in clinician self-reported skills. This is a viable and scalable method for health systems seeking to train their own workforce in serious illness communication.

1:30—2:30 pm

Concurrent Sessions

Using Improv to Enhance Communication Skills Practice (SA520)
Kathleen Neuendorf, MD, Cleveland Clinic, Cleveland, OH. Brooke Johnston, MD, Hands of Hope Comprehensive Pediatric Care, Greenville, SC. Connor Brunson, BS, University of South Carolina School of Medicine, Greenville, SC.

Objectives
- Recognize the commonalities of improvisation and healthcare communication and discuss ways these techniques are adaptable to different settings.
- Experiment with variations in tone of voice, physicality, and word choices and reflect on the impact.
- Restate frustrations as priorities and values.

Have you been asked to give grand rounds on communication skills and want to incorporate a meaningful exercise to enhance your didactic? Have you been facilitating communication skills training and feel bored with the current curriculum? Or maybe you are looking for a different perspective on the communication skills you are using. Many palliative care providers are not only relied upon for their excellent communication skills with patients, families and colleagues, they are asked to teach communication skills to others as well. Self and social awareness are valuable skills for identifying opportunities to find words that will resonate with patients in the present moment. However, as clinicians are being asked to do more with less and in shorter periods of time, opportunities for mindful, reflective practice can be harder to find. Idealized communication sessions that limit the number of participants and require hours of time are not always possible. Adapted improv techniques to practice communication skills, even in large group settings, allows for a safe and supportive environment that fosters participant spontaneity and honesty while raising awareness about what we communicate, whether it is intentional or not. In this session, presenters who are using improvisation in a variety of settings will quickly review the main tenants of improvisation and discuss how these tenants enhance clinical encounters and apply in healthcare communication. Participants will experience a selected group of improv exercises, discuss their relevance in communication skills training and hypothesize how these activities can be adapted to a variety of audiences. If you’ve been looking for ways to bring meaningful communication skills training to audiences from 10-1000 participants in a short amount of time, this session is for you. We promise that “being funny” is NOT a core tenant of improv and not required to attend this session.

In With the New: Managing Acute Malignant Pain in Patients on Opioid Replacement Therapy with Buprenorphine (SA521)
Lori Earnshaw, MD FAAHPM, University of Louisville, Louisville, KY. Zachary Sager, MD MA, BIDMC/Boston VA, Boston, MA. M. Kate Probst, PharmD BCACP BCGP, Sullivan University College of Pharmacy, Louisville, KY.

Objectives
- Compare and contrast the pharmacology of pure and partial opioid agonists.
- Describe an approach to treating acute pain in hospice patients receiving buprenorphine and naloxone therapy.
- Establish the role of buprenorphine in hospice and palliative care clinical practice.

After Dole and Nyswander introduced the role of methadone in drug rehabilitation in 1965, methadone became the standard for medication assisted therapy of opioid use disorders. Similarly, hospice and palliative care professionals have recognized the role of methadone in treating cancer-related pain. Since its release in the early 2000s, buprenorphine has become the preferred medication assisted treatment option given its ability to be prescribed in a less restrictive setting, the relative ease of dosing, and reduction in stigma. Given the popularity of buprenorphine for medication assisted treatment, hospice and palliative care practitioners must be prepared to manage patients on buprenorphine who require pain management for serious illness. We will present the case of a young hospice patient with terminal cancer whose pain was being managed with combination buprenorphine and naloxone therapy for opioid use disorder. We will describe the pharmacology of buprenorphine, how it is used in medication assisted treatment and how to transition patients on buprenorphine to a more traditional opioid agonist for acute pain management. Finally, we will discuss the possible role of buprenorphine for management of pain in the setting of an opioid use disorder.

Speed Dating for Kids 2.0 (SA522)
Emma Jones, MD, Pediatric Advanced Care Team, Boston, MA. Mary Lynn McPherson, PharmD MA MDE BCPS, University of Maryland School of
Pharmacy, Baltimore, MD. Jill Morgan, PharmD, University of Maryland School of Pharmacy, Baltimore, MD.

Objectives
- Discuss 3 pearls related to general pharmacology principles for pediatric patients.
- Discuss 3 pearls related to end of life symptom management for pediatric patients.
- Discuss 3 pearls related to newly approved medications that are pertinent to pediatric conditions.

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.

Objectives
1. Discuss 3 pearls related to general pharmacology principles for pediatric patients. Recognizing that hospice care for children is often provided by those primarily trained to care for adults, we provide some basic guidance and med management tips for treating kids.
2. Discuss 3 pearls related to end of life symptom management for pediatric patients. This session will present the latest tips and tricks for choosing and administering comfort medications ranging from tips on getting kids to swallow pills to logistics of home ketamine infusions.
3. Discuss 3 pearls related to newly approved medications that are pertinent to pediatric conditions. The concurrent care model is the norm in pediatric palliative care, therefore palliative care providers must have a broad knowledge of disease directed therapies patients are receiving.

iGrieve: Virtual Bereavement on Social Media (SA523)
David Buxton, MD, Center for Palliative Psychiatry, Richmond, VA. Sarah Rohrer, MSW LCSW ACHP-SW, CJW Medical Center, Richmond, VA.

Objectives
- Define thanatechnology and assess current research on virtual memorials.
- Evaluate examples of social media memorials and formulate about the effects of emotional rubbernecking.
- Interpret how thanatechnology can effect patients and what role providers should play in it.

Bereavement refers to the phase of mourning and grief following the death of a beloved person. Mourning is the term used to portray the public formalities or symbols of bereavement, such as holding funeral services or wearing black clothing. In the past, mourning was most commonly experienced in isolation. Due to the growing nature of digital bereavement, “grief shared is grief relieved” tends to be a more commonly held belief today. Thanatechnology, was coined by researcher Carla Sofka to describe the way people use the Internet to display their feelings of grief when a loved one has died. Similar to how people use Facebook to commemorate life events, people also use Facebook to virtual memorialize those who have died. Unlike traditional memorials, online memorial’s format allows 24 hour access, limitless room to add more context and the ability to be seen by anyone.

Due to the public nature of Facebook communication, a unique subgroup of people who did not personally know the deceased or ‘emotional rubbernecker’, can find virtual memorial groups and observe people grieve the loss of their friend or family member. Rubbernecker seems to be a way by which people who did not know the deceased cope with a death that affected them in some way.

The presenters will review current literature on thanatechnology and share examples of individuals who have been memorialized on social media. A discussion will be lead on the pros and cons of this new form of grieving highlighting how it may effect patients and what role palliative care / hospice providers should play in it.

Current Evidence in Palliative Care: A Systematic Review in Support of the National Consensus Project’s Clinical Practice Guidelines for Quality Palliative Care, 4th edition (NCP Guidelines) (SA524)
Sangeeta Ahluwalia, PhD MPH, RAND Corporation and UCLA Fielding School of Public Health, Los Angeles, CA. Anne Walling, MD PhD, RAND Corporation/Greater Los Angeles Veterans Affairs Healthcare System/UCLA David Geffen School of Medicine, Los Angeles, CA. Karl Lorenz, MD MSHS, VA Palo Alto Health Care System/Stanford University School of Medicine, Palo Alto, CA. Nathan Goldstein, MD, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives
- Characterize the care domains and topics in which strong or moderate evidence of palliative care impact exists.
- Understand the current gaps in the palliative care research base.
- Describe how the systematic review of palliative care research informs the Clinical Practice Guidelines for Quality Palliative Care, 4th edition.
Leveraging Global Partnerships to Expand Human Resources in Palliative Care: The Development of Regional Training Centers in Chile and Jamaica (SA526)
Mark Stoltenberg, MD MA, Massachusetts General Hospital, Boston, MA. Dingle Spence, MD, Hope Institute Hospital, Kingston, Jamaica. Pedro Perez-Cruz, MD MPH, Pontificia Universidad Catolica De Chile, Santiago, Chile. Bethany Rose Daubman, MD, Massachusetts General Hospital, Boston, MA.

Objectives
- Recognize the immense need for standardized, high-quality palliative care training programs in low and middle-income countries.
- Identify how training programs need to be carefully contextualized into the available local resources and needs of the local population.
- Explain strategies and best-practices to foster and maintain successful academic partnerships between different countries.

As recently highlighted by the Lancet Commission on Palliative Care and Pain Relief, there remains a morally unacceptable lack of access to palliative care services around the world. This access abyss is especially pronounced within low and middle income countries (LMICs), where despite having 81% of the world’s population, only two LMICs (Uganda and Romania) have advanced palliative care services that are integrated into the health system. As suggested by the WHO public health strategy for palliative care, the growth of available services requires appropriate public policies, adequate drug availability, and effective education and training programs.

With a direct focus on this 3rd strategy of providing education opportunities, The Program in Global Palliative Care at Harvard Medical School has sought to foster academic partnerships with palliative care leaders in LMICs to create and implement high-quality, standardized training programs. This session will focus on the partnerships formed between Harvard and two specific sites: the Pontificia Universidad de Catolica in Santiago, Chile and Hope Institute Hospital in Kingston, Jamaica. Through these academic partnerships, both sites are now offering various levels of formal training in palliative care across their own respective countries, and both are also considering strategies to offer training beyond their borders to the rest of Latin American and the Caribbean in the coming months.

In this session, colleagues from Chile, Jamaica, and Boston, will highlight our experience of forming these partnerships, with a focus on how training structures and educational content were contextualized for each site, as well as the lessons learned and best practices that were identified.

An Integrative Medicine Approach to the Utilization of Cannabis and Cannabinoids for Palliation in Advanced Cancer Patients: Canadian/US Perspectives and Practical Recommendations (SA527)
Sunil Aggarwal, MD PhD, SageMED, UW School of Medicine, MultiCare, Seattle, WA. Maria-Fernanda Arboleda, MD, McGill University, Montreal, Canada. Claude Cyr, MD, Clinique La Cité Médicale, Montreal, Canada. Antonio Vigano, MD MSC, McGill University, Montreal, Canada. Paul Daeninck, MD MSC FRCPC,
University of Manitoba, Winnipeg, Canada. Lynda Balneaves, PhD, University of Manitoba, Winnipeg, Canada. Andree Neron Montreal, Canada. Erin Prosk, MSC, Santé Cannabis, Montreal, Canada.

Objectives
- Describe current and future examples of research on medical cannabis for palliation in advanced cancer patients.
- Understand the various challenges to providing access and monitoring to medical cannabis in community-based, tertiary care and long-term care residences.
- Review key practical recommendations on the integration of cannabinoids for symptom management in palliative care patients.

Integration of cannabinoids into palliative care has been delayed by many obstacles, such as paucity of clinical research data, poor clinical knowledge on how to initiate and monitor cannabinoid treatments and conflicting or unsupportive regulatory frameworks. Cancer patients, on the other hand, are known to have high rates of cannabis use and desire but are not receiving information about cannabis from oncology providers. This session proposes to illustrate the different clinical settings where the use of the traditional plant botanical cannabis and its derivatives could be considered, as well as provide an overview regarding their appropriate use from an integrative medicine perspective—cannabinoid integrative medicine. The discussion will primarily be focused on the palliative care needs of patients with advanced cancer. The group of authors include both US and Canadian-based clinician-scientist/scholars who have developed a practical approach for the integration of cannabis into oncologic palliative care, including guidance on choice of chemovars (strains), titration and monitoring as well as development of clinical pearls based on their clinical experience and the published literature. Areas covered include symptom management, palliation of existential distress, and experimental use of cannabinoids in disease modification.

Shared Decision Making for Long-Term Opioid Therapy for Cancer Pain (SA528A)

Objectives
- Describe provider and patients’ process of weighing the risks and benefits of chronic opioid therapy for patients with cancer and pain.
- Identify strategies that support shared decision making between providers and patients about the appropriate use of opioids for goal concordant pain care.

Original Research Background. Simultaneously, opioids pose potential risks and many patients with cancer pain are appropriately managed on long-term opioid therapy (LTOT).

Research Objectives. To compare patient and provider perspectives on weighing the risks and benefits of LTOT and strategies to support shared decision making for cancer pain.

Methods. Semi-structured interviews with 20 patients and 20 providers (Palliative care, oncology, and primary care based advanced practice nurses (APRNs) and physicians) from 2 VA medical centers. Transcripts were analyzed with constant comparison.

Results. Provider Results providers use stage, state, prognosis (“given the amount of time a person with terminal cancer is going to live, the risk is relatively small compared to the benefit”), mental health concerns, and history of substance use disorders to continuously weigh the appropriateness of LTOT for cancer pain. Given the dynamic nature of weighing the above, they also highlight the need for frequent touch points with patients and increasing provider time burden associated with prescribing opioids. Patient Results: patients report that current cancer prognosis/symptoms/related fears (“There are side effects [e.g. chemotherapy] that scare me a lot more than the opioids’ side effects”), personal experiences with substances (opioids, cannabis, previous addictions) witnessing opioid use and addiction experiences of family and close friends, and not being able to “afford being functionally impaired” by pain impact perceptions of the risks and benefits of opioids for their circumstance. Patients prefer to focus oncology visits on discussing cancer treatment rather than opioids. In lieu of using physician visit time, patients feel able to navigate dosing and tapering decisions with palliative care advanced practice nurses (APRNs) and clinical pharmacists.

Conclusion. Providers and patients have diverse and sometimes competing priorities when weighing LTOT risks; frequent patient-provider communication is necessary for dynamic shared decision making.

Implications for Research, Policy, or Practice. Further developing opioid prescribing roles
of palliative care-trained APRNs and clinical pharmacists represents an opportunity.

**Palliative Care Physician Comfort (and Discomfort) with Discussing Prognosis in Hematologic Diseases: Results of a Nationwide Survey (SA528B)**

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**Objectives**
- Recognize wide variability in palliative care physicians’ comfort in discussing prognosis of patients with hematologic diseases.
- Identify common reasons why palliative care physicians feel comfortable or uncomfortable discussing prognosis in these diseases.
- Discuss opportunities to improve palliative care physicians’ comfort in discussing prognosis with hematologic patients.

**Original Research Background.** Palliative care specialists provide supportive care for patients with hematologic diseases. Prior investigations have surveyed hematologists to characterize barriers to delivery of palliative care to these patients, but palliative care physicians’ perspectives remain unclear.

**Research Objectives.** This research is part of a larger study aimed to examine the beliefs, comfort levels, and attitudes of palliative care physicians toward their interactions with the field of hematology.

**Methods.** A survey was mailed to a random sample of the AAHPM physician contact list in 2017. Results were anonymized. Participants were asked about their comfort in discussing prognosis regarding hematologic malignancies. Written responses were analyzed, themes were identified, and individual topics within responses were coded in a binary fashion (ie, conveying comfort or discomfort).

**Results.** Four-hundred fifty-nine of 1,000 surveys included a written response. Fifty-point-eight percent of respondents were male. Community (34.9%), academic (38.5%), and hospice (26.7%) physicians were represented. In discussing prognosis of hematologic malignancies, 41.1% of responses contained only topics expressing comfort, 40.5% contained only topics expressing discomfort, 16.6% responses were mixed, and 2% were not applicable. Commonly cited explanations for comfort were training and clinical experience (47.9%), strong relationships with hematologists (37%), and clear trajectory given likely imminent death (12.8%). Nineteen-point-eight percent reported fellowship training in or practicing hematology as a reason for comfort. Commonly cited reasons for discomfort were lack of clinical exposure (51.9%), uncertainty of disease trajectories (22.9%), poor relationships with hematologists (17.2%), limited knowledge of hematologic diseases (13.7%), and rapidly-changing treatments (9.2%).

**Conclusion.** Palliative care physicians report varying comfort in discussing prognosis in hematologic diseases. This may be a function of clinical exposure to these diseases in practice and training, as well as strong relationships with hematologists.

**Implications for Research, Policy, or Practice.** These findings will help identify opportunities to improve palliative care physicians’ comfort in discussing prognosis with hematologic patients, leading to better provision of supportive care.

**Natural Language Processing to Assess End-of-Life Quality Indicators in Breast Cancer Patients with Leptomeningeal Disease (SA528C)**

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**Objectives**
- Describe that leptomeningeal carcinomatosis is a marker of serious illness in patients with breast cancer.
- Recognize the relationship between palliative care involvement and serious illness conversations in patients with leptomeningeal disease.

**Background.** Leptomeningeal carcinomatosis is a sign of poor prognosis in patients with metastatic breast cancer, and serious illness conversations have been recommended for patients with this diagnosis.

**Objectives.** Natural language processing (NLP) was used to (1) identify a population of breast cancer patients with leptomeningeal disease and (2) assess documentation of end-of-life process measures in the electronic health record.

**Methods.** Retrospective cohort analysis of patients with breast cancer and leptomeningeal disease based on administrative billing coding followed at 2 tertiary hospitals in Boston between 2010 and 2016. NLP was used to confirm leptomeningeal disease in magnetic resonance imaging reports. Subsequently, NLP was used to assess specialist palliative care involvement and three serious illness process measures: goals of care discussions, code status limitations, and hospice assessment. Regression analysis was performed to assess the impact of palliative care involvement on subsequent documentation of each process measure.

**Results.** NLP-assisted MRI review yielded 183 patients with leptomeningeal disease. The mean age was
56 years. In the 6 months after diagnosis with leptomeningeal disease, 63% had goals of care discussions documented, 72% had hospice assessment, and 89% had documentation of at least 1 of the 4 process measure. Logistic regression showed that early palliative care involvement was a significant predictor of documentation of goals of care (OR 2.43, 1.17-5.03) and hospice discussions (OR 3.44, 1.51-7.83). Median survival for 167 patients with known dates of death was 148 days.

**Conclusion.** Leptomeningeal disease is a marker of serious illness and should be considered a trigger for conversations about patients’ goals. Palliative care involvement may promote conversation and documentation of patients’ wishes.

**Implications for Research, Policy, or Practice.** Earlier involvement of palliative care in this patient population may help facilitate conversations about goals of care and serious illness.

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**Patterns of Whole Brain Radiation Therapy for Nonsmall Cell Lung Cancer Patients with Brain Metastases (SA528D)**

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**Objectives**
- Examine the type of dose-fractionation scheme used to provide whole brain radiation therapy (WBRT) to patients with non-small cell lung cancer (NSCLC) and brain metastases.
- Describe how patient’s clinical and nonclinical factors are related to the choice of dose-fractionation scheme for WBRT to NSCLC patients with brain metastases.

**Original Research Background.** Patients with non-small cell lung cancer (NSCLC) and brain metastases may benefit from whole brain radiation therapy (WBRT) to prevent or palliate neurological symptoms, but WBRT may not always provide meaningful benefit given acute toxicities and the short median survival of these patients.

**Research Objectives.** We examined the pattern of dose-fractionation schemes for WBRT among patients with NSCLC and brain metastases.

**Methods.** We included 42,327 NSCLC patients with brain metastases at initial diagnosis in the National Cancer Database from 2010-2013. We excluded patients who had missing radiation data, received stereotactic radiosurgery, received nonstandard WBRT dose-fractionation schemes, or lacked follow-up. We examined the distribution of dose/fractionation schemes for WBRT across patient and facility factors.

**Results.** Among NSCLC patients with brain metastases, 35.0% received WBRT (n=14,810). Patients with only brain metastases were not significantly more likely to receive WBRT than those with multiple metastatic sites (p=0.11). The most common schemes were 3 Gray/fraction for 10 fractions (60.6%) or 2.5 Gray/fraction for 14/15 fractions (38.1%), rather than 2 Gray/fraction for 20 fractions (3.17%) or 4 Gray/fraction for 5 fractions (1.47%). Patients prescribed longer courses were more likely to have Medicare or private insurance, rather than Medicaid or no insurance (p<0.001). Patients prescribed short-course WBRT lived farther from the medical center than those prescribed longer courses (median distance 26.13 miles for 3 Gray/fraction vs 18.98 miles for 2 Gray/fraction; p<0.001). Patients with no important comorbidities were not significantly more likely to receive long-course WBRT than those with multiple comorbidities (p=0.45).

**Conclusion.** The dose-fractionation scheme of WBRT for patients with NSCLC and brain metastases is associated with several nonclinical characteristics, including their distance to the cancer center, rather than multiple metastatic sites or comorbidities.

**Implications for Research, Policy, or Practice.** Policy changes should be considered to ensure that patients with NSCLC and brain metastases are selected carefully for long dose fractionations of WBRT, based primarily on clinical characteristics.