Hospice Medical Director Update and Exam Prep (P01)

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Objectives

- Employ the clinical, regulatory, leadership, and administrative skills and ethical knowledge required in the role of hospice medical director.
- Assess and manage pain and other symptoms based on the best available evidence.
- 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.
Addressing Goals of Care: Intensive Small Group Training (P02)

Robert Arnold, MD, University of Pittsburgh, Pittsburgh, PA
Anthony Back, MD, University of Washington, Seattle, WA
James Tulsky, MD, Duke University, Durham, NC

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: give bad news, assess what is important to the patient, and make a recommendation about how to best proceed. The core skills helpful in accomplishing these tasks include “ask, tell, ask”; responding to emotion; and “wish” statements. Using a mix of short didactic talks and experiential practice, this workshop will help participants develop a model for handling these difficult conversations. This workshop will be unique in that learning will occur predominantly in small groups (one faculty member:eight 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.
AAHPM Leadership Forum: Ignite—Financial Decision-Making Approaches for Hospice and Palliative Medicine Physician Leaders (P03)

Hugh W. Long, PhD JD MBA, Department of Global Health Systems and Development, Tulane University School of Public Health and Tropical Medicine, New Orleans, LA

Objectives

- Explore financial management terminology to increase understanding and application of financial data.
- Apply introductory accounting and finance principles to translate financial reports/statements and optimize available resources.
- Identify basic approaches to fiscal forecasts and their potential for informing fiscal decisions.

Ignite your leadership potential. Financial Decision-Making Approaches is designed to equip hospice and palliative medicine physicians with foundational principles in financial management to increase their understanding of institutional or organizational financial reports. This course will provide an introduction to financial concepts and terminology followed by an exploration of cost analysis and resource allocation using sample financial tools and documents, case studies, and scenarios to provide practical relevance for HPM physicians. This preconference program is offered in partnership with the American Association for Physician Leadership (Association) and presented by Association faculty. This session applies to all physician leaders and practice settings looking to enhance their financial management understanding and decision-making for their organization.

Primary leadership competencies addressed in this program include financial acumen and resource management.

AAHPM Ignite is one of three sessions included in the AAHPM Leadership Forum. AAHPM and the American Association for Physician Leadership have designed a comprehensive leadership training program that offers a variety of learning opportunities and varied environments, including face-to-face didactic instruction and Web-based self-study. You can create your own customized and flexible learning pathway and select content based on your unique leadership development goals and career pathway. Learn more at aahpm.org/career/leadership.
Fellowship Directors' Program—What Keeps Us Awake at Night: Addressing the Challenges of Palliative Medicine Fellowship Programs as the Next Accreditation System and the Match Become Reality (P04)

Lori Earnshaw, MD, University of Louisville, Louisville, KY
Jeffrey Klick, MD, Children's Healthcare of Atlanta, Atlanta, GA
Stacie Levine, MD FAAHPM, University of Chicago, Chicago, IL
Wayne McCormick, MD, University of Washington, Seattle, WA
Gary Buckholz, MD FAAHPM, University of California, San Diego, San Diego, CA
Lindy Landzaat, DO, University of Kansas Medical Center, Kansas City, KS
Laura J. Morrison, MD FAAHPM, Yale University School of Medicine, New Haven, CT
Steven Radwany, MD FAAHPM, Summa Health System, Akron, OH
Sumathi Misra, MD MPH, Tennessee Valley Healthcare System, Nashville, TN

Objectives

• Explain the NRMP Match and ERAS processes.
• Analyze the impact of the NRMP Match and ERAS on recruitment, interviewing, and candidate selection.

Major changes are on the horizon for HPM fellowship training programs as the specialty transitions to the Next Accreditation System (NAS) and participation in the National Resident Match Program (NRMP). With the NAS comes new requirements for implementation of milestones-based reporting, the development of Clinical Competency Committees, annual self-study, Clinical Learning Environment Review visits, revised common program requirements, and changes in annual data review and reporting. In addition to the NAS, hospice and palliative medicine will participate in the Match for the first time in the academic year starting July 1, 2016. Electronic Residency Application Service (ERAS) registration for this Match cycle will occur in spring 2015. This program offers a facilitated forum for fellowship program directors to discuss practical matters related to the implementation of the NAS and Match logistics, build collaborative and supportive relationships with other educators and the Academy, and exchange ideas and tools to help enhance current processes.
Precision Pharmacopalliation: A No-Nonsense, Boots-on-the-Ground Approach to Medication Management at the End of Life (P05)

Mary Lynn McPherson, PharmD MA BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD
Michael J. LaPenta, MD, Hospice of the Chesapeake, Annapolis, MD
Kat Walker, PharmD BCPS CPE, University of Maryland School of Pharmacy and MedStar Health, Baltimore, MD
Christopher D. Kearney, MD, Palliative Medicine, MedStar Health, Baltimore, MD

Objectives

- Recognize discriminating history, physical exam, and other information that drives drug-therapy decision-making designed to treat the complaint of pain or one of the top ten nonpain symptoms.
- Select medications that reflect consideration of patient- and drug-related variables.
- Recommend an appropriate starting dose, titration schedule, and plan for discontinuing therapy.
- Describe three strategies in medication selection that will make for a smooth transition. To be successful, this will include recommending discontinuation of futile medications and selecting specific medications that are user-friendly in hospice care.

Patients experiencing advanced, life-limiting illnesses frequently require drug therapy to achieve symptom control. However, it is imperative that medications are selected with meticulous care and attention to both patient- and medication-related variables. Participants in this highly practical, fast-paced session will learn how to consider a discriminating history, physical exam, and other information that will result in selection of the best medications that deliver the most benefits with the least burden.

Participants will learn the specifics of not only how to select medications but also how to initiate dosing and titration strategies (amount of drug and how quickly) and how to discontinue medications (titration down or abrupt stop). This session is designed for both hospice and palliative care practitioners and will deliver on the promise of how to make drug therapy decisions that ensure smooth transitions in care. This will include patients who transition from home-based hospice to inpatient palliative care and vice versa and how palliative care teams can initiate drug therapies that ensure seamless transition to hospice. Participants will leave this session with a bag full of tips and strategies they can implement the next day back on the job.
Advanced Clinical Topics in Pediatric Palliative Care (P06)

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Tammy Kang, MD, Children’s Hospital of Philadelphia, Philadelphia, PA
Elissa Miller, MD, Nemours Children’s Hospital System, Philadelphia, PA
Sarah Friebert, MD FAAP FAAHPM, Akron Children’s Hospital, Akron, OH
Gina Santucci, MSN RN APRN-BC, Children’s Hospital of Philadelphia, Philadelphia, PA
Wynne Morrison, MD, The Children’s Hospital of Philadelphia, Philadelphia, PA
Jeffrey Klick, MD, Children’s Healthcare of Atlanta, Atlanta, GA
Richard Goldstein, MD, Dana Farber Cancer Institute, Boston, MA
Kathie Kobler, MS APN PCNS-BC CHPPN, Advocate Lutheran General Hospital, Park Ridge, IL
Lindsay Burns Ragsdale, MD, Kentucky Children’s Hospital, Lexington, KY
Joseph Rossano, MD MS FAAP FAAC, The Children’s Hospital of Philadelphia, Philadelphia, PA
Roxanne Kirsch, MD FRCPC FAAP, The Children’s Hospital of Philadelphia, Philadelphia, PA
Samuel B. Goldfarb, MD, The Children’s Hospital of Philadelphia, Philadelphia, PA
Kathryn Dodds, MSN CRNP, The Children’s Hospital of Philadelphia, Philadelphia, PA
Jeremy Hirst, MD, University of California at San Diego, San Diego, CA
John Giamalis, PharmD, Nemours/Al DuPont Hospital for Children, Wilmington, DE
Charles Berde, MD PhD, Harvard Medical School, Boston, MA

Objectives

• Characterize the challenges of providing palliative care to children receiving support from advanced medical technologies, including solid organ transplants, ECMO, and VADs.
• Compare and contrast current psychopharmacologic and nonpharmacologic strategies to manage common mood and behavioral disturbances experienced by children receiving palliative care.
• Construct pain management plans for two hypothetical patients using interventional pain management techniques as well as medications discussed during this session that may not be a part of your current practice.

This full-day workshop will focus exclusively on advanced medical topics that profoundly influence the practice of pediatric palliative care. Ten pediatric faculty representing seven programs across the country will serve as session moderators and small-group leaders, while the core content will be delivered by national experts in a variety of disciplines, including cardiology, transplant medicine, critical care, pain management, and psychopharmacology, who were invited by the core pediatric palliative care faculty. Topics will include solid organ transplant, ECMO, VADs, advanced pain management, and psychopharmacology. In addition, a panel discussion will focus on the ongoing growth and evolution of pediatric palliative care programs. This course is designed especially for the experienced palliative care practitioner.
ACHPN Certification Review Course—Advanced Practice Registered Nurse (PO7)

Objectives
- Describe a comprehensive problem focused on physical, emotional, social, cultural, and spiritual assessments of patients and families experiencing advanced illness.
- Recognize evidence-based practice standards and expected outcomes in hospice and palliative care.
- Discuss ethical principles in the care of patients with advanced illness.
- Identify strategies to initiate and develop palliative care programs across healthcare settings to promote continuity of care and integrated palliative care services.
- Review physical and psychological symptoms associated with advanced illness and discuss pharmacological and nonpharmacological interventions.
- Use educational methods consistent with patients’ and families’ preferred mode of learning to promote understanding of serious or life-threatening illness, treatment options, management, and supportive resources.

The Hospice and Palliative Nurses Association (HPNA) supports nurses seeking advancement of their professional development and career with specialty certification. This 1-day course encompasses the fundamental concepts of palliative nursing. The review course will provide a review of the content areas based on the NBCHPN® detailed test content outline. This course may be used to increase the hospice and palliative nurse’s knowledge of general palliative nursing or to assist the nurse in identifying topics that require further preparation and study in advance of sitting for the specialty certification examination. Note: Participation in a review course does not guarantee successful completion of a certification test.

Required materials
- Core Curriculum for the Advanced Practice Nurse (order from the HPNA Specialty Shoppe)
- ACHPN® Candidate Handbook (print free from the NBCHPN® website)
CHPN Certification Review Course—Registered Nurse (P08)

Objectives
• Discuss establishing goals of care for hospice and palliative care patients and caregivers.
• Review common symptoms experienced by a patient at the end of life.
• Describe appropriate pharmacological and nonpharmacologic interventions for the management of symptoms at the end of life.
• Discuss the management of dying, grief, loss, and bereavement.
• Recognize the importance of effective communication.
• Identify professional issues related to hospice and palliative nursing.
• Review test-taking techniques and the development of a study plan.

The Hospice and Palliative Nurses Association (HPNA) supports nurses desiring to advance their professional development with specialty certification. HPNA is offering this 1-day course that encompasses the fundamental concepts of palliative nursing. This review course will provide a review of the content areas based on the NBCHPN® detailed test content outline. This course may be used to increase the hospice and palliative nurse's knowledge of general palliative nursing or to assist the nurse in identifying topics that require further preparation and study in advance of sitting for the specialty certification examination. Participation in a review course does not guarantee successful completion of a certification test.

Required materials
• Core Curriculum for the Generalist Hospice and Palliative Nurse (order from the HPNA Specialty Shoppe)
• CHPN® Candidate Handbook (print free from the NBCHPN® website)
Building Social Resilience in Providers, Patients, Families, and Systems: SRM's Skills-Based Approach for Healthcare Practitioners (P09)

Jan Jahner, RN-BCCHPN, Christus St. Vincent Hospital, Santa Fe, NM
Laurie Leitch, PhD, Threshold Globalworks, Brooklyn, NY

Objectives

• Describe and explore how emerging neuroscience principles can be applied to identify and alleviate stress, distress, and trauma and build resilience in healthcare clinicians and systems.
• Identify domains of stress/distress/trauma symptoms particular to the healthcare setting.
• Describe three ways neuroscience concepts can be applied to the systems level.

Healthcare systems, like so many other enterprises in today’s complex, highly networked world, are immersed in the impact of disruptive change. This calls for timely strategies that build adaptable and flexible workplaces that foster the well-being and resilience of staff and patients. Thriving depends upon capacity to anticipate, improvise, adapt, and overcome. Research from neuroscience and brain imaging has led to new understandings about the impact of stress, distress, and trauma on the human mind-body system. The essential role of the nervous system in responding to threat and fear and its capacity to rebound from distressing events has been scientifically well documented. The workshop presents key neuroscience concepts relevant to enhancing resilience in healthcare administrators, workers, and their patients, enabling participants to develop a neurobiological lens as part of a “well-being toolkit.”

The Social Resilience Model (SRM) is a neurobiologically oriented set of skills designed to teach practical ways to stabilize the human nervous system, build resilience, and reduce and/or prevent the symptoms of stress, distress, and trauma. This workshop will discuss how SRM skills can be used for the self-care of healthcare workers and work teams who are exposed to challenging situations (e.g., patient pain and fear; family members’ reactivity [anger, despair]; moral distress and burnout; traumatic sights, sounds, and smells) as well as for individuals who are directly experiencing events that are sad or frightening. SRM skills target workers’ capacity to foster compassion, cooperation, awareness, and understanding with regard to the management of chronic suffering and the mortality we all share.

These same principles and tools can assist an organization in promoting resilience at a systems level, strengthening the potential for flexibility and problem solving.
Responding to Suffering: An Introduction to Mindful Practice and Mindful Communication (P10)

Ronald Epstein, MD, University of Rochester, Rochester, NY
Timothy E. Quill, MD FACP FAAHPM, University of Rochester Center for Experiential Learning, Rochester, NY

Objectives

- Describe the nature of suffering and the types of responses to it.
- Enact principles of mindful practice to enhance participants’ ability to respond effectively to suffering.

Palliative care, which promotes compassionate care amid serious illnesses, depends on practitioners’ ability to cultivate attentiveness, self-compassion, resilience, and mindfulness in their interactions with patients, families, and colleagues. AAHPM prioritizes “identifying opportunities for enhanced self-care and resilience” as a key objective for its Annual Assembly sessions. However, few structured opportunities exist for practitioners to develop self-awareness amid the unpredictability and stresses of clinical practice. This workshop will offer an experiential introduction to mindful practice—“moment-to-moment purposeful attentiveness to one’s own mental processes during every day work with the goal of practicing with clarity and compassion.” The format is based on intensive courses for health professionals, which have resulted in greater resilience, empathy, and psychosocial orientation while reducing burnout. We will introduce principles of mindful practice through formal and informal contemplative practices, narrative and appreciative inquiry exercises, and research on mindful practice training for clinicians—building on intellectual foundations outlined in two seminal articles in JAMA (Epstein, 1999; Krasner et al., 2009) and Academic Medicine (Beckman et al., 2012).

The workshop will address noticing suffering and responding to it, building on themes addressed in prior AAHPM sessions. After discussing principles of mindful practice, we will explore ways clinicians notice and respond to suffering including “fixing,” “compassionate solidarity,” and “transformation.” We will introduce brief secular, contemplative exercises to draw attention to bodily sensations, thoughts, and feelings to promote self-awareness and awareness of one’s environment. A narrative reflective writing exercise will focus on personal clinical experiences related to suffering and “turning toward suffering”; participants will take turns telling and listening to each other’s stories using techniques of reflective questioning. Next we will address ways in which mindfulness can be applied to clinical practice. Finally there will be discussion about how to grow and sustain mindful practice in participants’ own work settings.
The Art and Craft of Writing for Self-Care and Narrative Advocacy: A Workshop in Reflective and Public Writing (P11)

Louise Aronson, MD MFA, University of California, San Francisco, San Francisco, CA
William Schwalbe, author of End of Your Life Book Club

Objectives

• Discuss (and practice) writing stories for self-care, education, or advocacy.
• List strategies for success in writing reflections, op-eds, personal narratives, and narrative advocacy articles.
• Identify publication options for narrative articles by health professionals in the lay press, medical press, and blogosphere.

Stories are everywhere in health care. By learning to tell their stories, health professionals can engage in self-care, advocate for patients, and educate the public and their colleagues. Reflective writing improves professional satisfaction and lifelong learning, while public writing offers opportunities for increased impact on health and health care. This workshop will begin with a discussion of different sorts of writings by healthcare professionals, drawn from op-eds, medical journal perspectives essays, and personal and policy narratives. We will consider when writing is for self-care and when it might be used for public education and advocacy and note techniques and strategies for success, including how to balance story and data and capitalize on your expertise. Participants will then pick a story or topic and draft the beginning of a reflection, op-ed, personal narrative, perspective, or advocacy piece. Finally participants will receive feedback on their draft from colleagues in small groups—the part of the workshop participants fear the most at the beginning and value the most at the end.
Do No Harm: Compassionate and Practical Policies for Addressing Substance Abuse and Diversion in Hospice and Palliative Care Settings (P12)

Joshua Barclay, MD FACP, University of Virginia, Charlottesville, VA
James Ray, PharmD, University of Virginia, Charlottesville, VA
Paula Capobianco, MSW, University of Virginia, Charlottesville, VA
Leslie Blackhall, MD, University of Virginia, Ivy, VA
Debbie Eggleston, MSN, University of Virginia, Charlottesville, VA

Objectives
• Describe methods of screening, ensuring compliance, and adhering to regulatory issues when dealing with substance abusing patients.
• Describe techniques for dealing with common substance abuse issues.
• Identify the roles and needs of individual members of the interdisciplinary team.

Concern about the rapid increases in deaths due to substance abuse and diversion is leading to calls for changes in the way we prescribe controlled substances. These concerns deeply affect the practice of hospice and palliative care clinicians, who routinely use many Schedule II medications to treat symptoms of patients with life-limiting illnesses. Since substance abuse is common in the general population, it is common in the patients we treat, and failure to address this issue can lead to legal risk for providers. However, this issue is vital not just because of increased regulatory scrutiny, but also because substance abuse is a form of severe suffering, and addressing this suffering is no less important than treating physical pain. In this workshop, we will present a draft white paper (developed by the Substance Abuse and Diversion SIG) on model policies and best practice procedures for managing these issues in palliative care and hospice. We will discuss our experience in implementing these policies in inpatient practice and at an outpatient palliative care clinic at the University of Virginia Cancer Center and in hospice settings. We will use case discussions, role play, breakout sessions, and other interactive methods to demonstrate how to assess, monitor, and respond to substance abuse and diversion in a variety of settings. Specific challenging situations—such as a patient with severe cancer-related pain who is an active substance abuser, drug diversion and abuse in family caregivers, and managing comorbid psychiatric problems—will be addressed in detail. Special attention will be paid to the context of clinical practice and an interprofessional approach to this difficult issue. Attendees are encouraged to bring specific concerns from their own practice area for discussion.
**Palliative Care in Long-Term Care Update: Practical Pointers, Policies, Programs, and Regulatory Pitfalls (P13)**

Kimberly Curseen, MD, University of Arkansas for Medical Sciences, Little Rock, AR
William Smucker, MD CMD, Summa Health Care System; NE Ohio University, Westfield Center, OH
Jessica Kalender-Rich, MD, University of Kansas Medical Center, Overland Park, KS
Betty Lim, MD, Icahn School of Medicine at Mount Sinai, New York, NY
Paula Sanders, JD, American Health Lawyers Association, Harrisburg, PA
Cari Levy, MD, University of Colorado School of Medicine, Denver, CO

**Objectives**

- Apply evidence-based practical guidelines for palliative care symptom management and advance care planning in the long-term care setting; list how palliative care can positively affect hospital readmission rates and can impact transition of care to long-term/postacute care settings; and be able to compare and contrast two successful practice models for delivery of palliative care in long-term care.
- Identify and list important CMS regulations and legal issues that specifically affect how palliative care is delivered in long-term care, with and without hospice; apply this information to their own practice settings.
- Apply a practical framework for providing palliative care in nontraditional long-term care settings, including assisted living facilities, medical foster homes, and group homes.
- Identify barriers to palliative care practice in these setting and how to negotiate these barriers to provide care.

In the United States, people aged 65 and older have a 40% chance of living in a long-term care (LTC) setting during their lifetime. Palliative care programs are being developed in LTC to fill gaps in patient transitions from acute care to long-term/postacute care and as a way to reduce 30-day hospital readmission rates for frail older adults. In order to do this effectively, palliative care providers will have to be adept at navigating the regulatory barriers and culture of traditional and nontraditional LTC environments. This preconference workshop will bring together a panel of experts who have both academic and private-sector experience in providing quality palliative care to this population. This will be a case-based, interactive workshop.

Part I focuses on practical ways to provide palliative symptom management within the culture and regulatory environment of LTC. This section will address the issues surrounding providing palliative care with and without hospice. This section will also introduce the audience to successful models for LTC consultation as well as show how palliative care can affect patient care transitions and hospital readmissions.

Part II will focus on regulations and legal issues with which every healthcare provider who provides palliative care in LTC should be familiar. Often lack of familiarity with the regulatory environment is a barrier to providing successful palliative care in an LTC setting. Part II will be delivered by an expert in LTC regulation and litigation.

Part III of the workshop goes beyond the traditional LTC. These environments have their own culture and regulations, which must be understood to develop and execute effective treatment plans. This section will discuss providing palliative care within the unique framework of medical foster homes, assisted living facilities, and group homes.
Ethical Issues in Everyday Hospice and Palliative Care Practice (P14)

Terry Altilio, LCSW ACSW, Mount Sinai Beth Israel, New York, NY
Nessa Coyle, PhD APRN FAAN, Memorial Sloan Kettering Cancer Center, New York, NY
Timothy W. Kirk, PhD, CUNY York College, Jamaica, NY
Debra Wiegand, PhD FPCN FAAN, University of Maryland, Baltimore, MD

Objectives

- Demonstrate an approach to addressing ethically challenging situations that clinicians often face when caring for patients and their families receiving hospice and palliative care.
- Recognize the influence of communication techniques on the patient’s end-of-life decision-making.
- Discuss strategies to address ethical challenges faced in clinical practice.
- Identify and engage ethical opportunities in giving and receiving care.
- Recognize the ethics resources available to clinicians through HPNA, AAHPM, NHPCO, and other hospice and palliative care organizations.

The primary purpose of this preconference workshop is to explore ethical challenges that clinicians commonly face when caring for patients and their families in hospice and palliative care settings. A secondary purpose is to help clinicians prospectively identify ethical opportunities in care relationships—opportunities that, if engaged, may help reduce the frequency or intensity of ethical crises in the course of care. Through discussion and interactive group exercises, we will demonstrate approaches to addressing ethical issues focusing on the use of language and effective communication. Emphasis will be placed on developing skills and capacities directly related to clinical practice. We will also discuss the importance of developing organizational resources in ethics to support hospice and palliative care clinicians, patients, and families.
Evolving Role of Palliative Care and Hospice for Patients with Advanced Cardiac Disease (P15)

Jatin Dave, MD MPH, Tufts Health Plan, Brigham and Women’s Hospital, Watertown, CT
Eldrin Lewis, MD MPH, Harvard University, Boston, MA
Ellin Frair Gafford, MD, Ross Heart Hospital, Columbus, OH
Dan Matlock, MD, University of Colorado, Denver, CO
Keith Swetz, MD FACP FAAHPM, Mayo Clinic College of Medicine, Rochester, MN
Sara Wordingham, MD, Mayo Clinic College of Medicine, Phoenix, AZ
Sharene Hollenbach, RN BSN OCN, Mayo Clinic, Phoenix, AZ

Objectives

• Assess workshop participants’ needs, using an audience response system, regarding attitudes, knowledge, and skills on common issues in palliative and hospice care of patients with advanced cardiac diseases and tailor discussion based on audience needs.
• Define a model for high-quality, patient-centered care across the continuum for patients with cardiac diseases from the time of diagnosis to death.
• Describe the role of palliative care and hospice in cardiac disease, with special emphasis on barriers and strategies to overcome them.

Advances in cardiovascular medicine have led to remarkable success in life extension, which in turn has increased the prevalence of people living with heart failure and other chronic cardiac diseases. Many patients with advanced cardiac diseases require coordinated symptom management and decision support as the illness progresses, which offers an opportunity for synergism between HPM providers, primary care physicians, cardiologists, and cardiothoracic surgery teams. The opportunity for palliative care clinicians to partner in the care of cardiac patients will continue to grow in the future.

Despite heart disease being the leading cause of death and evidence supporting palliative care as an obvious strategy to address the needs of patients with cardiac disease, numerous studies have documented underutilization of palliative care and hospice. Patients with cardiac disease are often not receiving palliative care interventions, even at the end of life. For example, less than 10% of heart failure patients receive palliative care services, and heart disease is the primary diagnosis in less than 12% of hospice patients. Numerous studies have documented unmet needs, such as symptom management, difficulties performing daily activities, and psychosocial concerns in patients with cardiac disease.

With increasing recognition of the effectiveness of palliative care, a growing number of cardiologists and cardiothoracic teams are developing innovative programs to deliver timely palliative care interventions for patients and their caregiving families across the continuum of this complicated illness trajectory. Recent financial and delivery model reform has led to growing support for the palliative care and hospice model to improve outcomes such as readmissions.

An interdisciplinary team representing cardiology, palliative care, nursing, and primary care will lead this comprehensive, coordinated, and evidence-based workshop. They will share practical tools for decision support, prognostication, and program development. They will conduct a panel discussion on policy implications and discuss practical implications during the last 30 minutes.
Navigating the Maze of Physician Billing Documentation and Coding (P16)

Jean Acevedo, LHRM CPC CHC CENTC, Acevedo Consulting Incorporated, Delray Beach, FL

Objectives

• Discuss the importance of “medical necessity” for physician billing.
• Identify the appropriate circumstances for using time to choose an Evaluation & Management (E & M) Services code.
• Define the “key components” for choosing an Evaluation & Management Services code based on complexity.

With changing and shrinking reimbursement, the ability of hospice and palliative care organizations to bill appropriately for all billable services is more important than ever. Optimizing physician billing requires an understanding of the regulatory requirement of the levels of care under the Medicare hospice benefit. Hospices and palliative care physicians and nonphysician practitioners struggle with the counterintuitive documentation requirements of billing for physician services. Physicians and nonphysician practitioners coming from private practice may be familiar with office visit codes, but now find themselves trying to code for “something called GIP,” home, ALF, and nursing facility services. One set of E & M codes may have five levels of service, another four, and still another three; no wonder there is confusion. And there are two sets of documentation guidelines: 1995 and 1997. Yet the threat of audits and recoupment makes understanding the requirements a must. This session will discuss how to properly document a patient’s visit using the three key components, or time, to help ensure third-party payers are not successful in retrospective recoupments. The session will begin with the documentation requirements and end by applying this knowledge with an interactive, hands-on auditing of some “typical” hospice and palliative physician notes.
Using “Action Methods” to Enhance Role-Play Simulations in Teaching Communication Skills (P17)

Walter Baile, MD, University of Texas MD Anderson Cancer Center, Houston, TX
Kathleen Neuendorf, MD, The Cleveland Clinic Foundation, Cleveland, OH
Rebecca Walters, MS, Hudson Valley Psychodrama Institute, Highland, NY

Objectives

- Discuss how to prepare a group for role-plays using sociodramatic warm-up exercises that are designed to enhance spontaneity and the creativity necessary for role-plays to be successful.
- Recognize how to use these warm-up exercises interactively to guide the selection of cases for role-play from those you are teaching.
- Apply one or two techniques that you learned to your teaching.
- Demonstrate how to debrief learners using sharing and reflection.

Communication skills are a core competency in clinical care, and role play is an important method for teaching communication skills using simulation. However, many teachers have experienced resistance and reluctance on the part of learners to participate in this method of learning. In this workshop, we will demonstrate methods for enhancing role-plays, generating enthusiasm on the part of learners, increasing their involvement, and making teaching and learning more enjoyable. Specifically we will show a model for enlivening role-plays called “empathy in action.” It borrows from psychodrama and sociodrama in that it uses specific “action methods” to create learner-centered, interactive, experiential scenarios in which learners provide the material for role-plays and participate in the enactments. These methods include the following:

1. Warm-up exercises—We recognize that role-plays often fail because learners are anxious and not ready to assume the role they may asked to take, so they are unable to be spontaneous and creative in portraying characters such as patients, family members, and providers. Warm-up exercises “loosen up” the group, preparing them for an enactment that generates “themes” or “challenges” (such as giving bad news to young people with a serious disease).

2. Leading the group in creating characters for the enactment and assigning them names, genders, and other characteristics.

3. Using the group in “doubling,” or becoming the alter ego of characters (patients, family members, etc.) who will be portrayed, thus revealing hidden thoughts and feelings.

4. Conducting the role play, including incorporating teaching points.

5. Sharing of experiences among the role-players and audience. We have conducted workshops using these methods for clinicians in the United States and abroad and published a number of papers describing their use. In demonstrating these techniques, we will walk the participants through the methodology and provide time for questions and interaction.
Be the Change... An Advocacy Boot Camp (P18)

Sponsored by the AAHPM Public Policy Committee
Sue Ramthun, Hart Health Strategies, Washington, DC
Philip E. Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI
Paul E. Tatum, III, MD MSPH CMD AGSF FAAHPM, University of Missouri, Columbia, MO
Ruth M. Thomson, DO HMDC FACOI FAAHPM, Hospice of Dayton, Inc., Dayton, OH
Gregg K. VandeKieft, MD MA FAAHPM, Providence St. Peter Hospital, Olympia, WA

Objectives
- Understand how healthcare professionals can influence the legislative and regulatory processes and why it is important to do so.
- Identify current health policy developments with implications for hospice and palliative care.
- Use effective grassroots communication techniques and other strategies for successful advocacy.

Are you frustrated by increasing regulatory burdens on your practice, concerned about efforts to restrict opioid prescribing, or anxious about whether emerging healthcare payment and delivery models will work for hospice and palliative care? Lawmakers and regulators rely on input from constituents and stakeholders when crafting health care policy; is yours the voice they are hearing? If not, come participate in this interactive workshop and learn how to become an effective advocate for your patients, your practice, and your profession. It’s easier than you think—and you don’t have to travel to Washington, DC, to make a difference!

In this advocacy “boot camp” sponsored by AAHPM’s Public Policy Committee, you’ll hear from government relations experts and colleagues with a wealth of advocacy experience in the legislative and regulatory arenas at both the state and federal levels. Come learn about effective grassroots communication and how to shape your messaging for maximum impact. Whether planning local meetings with elected officials and their staff, attending a town hall, engaging on social media, or responding to a call for public comments on proposed regulations, you’ll benefit from the tips, tools, and resources this workshop will highlight. The session will also include a brief overview of the public policy process, priority issues for the field of hospice and palliative care, and federal legislation that would benefit patients with serious illness and the providers who care for them.

First-timers and experienced advocates looking for a refresher will appreciate the opportunity to ask questions of our experts and share stories from the front lines. You’ll be able to apply the lessons learned, whether advocating for sound public policy or working to advance palliative care within your institution. In today’s evolving healthcare marketplace, hospice and palliative care professionals simply can’t afford not to make advocacy part of their job description!
ER/LA Opioids: Achieving Safe Use While Improving Patient Care (P19)

Objectives

- Summarize why risk evaluation and mitigation strategies (REMS) are necessary for opioid drugs.
- Effectively assess benefits and risks of prescribing extended release/long-acting (ER/LA) opioids.
- Define the concepts and federal and state regulations regarding effectively initiating, modifying dosing, and discontinuing ER/LA opioids.
- Apply strategies to effectively manage risk of side effects, abuse, and diversion.
- Counsel patients and families about general characteristics, risks, and safe management of ER/LA opioids.
- Apply general information and specific characteristics of ER/LA opioids in practice.

The US Food and Drug Administration (FDA) has determined that a risk evaluation and mitigation strategy (REMS) is required for extended-release (ER) and long-acting (LA) opioid medications to ensure that their benefits outweigh their risks. AAHPM has been a strong advocate of availability of these medications for use in palliative and hospice care settings while acknowledging the significant increase of unintentional deaths, emergency department visits, and admissions to substance abuse treatment due to abuse of pain relievers. Prescriber education and patient education are vital components of these REMS. This workshop will cover all six content areas defined in the FDA's Blueprint for Prescriber Continuing Education Program, refined specifically for hospice and palliative care prescribers. While prescriber education is currently voluntary, mandates are anticipated through federal legislation in the near future. Anticipate an engaging, case-based session that informs your practice going forward.
Prognosticating the Survival of the Hospice Industry (P20)

Judy Bartel, ACHPN®, CHPCA®, FPCN®, Chief Clinical Officer Hospice of the Western Reserve
William Finn, MBA, Hospice of the Western Reserve, Cleveland, OH
Clement J. Hearey, MBA, Hospice of the Western Reserve, Cleveland, OH

Objectives

• Discuss the Affordable Care Act's impact on hospice sustainability.
• Discuss the future roles of quality, value propositions, and varied service models.
• Identify how new regulations and increased scrutiny will affect staff.
• Discuss impending workforce issues and staff engagement solutions.

In the past, hospices have been an accepted part of the service continuum. The hospice industry of today, however, is having a watershed moment, the recognition of which is pivotal to sustainability. Even though the Affordable Care Act has rightly highlighted the necessity of postacute care, many hospices have failed to understand that a nod from the government does not ensure viability and that success can only come from quality and from a concerted, industry-wide movement to educate health systems about hospice's value. In order for this to happen, hospices must adapt, changing, in particular, the way they manage their workforce. Engagement of staff will be critical to the success of the hospice of the future. The presenters will address these issues and offer participants concrete solutions to surviving the current and future healthcare storm.
All In: How High-Performing Teams Develop a Culture of Collaboration, Belief, and Renewal (101)
Chester Elton, motivational speaker and best-selling author

Objectives
- Identify three key characteristics of high-performing professional teams.
- Recognize how members of the interdisciplinary team can build a productive workgroup culture that inspires collaboration and partnership.
- Create positive change by incorporating both heart and spirit into your organization’s culture.

This engaging session is based on The New York Times best-selling business book All In, which includes research from more than 300,000 people, including individuals who work in successful healthcare organizations. Speaker Chester Elton will teach learners new techniques for how to engage, enable, and energize their teams. This “E+E+E” formula outlines how high-performing organizations deliver extraordinary results by creating a vibrant, productive culture where people believe that what they do matters and that they can make a difference. This presentation will feature inspiring stories of leaders in action that vividly depict just how these powerful methods can be implemented.

Chester Elton is the best-selling coauthor of The Carrot Principle and the Orange Revolution. His books have sold more than a million copies. As a motivation expert, Chester has been featured in Financial Times, The Washington Post, Fast Company, and The New York Times and on “60 Minutes,” CNN, ABC’s “Money Matters,” MSNBC, and NPR. He is the founder of the Culture Works, which provides consulting and training in recognition, teamwork, and culture, but he is most proud to be the father of four exceptional children. Visit www.chesterelton.com to learn more.
Walking the Line with Difficult Parents: Ethical Decision-Making with Families at the Fringes (TH300)

Liza Marie Johnson, MD, St. Jude Children’s Research Hospital, Memphis, TN
Deena Levine, MD, St. Jude Children’s Research Hospital, Memphis, TN
Justin N. Baker, MD FAAHPM, St. Jude Children’s Research Hospital, Memphis, TN

Objectives

• Differentiate when parental refusal of a recommended therapy does and does not constitute medical neglect.
• Recognize when familial requests are demands for futile or medically inappropriate care.
• Discuss how to negotiate a treatment plan for families at either extreme using the principles of ethical reasoning and shared decision making.

Medical decision making in the United States has moved from a paternalistic, physician-driven process to a patient-driven, autonomy-based standard. Over the past 10 years the pendulum has shifted to a balanced, meet-in-the-middle approach commonly defined as shared decision making. Families who listen to all medical options and select the recommended (standard) option are often perceived to be equal partners. Families that refuse medical recommendations or demand medically inappropriate interventions exist outside of the norm and challenge the communication and shared decision-making skills of clinicians. In this interactive session, we will review general concepts of ethical decision making in the context of pediatrics and discuss difficult end-of-life decision making. Participants will learn the ethical principles used when evaluating possible medical neglect or demands for futile or medically inappropriate care. This session will provide participants with strategies for communicating with families perceived to be “unreasonable” or at the fringes.
When Eating Problems Arise in Advanced Dementia: An Interdisciplinary Approach to Communicating with Caregivers (TH301)

Erika Manu, MD, University of Michigan Health System/VA Ann Arbor GRECC, Ann Arbor, MI
Caroline Vitale, MD, University of Michigan Health System/VA Ann Arbor GRECC, Ann Arbor, MI
Joseph Murray, PhD, VA Ann Arbor Healthcare System, Dearborn, MI
Amy P. Lustig, PhD MPH CCC-SLP, Restorative Speech, Elkins Park, PA

Objectives

• Describe the natural history of advanced dementia.

• Identify the nature and the causes of the eating/feeding problems in a patient with advanced dementia and describe potential treatment burdens associated with artificial nutrition in patients with advanced dementia.

• Discuss various options for addressing eating/feeding difficulties in patients with advanced dementia.

With the aging population of the United States, dementia is becoming a national healthcare problem. Geriatricians and palliative care providers will be unable to provide care to the rapidly growing number of patients with advanced dementia; therefore it becomes imperative to train as many healthcare providers and interdisciplinary team members as possible about the course of the dementia and nature of the complications in the advanced stages of the disease. Advanced dementia is often not recognized by healthcare providers as a terminal disease. This lack of knowledge is cited as the major barrier in developing plans of care aligned with patient needs. Eating and feeding problems are frequent complications in advanced dementia patients. We aim to provide the session participants with a model interdisciplinary approach to discuss eating/feeding problems and treatment approaches with the family of a patient with advanced dementia. The educational intervention can be provided to various levels of medical trainees as well as other disciplines such as nursing, speech pathology, and social work. The video of a family meeting we developed and produced has important and challenging trigger questions meant to be discussed with the participants. The video will be used as a centerpiece for a group workshop that will start out with a clinical case. We will then play the video until a trigger question is shown; we will allow the participants to test their own knowledge base and approach to the question raised in the video. Faculty then will facilitate a group discussion, during which the participants will share their answers while faculty touch upon the most recent evidence pertaining to each individual question. Attendees’ self-reported skill level and satisfaction with the workshop will be assessed via a retrospective pre-post survey. Session participants can apply the knowledge, skills, and materials shared to improve the care of patients with advanced dementia.
Cultivating the Contemplative Clinician: The Practice and Pedagogy of Reflection in Palliative Education (TH302)

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Tara Schapmire, CCM LCSW MSW OSW-C PHD, University of Louisville, Louisville, KY
Frank Woggon, PhD BCC, University of Louisville, Louisville, KY
Mark Pfeifer, MD, University of Louisville, Louisville, KY

Objectives

• List five reasons for using reflective activities when teaching palliative care.
• Describe evidence from the literature supporting the use of reflection as a pedagogical approach in palliative education.
• Integrate effective tools for stimulating and evaluating reflective activities.

Sound clinical practice, especially in palliative care, requires much more than the memorization and accumulation of factual knowledge. Indeed, reflective capacity has been linked to deeper understanding of the patient experience, the development of empathy, practitioner well-being, and personal and professional growth and development—all essential for meaning and success in palliative care. Reflective activities range from reflective writing; journaling; developing portfolios; producing video essays; and reacting to art, videos, or writings of others. This interactive workshop will explore the use of reflection as an important pedagogical component of palliative education. The rationale and current evidence supporting the use of reflective activities will be described. Beyond acknowledging its value, this workshop will provide the learner with tools to enhance and evaluate reflective educational experiences. Participants will begin with a reflective exercise that will serve as a foundation for the workshop and be used to illustrate the value of and rationale for reflective activities. Participants will be exposed to a variety of “prompts” used to stimulate reflection and will develop their own prompts as part of the session. The substance and importance of meaningful student feedback that is both supportive and stimulating will be discussed. Examples of effective feedback will be shared. Methodologies for analyzing and reporting the results of reflective activities will be presented. Participants will also develop a plan for integrating reflective activities into their educational efforts.
A Health Plan's Innovative Telephonic Case Management Model to Provide Palliative Care (TH303)

Rebecca Yamarik, MD, Providence Health & Services, Long Beach, CA
Romilla Batra, MD, SCAN Health Plan, Long Beach, CA
Lianne Matthews, BSN CCM CPHQ MBA RN, Scan Health Plan, Long Beach, CA

Objectives

• Describe SCAN’s Program for Advanced Illness.
• Discuss how SCAN is using palliative care to improve quality of care and patient satisfaction.
• Describe measured outcomes for the first year of an advanced illness management program.

SCAN Health Plan is a Medicare Advantage Plan in California and Arizona serving 170,000 members. In 2013, SCAN launched a case management program to assist members with multiple chronic health conditions manage their symptoms and medications. The Program for Advanced Illness (PAI) is designed to manage the sickest patients in the last months and years of life. The goals of the program are to better manage symptoms, improve member and family/caregiver satisfaction, and improve overall quality of care, while reducing inpatient/ER utilization. PAI is one of several case management programs provided by SCAN to its members. Other programs include Complex Care Management, Memory Program, Care Transitions, and Disease Management.

The PAI program provides telephonic case management for members at any stage of an advanced illness. The approach is patient centered and holistic and incorporates psychosocial, cultural, and spiritual aspects of care. Registered nurses provide the telephonic case management to members and are supported by an interdisciplinary team of social workers, geriatricians, chaplains, and palliative care physicians.

Activities of the program include education about goals of care and documentation of goals, coaching of members and families about how to discuss end-of-life wishes with providers, facilitation of discussion of members’ wishes, pain and symptom management, identifying resources for care, and education about POLST and advanced healthcare directives.

We will present SCAN’s program in detail. We will discuss the training of the RN case managers using a board-certified palliative care physician who provides training and ongoing support. Outcome measures for the first year of the program will be presented. These metrics include increased length of stay in hospice, member wishes followed at end of life, death in place of preference, decreased hospitalization, decreased ICU utilization, and member/caregiver satisfaction.
The Evolving Role of Palliative Care in the Trauma Patient (TH304)
Alan Roth, DO, Jamaica Hospital Medical Center, Jamaica, NY
Angelo Canedo, Jamaica Hospital Medical Center, Jamaica, NY

Objectives
• Review the current literature on the utilization of palliative care in the trauma patient.
• Describe the use of trigger tools for palliative care consultation using Surgical Injury Severity scores to assist in prognostication.
• Discuss our success in this area and explore with the audience best practices for the care of these severely injured patients.

Each year trauma accounts for 41 million ED visits, 2.3 million hospitalizations, and over 180,000 deaths in the United States. Trauma accounts for 30% of all life years lost in the United States as compared with cancer (16%) and heart disease (12%). Trauma is the leading cause of death in the 1-44 age group and the number three overall cause of death. The economic burden of trauma is staggering and is associated with a significant financial impact of over $406 billion in both healthcare costs and lost productivity. Trauma hospitalizations are associated with significant morbidity and mortality and lengthy ICU stays.

Trauma is a sudden event that often has a dramatic impact on the patient and family, leaving little time for decision making, acceptance, and grieving. These catastrophic events take a large toll on patients’ families, making goals-of-care discussions ever more complex and difficult.

Classification of the trauma patient utilizing the Trauma Injury Severity Score (TRISS) is helpful in determining the severity of the injury and identifying those with higher morbidity and mortality. Using this score as a trauma prognostication tool can help identify patients who would be most appropriate for palliative care consultation.

The literature reviewing the use of trigger tools for palliative care consultation in the trauma patient is only recently emerging. A recent article in this field by Mosenthal et al., “Integrating Palliative Care in the Surgical and Trauma Intensive Care Unit: A Report from the Improving Palliative Care in the Intensive Care Unit (IPAL-ICU) Project,” highlights that optimal use of trigger tools for palliative care consultations has not been standardized.

We will discuss how we have incorporated the latest evidence-based guidelines into formulating a trauma prognostication tool to assist in early identification of those patients and families who would most benefit from palliative care services.
Do Steroids Prolong Suffering? End-of-Life Care for Patients with Primary Brain Tumors (TH305)

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Robyn Anderson, RN MSN ACHPN, James J. Peters VA Medical Center, Bronx, NY

Objectives

- Recognize the various symptoms and treatments associated with the terminal phase of primary brain tumors.
- Recognize decisions for care that need to be reviewed with the patient and/or family in anticipation of the terminal phase of primary brain tumors.
- Recognize the indications for use of steroids in primary brain tumors and the implications for symptom management and life prolongation if they are discontinued.

Prognosis for primary brain tumors remains poor, despite aggressive treatment. In the late stages of the disease process, patients experience myriad symptoms for which there are little data in the literature to guide treatment decisions. These include seizures, headache, drowsiness, dysphagia, death rattle, agitation, and delirium. The literature that does exist suggests that end-of-life planning is limited regarding eliciting treatment preferences from patients or their surrogates, but that decisions are frequently made to withhold certain treatments in an effort to not prolong the dying process. In the studies that review the types of decisions made regarding withdrawal of treatments, steroids are often mentioned, but little explanation is provided as to the mechanisms involved and the implications for symptom management that may follow this decision. This session is designed to explore the withholding of steroids further in an effort to generate guidelines that will inform discussions with patients and families about end-of-life care in brain tumor cases, as well as inform the subsequent care of patients for whom the decision is made to withdraw this treatment.
**Economic Evaluation of Specialist Inpatient Palliative Care Consultation Teams: Cost Effect Estimates Vary by Treatment Timeliness (TH306-A)**

Peter May, Trinity College Dublin, Dublin, Ireland  
R. Sean Morrison, MD FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY

**Objectives**  
- Understand that previous economic evaluations of in-hospital palliative care consultation teams have defined treatment as a consult at any time during hospitalization.  
- Understand the variance in timeliness of in-hospital palliative care consultation.  
- Understand that timeliness of consult has a major impact on treatment effect on cost; earlier consult is associated with greater cost reduction.

**Original Research Background:** Economic evaluations of specialist inpatient palliative care consultation teams (PCCTs) have consistently defined treatment as binary (seeing a PCCT at any time during hospitalization). However, consultations at any time during hospitalization may not be equal or comparable, and treatment effect may vary accordingly.

**Research Objectives:** To estimate the effect of consultation timeliness on hospital cost for patients with advanced cancer.

**Methods:** Using a prospective, observational design, data were collected on patients admitted with advanced cancer at four hospitals in a 4-year period (n=969, of whom 256 saw a PCCT at any time during their hospital stay). Four binary treatment variables were generated according to timeliness. These variously defined treatment as a PCCT (a) at any time (100% of PC patients), (b) within 10 days of admission (95%), (c) within 7 days (90%), and (d) within 2 days (75%). Generalized linear models (GLMs) with a gamma distribution and a log link were used to regress daily and total cost of hospital stay against each treatment variable, 33 baseline socioeconomic and clinical covariates, and dummy variables for each site. Propensity score weights were calculated to balance the intervention and control arms on the basis of observed covariates.

**Results:** Treatment reduces cost within 10 days of admission (p<0.05), and that effect is larger for 7 days (p<0.03) and 2 days (p<0.01). The treatment effect for PCCT overall also appears cost saving, although this is masked in some models by a small number of late consults.

**Conclusions:** Timeliness of treatment has an important effect on results. Earlier consultation is associated with larger treatment effect.

**Implications for Research, Policy, or Practice:** PCCTs should be involved in patient care early in the hospitalization to maximize scope for treatment effect on cost. Economic evaluations of inpatient palliative care should consider incorporating timeliness into analysis as these not only have an important effect on results but also model selection.
Analysis of Part B Physician Services by Hospice Beneficiaries (TH306-B)

Michael Plotzke, PhD, Abt Associates, Des Peres, MO
Alyssa Pozniak, PhD, Abt Associates, Cambridge, MA

Objectives

• Inform the hospice and palliative community about beneficiaries’ use of Medicare Part B physician services while on hospice.
• Better understand the procedures and timing of physician services received by hospice beneficiaries and billed under Part B.

Original Research Background: Beneficiaries waive all rights to Part B payments for services related to the terminal illness and related conditions during hospice benefit election period. However, hospice beneficiaries may still receive care under Part B for care unrelated to the terminal illness and related conditions as well as care related to the terminal illness and related conditions when provided by their nonhospice employee attending physician. There is limited research that examines the use of Medicare physician services by hospice beneficiaries.

Research Objectives: To use Medicare claims data to examine the use of physician services by hospice beneficiaries that are billed under Medicare Part B.

Methods: We used 2011-2012 Centers for Medicare and Medicaid Services (CMS) physician carrier (“Part B”) and hospice claims to present descriptive analysis on Part B utilization by hospice beneficiaries.

Results: Of the 2.2 million beneficiaries with a hospice claim in 2011-2012, approximately 34% had a Part B claim during their hospice period. There were over 6.4 million Part B claim line items for hospice patients that accounted for over $372 million, the majority of which was for physician services unrelated to the terminal diagnosis ($260 million). Of the 4,550 unique Healthcare Procedure Coding System (HCPCS) codes on the Part B claims, five appeared on 25% of all claims, and 20 appeared on 53% of all claims. Among the top five HCPCS, about one-quarter were billed within the first 2 weeks of the hospice period, and 60% were billed within the first 90 days.

Conclusion: A sizable minority of hospice beneficiaries receive physician services under Part B while on hospice, with most of the services for care unrelated to their terminal diagnosis. HCPCS are highly concentrated, with 20 appearing on over half of all Part B claims.

Implications for Research, Policy, or Practice: Ongoing analyses seek to better understand hospice level of care, site of service, and provider characteristics when billing under Part B.
Economic Evaluation of Specialist Inpatient Palliative Care Consultation Teams: Treatment Effect Varies by Patient Complexity (TH306-C)

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R. Sean Morrison, MD FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY

Objectives

• Understand that patient-level factors determine a high level of cost in many health economics studies and that previous economic evaluations of in-hospital palliative care consultation teams have not addressed patient-level factors.
• Understand that palliative care consult treatment effect on cost varies according to individual patient complexity.
• Understand the implications of these findings for clinical practice and for future palliative care research.

Original Research Background: Patient-level factors may determine a high proportion of hospital costs in providing care to patients with serious illness. For example, economic evaluations taking into account individual complexity may offer new and valuable information for understanding variations in cost. Studies of specialist inpatient palliative care consultation teams (PCCTs) have yet to attempt this.

Research Objectives: To compare how treatment effect of PCCT on hospital cost varies according to patient complexity.

Methods: Using a prospective, observational design, data were collected on patients admitted with an advanced cancer diagnosis at four hospitals in a 4-year period (n=1,023). Treatment was defined as seeing a PCCT within 3 weeks of hospital admission (n=271); all other patients were put into the control arm (n=762). Overlapping subsamples were created according to number of comorbidities on the Elixhauser Index at baseline: (a) All Patients (n=1023); (b) 3< = Elixhauser total (n=680); (c) 4< = Elixhauser total (n=489); (d) 5< = Elixhauser total (n=300). Generalized linear models (GLMs) with a gamma distribution and a log link were used to regress daily and total cost of hospital stay against each treatment variable, 33 baseline socioeconomic and clinical covariates, and dummy variables for each site. Subsample specific propensity scores were calculated to balance the intervention and control arms on the basis of observed covariates.

Results: Treatment effect was cost reducing for all subsamples. The estimated $ treatment effect and statistical significance were greatest for (d), then (c), then (b), then (a).

Conclusions: Individual patient complexity influences the economic impact of PCCTs. Higher patient comorbidities are associated with larger treatment effect.

Implications for Research, Policy, or Practice: PCCTs should be involved in the care of complex patients to maximize treatment effect on cost. In our study only 34% of patients with four or more comorbidities saw a PCCT. Economic evaluations of palliative care interventions should consider patient-level factors, which may determine a high proportion of cost of care.
Carve In or Carve Out: Hospice Live Discharge Rates in Medicare Advantage Compared to Medicare Fee-for-Service (TH306-D)

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Objectives
- Understand the concerns with live discharges as vulnerability of the Medicare hospice benefit.
- Become familiar with the research findings on the difference in hospice enrollment, length of stay, and rate of live discharges among Medicare Advantage vs. fee-for-services.

Original Research Background: When enrollees in Medicare Advantage (MA) plans elect hospice care, all covered services are reimbursed under the Medicare fee-for-service (FFS) program. This financial arrangement may incentivize MA plans to refer persons to hospice.

Research Objectives: Characterize hospice live discharge rates by MA plan members vs fee-for-service (FFS) Medicare beneficiaries.

Methods: Two cohorts were utilized: (1) Medicare decedents in 2010 and (2) Medicare beneficiaries discharged from hospice in 2010 with 1-year follow-up post discharge. For cohort 1, we examined the association between MA enrollment and hospice referral using multivariate logistic regression models adjusted for age, sex, race, and state MA enrollment rate. For cohort 2, a multivariate logistic model predicted whether a patient was discharged alive, the pattern of live discharges, and 1-year mortality post discharge after adjustment for age, sex, race, and hospice primary diagnosis. A robust variance estimator accounted for clustering of persons within hospice programs.

Results: Among 1,766,935 Medicare decedents, 22% (n=389,724) were covered by an MA plan. MA plans compared to FFS referred more patients to hospice (49.1% vs 45.0%; AOR 1.20; 95% CI, 1.15-1.22). Compared with FFS beneficiaries, MA enrollees had a higher live discharge rate (18.6% vs 18.0%; AOR 1.06; 95% CI, 1.03-1.09) but similar rates of hospice discharges among stays greater than 180 days (26.1% vs 26.7%; AOR, 0.99; 95% CI, 0.95-1.03). The rate of early live discharges within the first 7 days of starting hospice was similar (10.1% in MA vs 11.0% in FFS; AOR 0.89; 0.85-0.93). Among MA patients discharged alive from hospice, the 1-year mortality was slightly lower (58.1% in MA vs 60.0 in FFS; AOR 0.91; 95% CI, 0.89-0.94).

Conclusions: Compared with FFS beneficiaries, MA enrollees are more likely to use hospice, but the rate and pattern of live discharges are similar.

Implications for Research, Policy, or Practice: Further research is needed to examine consumer perceptions of the quality of care.
Disability Trajectories at the End of Life Among the Very Old (TH307-A)

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Objectives

- Assess functional trajectories as they differ by cause of death.
- Separate disability due to underlying chronic conditions from disability associated with end of life.

Original Research Background: Investigators have identified varying trajectories of disability before death, but little is known about how decedent trajectories compare with those of matched survivors.

Research Objectives: We examined self-reported disability at 6-month intervals before death among the 1,859 participants in the Health, Aging and Body Composition Study (Health ABC) who died before 2014 and made multiple comparisons with surviving participants.

Methods: The original 3,075 study participants were recruited in 1997 from Medicare beneficiaries in Pittsburgh, PA, and Memphis, TN, who were at least 70 years of age and well functioning. Follow-up has continued for 17 years.

Results: Disability trajectories among the decedents varied as expected. For example, difficulty dressing was reported 12 months before death by 27.5% of decedents with CHF or COPD compared with 8.1% who died from cancer (p<.0001). Compared to age-matched survivors, decedents with a history of stroke, dementia, pneumonia, or falls were more likely to report difficulty transferring at 6 months (46%-50% vs 22%, p<.0001) and also at 18 months before death (39%-45% vs 20%, p<.0001). Cancer decedents significantly differed from survivors only at 6 months before death. As expected, the proportion of study participants able to walk a quarter mile without difficulty decreased as the cohort aged; notably the difference in mobility between decedents and survivors remained constant over time.

Conclusions: Disability varied in expected and unexpected ways among decedents and survivors.

Implications for Research, Policy, or Practice: A better understanding of how disability due to persistent chronic disease differs from disability associated with end-stage disease is valuable for treatment and care decisions.
Prospectively Identifying People with Serious Illness (TH307-B)

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Kenneth Covinsky, MD, San Francisco, CA
R. Sean Morrison, MD FAAHPM, New York, NY
Christine Ritchie, MD FAAHPM, San Francisco, CA

Objectives

- Understand the need to prospectively identify those with serious illness.
- Understand the 3 proposed definitions of serious illness and how well they predict hospital admission, mortality, and total Medicare spending.

Original Research Background: Upstream identification and provision of appropriate services for the seriously ill may improve care and lower costs. A recent survey of experts in the clinical, research, and policy arenas of palliative care produced the following conceptual definition: “Serious Illness is a condition that carries a high risk of mortality, negatively impacts quality of life and daily function, and/or is burdensome in symptoms, treatments or caregiver stress.”

Research Objectives: We created and tested three possible specifications of serious illness, ranging from broad (ie, population for screening) to restricted (ie, population for targeted services) to identify persons at highest risk of mortality, hospital admission, and high total Medicare spending.

Methods: Using the nationally representative, longitudinal Health and Retirement Study (HRS) from 2000-2010, we evaluated subjects with each of three serious illness definitions: (a) one or more severe medical conditions (Condition) and/or receiving assistance with any basic activities of daily living (ADL; Functional Limitation); (b) Condition and/or Functional Limitation and one or more hospital admissions in the last 12 months and/or residing in a nursing home (Utilization); and (c) Condition and Functional Limitation and Utilization. Those meeting one of these three definitions were then followed for 1 year to assess outcomes.

Results: Of 10,500 eligible subjects, 4,713 met definition A; 2,612, definition B; and 1,200, definition C. The definitions of serious illness revealed the following 1-year outcomes: mortality of 11% (A), 18% (B), 27% (C); hospitalization 32% (A), 43% (B), 47% (C); and total average Medicare costs of $16,680 (A), $22,223 (B), and $26,463 (C).

Conclusions: Prospective identification of people with serious illness is feasible and critical to improving quality of care. Notably, most seriously ill patients identified are not in the last year of life.

Implications for Research, Policy, or Practice: Depending upon a program’s aim, these definitions may be used, for example, to screen patients for palliative care needs (A) or effectively target additional services (C).
Utilization of Hospice Services in a Population of Patients with Huntington's Disease (TH307-C)

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Objectives

• To describe a population of patients with Huntington’s disease enrolled in hospice.
• To compare the population of patients with Huntington’s disease enrolled in hospice with other populations to highlight characteristics and considerations unique to this population.

Original Research Background: Although the trajectory of Huntington’s disease and its complications have been well described, much less is known about the course of late-stage illness. In particular, little is known about the population of patients who enroll in hospice.

Research Objectives: To describe a population of patients with Huntington’s disease who enrolled in hospice.

Methods: Retrospective cohort study of electronic medical record data from 12 not-for-profit hospices in the United States.

Results: Of 164,032 patients admitted over 5 years, 101 (0.06%) had a primary diagnosis of Huntington’s disease. The median age was 57 (IQR: 48-65) and 53 (52.5%) were female. These patients were generally cared for by a spouse (n=36) or adult child (n=20). At the time of admission, most patients were living either at home (n=39) or in a nursing home (n=41). All were either bedbound or could ambulate only with assistance. The most common symptom reported during enrollment in hospice was pain (n=34) followed by anxiety (n=30), nausea (n=18), and dyspnea (n=10). Patients had a median length of stay in hospice of 42 days, which was significantly longer than for other hospice patients in the sample (17 days). Of 101 patients who were admitted to hospice, 73 died, 11 were still enrolled at the time of data analysis, and 17 left hospice either because they no longer met eligibility criteria (n=14) or because they decided to seek aggressive treatment (n=3). Of the 73 patients who died while on hospice, most were likely to die in a nursing home (n=29; 40%), followed by a hospital or inpatient hospice unit (n=27; 37%). Only 17 patients (23%) died at home.

Conclusions: Patients with Huntington’s disease are admitted to hospice much earlier than other patients are, but nevertheless have a significant symptom burden and limited functional status. Although hospice care emphasizes the importance of helping patients to remain in their homes, only a minority of patients with Huntington’s Disease were able to die at home.
CLAIM: Comprehensive Longitudinal Advanced Illness Management (TH307-D)

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Objectives

- Describe the objectives of the CLAIM program.
- Describe the CLAIM model of care and preliminary hospitalization and cost data.

Original Research Background: Although hospice provides comprehensive, interdisciplinary care to patients near the end of life, there is no dominant model of “upstream” palliative home care for patients who are not yet appropriate for hospice.

Research Objectives: The objective of this Centers for Medicare and Medicaid Services–funded project was to evaluate a palliative home care program (Comprehensive Longitudinal Advanced Illness Management; CLAIM) and its impact on acute care costs in a population of patients with advanced cancer.

Methods: Prospective cohort study of patients with cancer enrolled in a palliative home care program that provides access to visiting nurses, social workers, chaplains, home health aides, and nurse practitioners.

Results: Of 894 CLAIM patients served over 20 months, the hospitalization rate was 0.88 per 100 patient days. Compared with a historical home care control population (1.3 per 100 patient days), CLAIM was associated with a 41% reduction in acute care utilization. As of June 30, 2014, 383 patients (42% of discharges) transferred from CLAIM to hospice.

Conclusions: Compared with a historical home care control population, the use of palliative home care services is associated with a substantial reduction in acute care costs.

Implications for Research, Policy, or Practice: This research furthers our understanding of patient needs at the end of life and provides a model for serving patients in a way that prevents unnecessary hospitalizations and therefore reduces acute care costs.
Bang Your Head Here! Strategies to Survive in the World of Medicare Part D (TH308)

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Objectives
- Recognize the current climate that has developed between Medicare Part D and hospice.
- Describe methods of medication reconciliation across hospital and hospice settings.
- Describe methods of medication discontinuation.

Medicare Part D, also called the Medicare prescription drug benefit, is a federal program subsidizing the costs of prescription drugs and prescription drug insurance premiums for Medicare beneficiaries in the United States. Enacted as part of the Medicare Modernization Act of 2003, it went into effect January 1, 2006. With increasing regulation of hospice, recent announcements have identified significant medication coverage changes for hospice patients, which essentially require hospices to be responsible for all medications prescribed to Medicare hospice patients. Announcements also suggest that coverage for medications for conditions unrelated to the terminal condition will be granted “infrequently” and only under “unusual and exceptional” conditions. These conditions have not yet been delineated. Thus it appears that new strategies will be needed to help minimize costs, costs which might be catastrophic to smaller hospices. It appears that there are many things hospices can do to minimize costs until other channels for appeal are delineated. The primary defense will be scrutiny of medications that patients arrive with when enrolled in hospice. This session will focus on streamlining and providing effective pharmacotherapy for the patient in hospice and minimizing pharmaceutical costs in the extreme hospice regulatory environment. This interactive workshop will use didactics and clinical cases to delineate new strategies for survival under Medicare part D. The workshop will accomplish this by (a) describing the current climate that is developing with new Medicare Part D requirements in relation to hospice, (b) reviewing for the clinician effective and streamlined methods of medication reconciliation across hospital and hospice settings, (c) providing an overview of drug therapy problems encountered across the hospital and hospice settings, (d) describing rational approaches to medication discontinuation that is systematic and effective, and (e) role playing that illustrate communication patterns that lessen barriers between physicians and pharmacotherapy specialists.
Innovative Strategies to Address the Unique Cultural Beliefs and Spiritual Perspectives of African American Patients and Families at the End of Life (TH309)

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Objectives

• Recognize the unique cultural and spiritual preferences of African Americans at the end of life.

• Recognize how clinicians and organizations are responding to the cultural and spiritual perspectives of African American in end-of-life clinical care and program development to understand what is happening in other healthcare settings in the United States.

• Identify an innovative strategy (that other programs can implement) using community based participatory research in developing a culturally tailored palliative care program for rural African American communities, with full community partnership.

• Gain insight into an effective method of designing culturally tailored programs that others can incorporate into their own programs.

African Americans face disparities in healthcare access and quality that extend throughout the life cycle, including end-of-life care. They report less satisfaction with end-of-life care and more concerns with communication, and are more likely to experience poor pain management than Whites. Compared to conventional care, hospice and palliative care improve outcomes for patients and families and may reduce some racial disparities in care; therefore, timely access to these services may improve the care of African Americans. Yet, although African Americans endorse a greater need for hospice services and may substantially benefit from expertise in communication and symptom management, they enroll in hospice at lower rates than Whites. While there is little research on their use of non-hospice based palliative care, similar concerns about underutilization of services exist. Cultural and spiritual beliefs among African Americans may partly explain their lower use of hospice and palliative care, including mistrust of the healthcare system, preferences for life-prolonging care, and spiritual beliefs about the redemptive nature of suffering and the occurrence of miracles. The goal of this symposium is to present innovative strategies to improve end-of-life care for African Americans which consider their unique historical, cultural and spiritual perspectives. Presenters will discuss (a) research on cultural beliefs and spiritual perspectives that may influence decision-making and clinical strategies to improve end-of-life care, (b) commonly employed and effective community outreach strategies among hospice facilities to improve access to care based on a national survey, (c) developing a culturally tailored palliative care program for African American rural older adults using a community-based participatory research strategy, (d) spiritual care at end of life by African American churches (presented by a pastor), and (e) a call to action. By presenting strategies that “meet them where they are,” this session moves beyond discussing barriers, to highlighting potential solutions for improving care for diverse populations.
The Effect of Opioid Therapy on Endocrine Function (TH311)

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Objectives

• Discuss screening for opioid-induced endocrine symptoms in palliative care patients.
• Manage opioid-induced endocrinopathies in the context of patients’ goals of care for pain and symptom management.
• Discuss how to refer patients appropriately to an endocrinologist for opioid-induced endocrine side effects.

The symptoms of opioid-induced endocrinopathies are usually overlooked, because they are gradual and subtle. They tend to overlap with the physical and mood-related symptoms of pain disorders and often go unrecognized. As palliative care clinicians increasingly care for patients earlier in their disease trajectory, the prevalence of these endocrinopathies will increase in our patient population as they live longer. Opioids have well-documented effects on both the hypothalamic-pituitary-gonadal axis and the hypothalamic-pituitary-adrenal axis. These effects are confounded by illnesses and drugs outside the opioid class. Because these side effects may interfere with successful pain management and decrease the quality of the patient’s life, palliative care clinicians need to develop awareness, expertise, and, ultimately, standards of care for use in their patient care practices.

This interactive session will review the literature and evidence base for the endocrine effects of opioids. Using case presentations, an interdisciplinary team will discuss the practical aspects of the management of these side effects. This team will consist of a palliative medicine physician, a palliative care pharmacist, and an endocrinologist. The session will discuss a realistic approach for clinical symptom screening, appropriate laboratory evaluation, and differential diagnosis, including evaluating the contribution from concomitant nonopioid pharmacotherapy. Finally, although national guidelines have not been established for monitoring and treating hypogonadism or hypoadrenalism induced by opioids, this session will outline general treatment principles for use in palliative care.
Palliative Oncology as a Team Sport: How to Meet Oncologists “Where They Are” When Chemotherapy Is on the Table (TH312)

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Esme Finlay, MD, University of New Mexico Cancer Center, Albuquerque, NM
Thomas LeBlanc, MD, Duke University School of Medicine, Durham, NC

Objectives

• Discuss how to engage oncologists and the oncology team in productive conversations regarding the potential benefits of cancer-directed therapy in advanced cancer.
• Practice and refine scenarios in which productive discussions regarding cancer-directed therapy are needed.

When counseling patients with advanced cancer, palliative care and oncology clinicians sometimes offer conflicting advice about the role of cancer-directed therapy. As concurrent palliative care becomes the standard practice, it is increasingly important that we understand the perspective of our oncology colleagues. Palliative care clinicians often feel they may unintentionally cause tensions between the oncologist, palliative care team, and patient by recommending against chemotherapy in cases where it is likely to improve symptoms and quality of life. This makes it critical for us to better understand how oncologists think and make decisions. This presentation will serve as a primer about the palliative benefits of chemotherapy, highlighting counterintuitive situations that every palliative care clinician should know.

We will use a case-based and point/counterpoint format to facilitate discussions about when chemotherapy is “on the table.” Our panel features a multinstitutional panel of dually trained oncology and palliative care clinicians. The discussion will center around two patients, one with advanced lymphoma and the other with advanced lung cancer, whose palliative care goals could still be met with further cancer-directed therapy. The cases will highlight the different reasons for appropriate (or inappropriate) cancer-directed treatment despite advancing disease, poor performance status, high symptom burden, and/or limited prognosis. The panelist role playing the oncologist will convey the perspective that further cancer-directed therapy will improve the patient's quality of life, symptom burden, and/or survival. The panelist role playing the palliative medicine physician will discuss why pursuing supportive therapy, including potentially earlier referral to hospice, may be more beneficial. The audience may take either stance; they will be asked to vote by electronic audience response. Through this session, we aim to promote positive relationships between oncologists and palliative care clinicians, so a mutual understanding fosters a harmonious approach in meeting the patient’s goals of care.
Palliative Care and COPD: Bundling Up with Medicare (TH313)

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Denay Kirkpatrick, University of Alabama at Birmingham, Birmingham, AL
James Wells, MD, University of Alabama at Birmingham, Birmingham, AL
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Objectives
- Recognize the definition and features of a Medicare bundled payment (BP) program and an integrated practice unit (IPU).
- Define the possibilities for palliative and supportive care integration into the new forms of payment mechanisms within the Affordable Care Act.
- Discuss the results of a 1-year pilot bundled payment project for COPD incorporating palliative and supportive care.

Chronic obstructive pulmonary disease (COPD) is an increasingly common condition in the United States, and patients with advanced COPD represent significant utilizers of healthcare resources throughout their illness. Certainly as the disease progresses, the role of palliative and supportive care for these patients grows as they become more fragile and in many cases require increasing resources, including clinic and emergency department visits, home services, and hospitalizations. This session will provide a general introduction to several of the newer payment mechanisms emerging as part of the Affordable Care Act, with particular emphasis on integrated practice units (IPUs) and bundled payments. The session will also highlight the development of a bundled payment project at a large, greater-than-900-bed acute-care academic institution that incorporated palliative and supportive care interventions into the IPU care model. The session will be presented by members of the interdisciplinary team that developed this model, including palliative care and pulmonary physicians, a nurse practitioner, and a member of the healthcare system leadership team. Results from the first year of the COPD bundled payment project will be highlighted, including changes in medical care management, order sets, automated tracking and referrals for patients in the bundle, consultation with palliative and supportive care, involvement of home care and pulmonary rehabilitation, and initial financial results from the first cohort of patients.
Building a Successful Interdisciplinary Team—Learning to Love Conflict (TH314)

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Jane Jeuland, MDiv BCC, Yale University, New Haven, CT
Leslie Blatt, MSN APRN, Yale University, New Haven, CT

Objectives

• Describe models of conflict resolution styles and reflect about one’s own typical approach to conflict resolution.

• Identify how one’s own personal conflict resolution style may lead to pitfalls in communication with team members who may have different approaches to conflict resolution.

• Identify reasons for, and potential sources of, conflict among members of an interdisciplinary team.

Building a strong integrated team requires careful planning, commitment, and constant nurturing. This session will explore the development of a new palliative care interdisciplinary team, including the challenges and opportunities the team faced as it expanded. An effective, coordinated team must have an efficient mechanism for exchange of information. At the minimum, it requires space and a regular time to meet to share ideas and learn from each other. Given the team members’ mixture of skills and professional backgrounds, interdisciplinary collaboration is complex. A diversity of views and differences of opinion are inevitable. Conflict is both necessary and desirable in order for the team to grow and improve. Our team made a commitment to seek formal team training in order to solidify and strengthen our collaboration. During this session we will share what we learned, including writing a program mission statement, defining team core values, identifying our own personal conflict resolution style using validated instruments, and exploring strategies to effectively address conflict using Kerry Patterson’s “Crucial Conversations Model” as a guide. We will discuss the benefits of conflict on an interdisciplinary team by using cases that illustrate how conflict can encourage innovation, the acquisition of new knowledge, and creative problem solving. Practical conflict resolution skills will be applied to common disagreements among members of interdisciplinary teams, and session participants will be encouraged to strategize ways to apply these skills to the interdisciplinary teams with whom they work. By the end of this session, participants will be able to describe how successful confrontation and resolution of differences engender increased trust and understanding between team members, and they will create an action plan to address interdisciplinary team conflict within their own teams.
A Practical Guide to Making Decisions to Withhold and/or Withdraw Life-Sustaining Treatment: Walking the Walk, Teaching the Talk (TH315)

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Craig Blinderman, MD MA, Columbia University, New York, NY

Objectives

• Recognize the legal and ethical issues relevant to withholding and withdrawing life-sustaining treatment.
• Describe this practical and ethical framework for approaching decisions to withhold or withdraw life-sustaining treatment.
• Discuss the framework for educating ICU staff when the team is considering a decision to withhold or withdraw life-sustaining treatment.

Although withholding and withdrawing medical treatments from the seriously ill are not new, public debate over the appropriate use of life-sustaining treatment (LST) in seriously ill patients is at unprecedented levels, driven by multiple factors, including advances in medical technology, an aging population, ballooning healthcare costs, the increasing prevalence of life-threatening chronic disease, and more patients dying within healthcare institutions.

We will present a practical guide for clinicians who are faced with the prospect of withholding or withdrawing LST. We suggest clinicians approach these difficult and complex decisions in a systematic manner. We will review a set of specific questions that can aid the clinical team that is considering the withholding or withdrawing of LST. We will then use two common, but complex, cases to orient the learner to this decision-making framework. Finally, we will discuss using this framework as a basis for teaching ICU colleagues a practical and ethically sound approach to improve end-of-life decision-making in the ICU.
“I Walk with Her Every Day”: Parents’ Experiences of Pregnancy with a Lethal Fetal Diagnosis (TH316)

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Objectives
• Explain the gap in the literature that is filled by the Precious Pregnancy Study.
• State the three time periods of parent experiences with a lethal fetal diagnosis.
• Describe two key aspects of parent experiences with a lethal fetal diagnosis.

Perinatal palliative care is a growing field, although there is sparse literature about parents’ needs to inform care of families with lethal fetal diagnoses (LFD). In this session we will present the results and implications of the Precious Pregnancy Study, which significantly increases our knowledge about parents’ needs when continuing pregnancy with an LFD.

In an NINR-funded, qualitative, naturalistic study of 16 couples with LFDs, we interviewed mothers and their partners twice during pregnancy and twice after the birth and death of their baby, for a total of 60 interviews. Our aims were to understand their overall personal experiences with continuing pregnancy after an LFD and their experiences with and needs from healthcare providers.

Learning of a lethal condition during pregnancy causes a crisis in parents’ lives, with intense grief reactions, followed by a series of healthcare interactions, during which they learn and understand the diagnosis and plan and prepare for birth and death. Three time periods of pregnancy were identified: prediagnosis, learning the diagnosis, and living with the diagnosis. We will discuss how the parents’ experiences and needs changed through these three time periods.

We will describe their varied interactions with healthcare providers, and what they found helpful or unhelpful. Parents described the profound impact of ultrasounds, as a treasured moment with their baby and a conduit to understanding and making sense of the diagnosis. We will describe the ways they treasured their time with their baby, hoped for the best, parented their baby, and negotiated interactions with their family and social group.

Finally, we will present the implications of this study for healthcare providers, with practical suggestions for improving care.
Hospice Admissions for Cancer within the Last Three Days of Life: Independent Predictors and Implications for Quality Measures (TH317-A)

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Objectives

• Identify four patient characteristics associated with late admission to hospice among patients with cancer.
• Describe the importance of case-mix adjustment strategies for quality measures in end-of-life care.

Original Research Background: The National Quality Forum (NQF) and the American Society for Clinical Oncology (ASCO) have jointly endorsed quality measures for end-of-life care in cancer patients, including the proportion of hospice enrollments within the last 3 days of life. If late hospice enrollment is to be used as a quality measure, it is important to understand how patient characteristics influence performance.

Research Objectives: To define patient characteristics associated with hospice enrollment in the last 3 days of life and to describe adjusted proportions of patients with late referrals among patient subgroups that could be considered as case-mix adjustment variables for this quality measure.

Methods: Electronic health record–based retrospective cohort study of patients with cancer admitted to 12 hospices in the CHOICE network (Coalition of Hospices Organized to Investigate Comparative Effectiveness).

Results: Of 64,264 patients admitted to hospice with cancer, 10,460 (16.3%) had a length of stay ≤3 days. There was significant variation among hospices (range 11.4%-24.5%). In multivariable analysis, among patients referred to hospice, patients who enrolled in the last 3 days of life were more likely to have a hematologic malignancy, more likely to be male and married, and younger (age <65). Patients with Medicaid or self-insurance were less likely to be admitted to hospice within 3 days of death.

Conclusions: Quality measures of hospice lengths of stay should include case-mix adjustments for type of cancer and site of care. Patients with hematologic malignancies are at an especially increased risk for late admission to hospice.

Implications for Research, Policy, or Practice: As efforts to improve end-of-life care for patients with cancer continue, it will be essential to find ways to optimize transitions to hospice. The results of this study identify patient populations to target with education and outreach efforts. In addition, trustworthy quality measures tied to data and case mix adjustment strategies are critical for practice improvement.
Factors Associated with the Hospitalization of Patients Receiving Hospice Care (TH317-B)

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Objectives

• Understand the prevalence of hospitalization, ED visits, and ICU stays of Medicare beneficiaries who use hospice.
• Understand the patient-level and hospice-level factors associated with hospitalization, ED visits, and ICU stays of Medicare beneficiaries who use hospice.

Original Research Background: There is a growing body of evidence indicating that outcomes related to hospital utilization, including admission to the ICU and ED, are important characterizations of the quality of end-of-life care. Little is known, however, about the prevalence and correlates of hospitalization for individuals receiving hospice care.

Research Objectives: Estimate the prevalence and factors associated with hospitalization of hospice patients.

Methods: We conducted a longitudinal study of Medicare beneficiaries (N=149,814) newly enrolled in 591 hospices that responded to the National Hospice Survey (conducted September 2008 to November 2009) during the 3-month period following the hospice’s survey completion date. For each beneficiary, we obtained all Medicare claims from 1 year prior to hospice enrollment to death. We used multivariate logistic regression models to estimate the associations between patient and hospice factors and hospitalization, ED visits, and ICU stays.

Results: The proportion of beneficiaries hospitalized while receiving hospice care was 9.2%, with an average of 12.2 days spent in the hospital. The proportion of patients with ED visits was 7.8%, and 2.9% had a least 1 day in the ICU. In multivariate analyses, hospitalization was significantly higher for patients who were nonwhite (AOR, 1.54; 95% CI, 1.41, 1.64), had a noncancer diagnosis (AOR, 1.47; 95% CI, 1.39, 1.54), and who were cared for by a for-profit hospice (AOR, 1.86; 95% CI, 1.63, 2.11). There was also significant regional variation with the highest hospitalization rates in the South Atlantic and South Central regions. Results for the outcomes of ED visits and ICU stays were similar.

Conclusions: Medicare beneficiaries receiving hospice care demonstrate marked variation in hospital, ED, and ICU utilization.

Implications for Research, Policy, or Practice: Our results regarding hospice ownership and region are consistent with existing evidence of hospice practice variation and may warrant policy interventions. Our findings regarding race and diagnosis may assist hospices in identifying patients at increased risk of hospitalization.
Does Continuous Hospice Care Help Patients Remain at Home? (TH317-C)

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Objectives

- Describe patients who receive continuous care.
- Determine whether continuous care reduces the likelihood that patients will die in an inpatient unit or hospital.

Original Research Background: In the United States hospices sometimes provide high-intensity “continuous care” in patients’ homes. However little is known about the way that continuous care is used or what impact continuous care has on patient outcomes.

Research Objectives: To describe patients who receive continuous care and to determine whether continuous care reduces the likelihood that patients will die in an inpatient unit or hospital.

Methods: Patient data were extracted from the electronic medical records of 11 hospices in the CHOICE network (Coalition of Hospices Organized to Investigate Comparative Effectiveness). CHOICE is a research-focused collaborative of hospices that all use Suncoast Solutions Electronic Health Record (EHR) Software and which have agreed to share their data for research purposes.

Results: 99,687 (67.8%) patients were in a private home or nursing home on the day before death, and of these 10,140 (10.2%) received continuous care on the day before death. A propensity score-matched sample (N=24,658) included 8,524 patients who received continuous care and 16,134 patients who received routine care on the day before death. Using the two matched groups, patients who received continuous care on the day before death were significantly less likely to die in an inpatient hospice setting (350/8,524 vs 2,030/16,134; 4.1% vs 12.6%) (OR, 0.29; 0.27-0.34; p<0.001). When patients were cared for by a spouse, the use of continuous care was associated with a larger decrease in inpatient deaths (OR, 0.12; 0.09-0.16; p<0.001) compared with those patients cared for by other family members (OR, 0.37; 0.32-0.42; p<0.001).

Conclusions: Use of continuous care on the day before death is associated with a significant reduction in the use of inpatient care on the last day of life, particularly when patients are cared for by a spouse.

Implications for Research, Policy, or Practice: As hospice use continues to grow, it will be increasingly important that hospices define best practices in care.
Understanding Variation in Utilization of Hospice Inpatient Respite Care (TH317-D)

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Objectives
• Inform the hospice and palliative community about utilization of inpatient respite care (IRC) hospice services.
• Better understand characteristics of hospice providers who provide IRC services as well as those who do not provide any IRC services.

Original Research Background: Little is known about provision and utilization of inpatient respite care (IRC) by hospice providers and beneficiaries.

Research Objectives: To use claims data to analyze IRC utilization among hospice beneficiaries.

Methods: We used 2012 Medicare hospice claims to present descriptive analysis on IRC utilization.

Results: We found 3.5% (N=45,116) of hospice beneficiaries received at least one day of IRC in 2012. These beneficiaries had a total of 64,606 IRC stays associated with a total of 275,784 IRC days (IRC stay is defined as consecutive IRC days in the hospice claims). Among beneficiaries who had any IRC days, 77% had only one stay. The most common site of service for IRC was an inpatient hospice setting (34%), followed by skilled nursing facility (28%), LTC nursing facilities (18%), and hospitals (13%). The average length of stay for IRC was 4.3 days and varied by site of service (slightly shorter at inpatient hospitals compared to other settings). Sixty-two percent of IRC stays were 5 days; 5 days was also the mode and median.

Nearly 74% of hospice providers provided at least one IRC day in 2012. The average share of hospice days billed as IRC was 0.4%, but a small number of providers exceeded 2%. A higher proportion of older hospices provide IRC than younger hospices, and nearly all large hospices provide IRC compared to about a third of small hospices. A higher percentage of hospice providers in the Midwest and New England states provided IRC compared with hospice providers in the West or South.

Conclusion: There is variation in IRC utilization by LOS, site of service, and provision of IRC by provider characteristics.

Implications for Research, Policy, or Practice: Observed differences in utilization of IRC and provider characteristics may have implications regarding the availability of short-term inpatient relief for caregivers of hospice beneficiaries.
Disseminating Palliative Care Knowledge and Practice in Nursing Homes: Lessons from the Nursing Home Culture Change Movement (TH318-A)

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Objectives
• Describe the prevalence of palliative care and culture change practices in resource poor nursing homes.
• Contrast the presence of motivators and resources available for facilitating implementation of palliative care versus culture change practices in nursing homes.

Original Research Background: Resource-poor nursing homes (NHs) (ie, those that rely primarily on Medicaid funding) are less likely to implement innovative practices. However, in a 2009-2010 national survey we found some resource-poor NHs did implement higher levels of palliative care (PC) and/or culture change (CC) practice.

Research Objectives: To determine what factors enable resource-poor NHs to implement PC and/or CC practices.

Methods: In 2013 we conducted 16 qualitative telephone interviews with administrators of resource-poor NHs with differing levels of PC/CC practice implementation (per 2009-2010 survey): (a) low CC and PC, (b) low CC and high PC, (c) high CC and low PC, or (d) high CC and PC. Interviews began by asking about the types of PC or CC practices that had been implemented and then explored the strategies used to overcome barriers to implementation, including the resources and/or outside networks or groups that may have facilitated change. Interviews were coded and themes identified using a modified grounded theory approach.

Results: By 2013, most low CC NHs (in 2009-2010) had increased their implementation of CC practices, but low PC NHs had not increased their extent of PC practice. Administrators reported numerous facilitators of CC implementation but few for PC. To implement CC practices, administrators discussed receiving information, assistance, and motivation from outside entities such as state surveyors, culture change coalitions, and NH associations. In contrast, the few NHs who had implemented high levels of PC practices reported learning about PC primarily through their hospice provider.

Conclusions: Our results indicate that for innovative practices to be implemented in high Medicaid NHs, information and resources must be fairly ubiquitous.

Implications for Research, Policy, or Practice: Motivation, support, and informational resources from government entities, professional associations, and advocacy groups appear to be needed to encourage the widespread dissemination of PC in NHs.
Predictors of 6-Month Mortality Among Nursing Home Residents: Are Diagnoses More Predictive than Functional Disability? (TH318-B)

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Objectives

• Understand how diagnostic data can be used to predict mortality for patients upon hospital discharge.
• Understand how HELP index results can be used in care planning prior to and following hospital discharge.

Original Research Background: Functional deterioration is a predictor of 6-month mortality and is helpful for determining when patients are eligible for hospice based on a life expectancy of 6 months or less. However, in many care settings, functional data are not available. In this study we compare predictive accuracy of two indices designed to predict 6-month mortality among nursing home residents. One is based on traditional measures of functional deterioration and the other on patients’ diagnoses and demography.

Research Objectives: To create a mortality risk assessment tool for patients transitioning from a hospital to a nursing home.

Methods: We created the Hospice Eligibility Prediction (HELP) index by examining mortality of 140,699 Veterans Administration nursing home residents. For these nursing home residents, the available data on history of hospital admissions were divided into training (112,897 cases) and validation (27,832 cases) sets. The training data were used to estimate the parameters of the HELP index based on (1) diagnoses, (2) age on admission, and (3) number of diagnoses at admission. The validation data were used to assess the accuracy of predictions of the HELP index. The cross-validated accuracy of the HELP index was compared with the Barthel Index of functional ability obtained from 296,052 Veteran Administration nursing home residents. A Receiver Operating Characteristic curve was used to examine sensitivity and specificity of the predicted odds of mortality.

Results: The area under the curve (AUC) for the HELP Index was 0.838. This was significantly (alpha<0.01) higher than the AUC for the Barthel Index of 0.692.

Conclusions: For nursing home residents, comorbid diagnoses predict 6-month mortality more accurately than functional status. Implications for Research, Policy, or Practice: The HELP index can be used to estimate 6-month mortality from hospital data and can guide prognostic discussions prior to and following nursing home admission.
Predictors of Physical Restraint Use in Hospitalized Veterans at End of Life in the Acute Care Setting: An Analysis of Data from the BEACON Trial (TH318-C)

Elizabeth Kvale, MD, Birmingham VAMC, Birmingham, AL
F. Amos Bailey, MD FACP FAAHPM, Birmingham VAMC, Denver, CO
James Dionne-Odom, PhD RN, University of Alabama at Birmingham, Hoover, AL
David Redden, PhD, University of Alabama at Birmingham, Birmingham, AL
Kathryn Burgio, PhD, Birmingham VAMC, Birmingham, AL

Objectives

- Gain an understanding of the prevalence of restraint use in dying patients.
- Understand what patient characteristics and care processes place a patient at greater risk for being restrained at time of death.

Original Research Background: The use of physical restraints in dying patients should be limited to situations where patient death is unanticipated. Little is known about the prevalence or risk factors for restraint use at end of life.

Research Objectives: To determine the prevalence and predictors of physical restraint use at the time of death in hospitalized adults.


Setting/Participants: Data on the last seven days of life were abstracted from the medical records of 5,476 decedents from six Veterans Administration Medical Centers (VAMCs) in the southeast United States and from VA administrative databases.

Methods: Based on literature and expert clinical opinion, we prospectively identified potential risk factors for restraint use at the time of death from among all variables collected during the trial. Factors included location of death, medications given, nasogastric tube, intravenous (IV) fluids infusing, family presence at time of death, and receipt of a palliative care consultation. Generalized estimating equations, which account for correlation among patients within a site, were used to assess the relationship between each predictor and physical restraint use.

Results: Physical restraint use at time of death was documented in 890 decedents (16.3%). Restrained patients were more likely to have a nasogastric tube (OR, 2.30; p<.0001); and be receiving IV fluids (OR, 2.15, p<.0001), benzodiazepines (OR, 1.75; p<.0001), or antipsychotics (OR, 2.36; p<.0001). Use of restraints varied by location of death, with a higher risk associated with patients in intensive settings compared with decedents on medicine or surgery wards (OR, 1.7; p=0.006).

Conclusions: Factors associated with restraint use include therapies that may be disrupted by an agitated patient, care in intensive settings, and medications commonly used for delirium.

Implications for Research, Policy, or Practice: Further study should focus on interventions to reduce restraint use in dying patients.
Illness Trajectories Among Nursing Home Residents (TH318-D)

Cari Levy, MD, University of Colorado, Denver, CO
Janusz Wojtusiak, PhD, George Mason University, Fairfax, VA

Objectives

- Understand trajectories of illness among nursing home residents and how these differ from traditional trajectories in general populations.
- Understand how trajectories different comorbid conditions, independent of age.

Original Research Background: By 2020, 40% of all deaths in the United States are expected to occur in nursing homes. Trajectories of illness prior to death have traditionally been defined using four general patterns to include (a) sudden death, (b) a short period of decline, (c) long-term limitations with intermittent serious episodes, and (d) prolonged dwindling.

Research Objectives: The purpose of this study was to determine if these trajectories are observed among a cohort of nursing home residents.

Methods: Data for 324,435 residents of the Veterans Administration's (VA's) Community Living Centers (CLC) were extracted and analyzed within the VA Informatics and Computing Infrastructure. Data included diagnoses from 1,617,693 inpatient records; 145,575,072 outpatient visits; and 1,901,354 functional status evaluations given as the Minimum Dataset (MDS). The Barthel Index was constructed from MDS Data using nine ADLs (stair climbing was excluded). Diagnoses originally present as ICD-9 codes were converted to Charlson Comorbidity Categories (Deyo version).

Results: A total of 144 trajectories were analyzed for combinations of Charlson comorbidities and Barthel Index items. Daily likelihood ratios (probabilities) of ADL impairments were calculated for the 5-year period preceding MDS evaluation to form trajectories of decline over that period.

Four general patterns of trajectories were identified:
1. Steady decline—MI, dementia, renal failure, diabetes, peptic ulcer
2. Accelerated decline—observed in a unique trajectory for AIDS
3. Stable function—COPD, CVD, CHF, PVD
4. Overall decline with periods of recovery—metastatic cancer, rheumatologic disorders, liver disease, stroke

Conclusions: Trajectories of illness prior to death in this cohort of nursing home residents occurred in patterns distinct from those observed in other populations.

Implications for Research, Policy, or Practice: Given the lack of change in functional impairment prior to death for many common comorbid conditions, reliance on functional measures to aid in prognostication may not be sufficient.
“Are You My Mentor?” A Panel Discussion Featuring an All-Star Cast of AAHPM and HPNA Mentors and Mentees (TH319)

Rebecca Aslakson, MD PhD, Johns Hopkins Hospital, Baltimore, MD
Arif Kamal, MD, Duke Cancer Institute, Durham, NC
Laura Gelfman, MD, Mount Sinai Hospital, New York, NY
Polly Mazanec, PhD ACNP-BC FPCN, Cleveland Veterans Affairs Medical Center, Cleveland, OH
R. Sean Morrison, MD FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY
Betty Ferrell, PhD RN MA FAAN FPCN CHPN, City of Hope Medical Center, Duarte, CA
Joann N. Bodurtha, MD MPH FAAP FACMG, Johns Hopkins University, Baltimore, MD
Amy Abernethy, MD FAAHPM, Duke University Medical Center, Durham, NC
Thomas J. Smith, MD FAAHPM, Johns Hopkins Hospital, Baltimore, MD

Objectives
- Discuss the characteristics of a good (or perhaps well-intentioned but not so good) mentor and mentee.
- Identify potential mentors (and mentees) in your home environment and acquire skills beneficial in initiating and sustaining a mentor-mentee relationship.
- Discuss how mentoring enables one to better achieve academic, research, and personal goals.

Mentoring is paramount for a successful career in research and academia. Indeed, mentored individuals publish more and with greater frequency, demonstrate higher job satisfaction, and are more likely to mature into independent investigators. Moreover, successful mentors often shape successful mentees; a 1977 study showed that more than 50% of US Nobel Prize recipients had Nobel laureates for mentors. But what are the components of “good” mentoring and the characteristics of a “good” mentor for a research and academic medicine career? When you are looking for a mentor or a mentee, what questions should you be asking and how should you go about the process? Are there circumstances to avoid or embrace?

The initial speaker, Joann Bodurtha, will present evidence-based, expert-reviewed, and/or anecdotal data on what mentoring is, what makes for good (and bad) mentoring relationships, and how to approach finding a mentor. Also, as in good marriages, every good mentor-mentee relationship is successful in a unique way, and much can be learned from candid and honest discussion from exemplary mentor-mentee teams. Consequently, the bulk of the session will comprise a panel discussion with three all-star HPNA and AAHPM mentors—Amy Abernethy, Betty Ferrell, and R. Sean Morrison—paired with their mentees—Arif Kamal, Polly Mazanec, and Laura Gelfman. The panel members will each give a brief history of how their relationship started and evolved. Audience participation and questions will be an important part of the session. Demonstrating the importance of collaboration, the session will be moderated by the mentor-mentee pair of Thomas Smith and Rebecca Aslakson.
Payment Reform: A Key Ingredient in the Financial Case for Pediatric Palliative Care (TH320)

Stefan Friedrichsdorf, MD, Children’s Hospitals & Clinics, Minneapolis, MN
Sarah Friebert, MD FAAP FAAHPM, Akron Children’s Hospital, Akron, OH

Objectives
• Identify current and potential sources of revenue and reimbursement to support a pediatric palliative care program.
• Describe components of US healthcare reform that support a business model for pediatric palliative care.
• Review examples supporting pediatric palliative care as a strategy in an accountable care organization.

The majority of children at the end of life in the United States do not have access to designated pediatric palliative care (PPC) services. A key obstacle to implementing inpatient and outpatient/community-based PPC programs appears to be a lack of adequate reimbursement to make a financial case. This session reviews the current pillars of PPC reimbursement in the United States: fee-for-service (including the 2010 Concurrent Care for Children requirement), philanthropy, and institutional support. Looking into the future, through current payment reform, the fee-for-service model appears to be moving toward value-based or accountable care organization/bundled billing strategies. PPC can be a key health-system strategy in realigning healthcare delivery, as population health management includes seriously ill children (highest risk and highest cost). Emerging data will be reviewed to help participants make the case that the integration of PPC not only improves quality of life and symptom management during the end-of-life period for children but also lowers costs.
Strength in Diversity: Supporting an Inclusive Field (TH331)

Timothy Quill, MD FACP FAAHPM, University of Rochester Center of Experimental Learning, Rochester, NY
Tammie Quest, MD, Emory University, Atlanta, GA
Ann Broderick, MD MS, University of Iowa, Iowa City, IA
Kimberly Johnson, MD MHS, Duke University Medical Center, Durham, NC
Sean O’Mahony, MD MS, Rush University Medical Center, Chicago, IL
Vyjeyanthi Periyakoil, MD, VA Palo Alto Health Care System, Palo Alto, CA
Jorge Ramirez, MD FAAHPM, Ford Meade VAMC, Clancy, MT

Objectives
• Recognize the benefits of greater diversity and inclusion within the Academy and at member institutions.
• Identify common diversity-related gaps present within many organizations.
• Identify outreach strategies to engage underrepresented groups.

The AAHPM Diversity Advisory Group is actively engaged in developing a multiyear diversity strategy and plan. The ultimate goal is increased outreach, education, and engagement of a broader spectrum of members, resulting in improved and expanded care to patients and families who are too often underserved. During this 1-hour forum, participants will learn more about these diversity and inclusion efforts and the benefits of promoting greater diversity and inclusion within the Academy and at member institutions. Cultural, ethnic, gender, religious, sexual orientation, nationality, disability, and generational differences will be discussed.
The Project on Death in America: History, Impact, and Continuing Relevance (TH332)
David Clark, University of Glasgow, Scotland, UK

Objectives
- Foster a critical understanding of the history and contribution of the Project on Death in America (PDIA).
- Identify lessons and sources of inspiration from the PDIA that might be applied elsewhere.
- Consider how the PDIA legacy might make an impact in the current global context of palliative care.

From 1994 to 2003, the Project on Death in America (PDIA) played a prominent part in end-of-life-care innovations in the United States. The PDIA produced a wide range of novel activities that explored the meanings of death in American culture and highlighted experiences of care at the end of life. It led to extensive service development and practice innovations. It contributed to the evidence base for palliative care and the emergence of a new field of specialization. It addressed the needs of underserved communities at the end of life and barriers to improved care as well as legal and ethical challenges. The PDIA generated strategies for “transforming” the culture of end-of-life care by empowering individuals and communities promoting organizational change, encouraging research and educational activities, and supporting public debate together with the consideration of ethical issues.

The project occurred at a time of major philanthropic interest in end-of-life issues, so its impact is difficult to disentangle from that of other funders and initiatives. But it undoubtedly made a significant and enduring contribution to the improvement of end-of-life care in the United States. What can we learn from that impact? What is the enduring legacy of the PDIA? Are there lessons from the PDIA that can continue to inform the development of the palliative care field, not only in the United States but also further afield? Is the PDIA approach still a relevant resource for responding to the growing palliative care needs of countries around the world?
The Sunshine Act: What Every Physician Needs to Know (TH333)
Centers for Medicare and Medicaid Services Speaker Invited

Objectives

• Explain the intent and basic tenets of the Physician Payment Sunshine Act.
• Describe the reporting requirements as they relate to your practice and/or your institution.
• Identify where to access tools related to the Sunshine Act and how to monitor what is being reported.

The Physician Payments Sunshine Act requires that all manufacturers of drugs, devices, and biological and medical supplies covered by federal healthcare programs begin recording any physician payments that are worth more than $10. This includes stock options, research grants, gifts, meals, and consulting fees. The interactions between industry and physicians are published by the Centers for Medicare and Medicaid Services (CMS) starting September 2014.

There has been confusion about the Sunshine Act and its implications because of changes during the rulemaking process. It is important that physicians and those in teaching hospitals be able to navigate the changes and understand what is reported and how to monitor its accuracy.

A representative from CMS has been invited to provide an overview of the critical information you need to know about the Sunshine Act.
**PDIA Awards Presentation (TH334)**

Nancy Hutton, MD FAAP FAAHPM, AAHPM/PDIA Palliative Medicine National Leadership Award
Debra Oliver, PhD MSW, and David Oliver, PhD, AAHPM/PDIA Palliative Medicine Community Leadership Award
Verna Hendricks-Ferguson, PhD RN, HPNF PDIA Nursing Leadership Award in Palliative Care
SWHPN PDIA Career Achievement Award
Christine Ritchie, MD MSPH FACP FAAHPM, moderator

**Objectives**

- Recognize innovative educational approaches to end-of-life care directed by physicians, nurses, and social workers.
- Examine shared opportunities to advance the field of palliative care through education and mentoring junior leaders.

The Project on Death in America (PDIA) Awards recognize leaders who have made outstanding contributions to the field of hospice and palliative care. The awards are made possible through the generosity of a grant from the Open Society Institute's Project on Death in America. Over the course of 9 years, from 1994 to 2003, the PDIA created funding initiatives in professional and public education, the arts, research, clinical care, and public policy that transformed care for patients living with serious illnesses in the United States.

Four PDIA Awards will be presented: the AAHPM PDIA Palliative Medicine National Leadership Award, the AAHPM PDIA Palliative Medicine Community Leadership Award, the HPNF PDIA Nursing Leadership Award in Palliative Care, and the SWPHN PDIA Career Achievement Award.

Award recipients will participate in panel presentations on topics such as career trajectory, lessons learned, and take-away “pearls” for the attendees.
**Add Your Voice: Vetting the Entrustable Professional Activities for HPM Physicians (TH335)**

Michael David Barnett, MD, University of Alabama at Birmingham, Birmingham, AL  
Gary T. Buckholz, MD FAAHPM, University of California, San Diego, San Diego, CA  
Jillian Gustin, MD FAAHPM, Ohio State University Medical Center, Columbus, OH  
Jennifer M. Hwang, MD MHS, The Children’s Hospital of Philadelphia, Philadelphia, PA  
Lindy Landzaat, DO, University of Kansas, Kansas City, KS  
Stacie K. Levine, MD FAAHPM, University of Chicago, Chicago, IL  
Laura J. Morrison, MD FAAHPM, Yale University School of Medicine, New Haven, CT  
Tomasz Okon, MD, Marshfield Clinic, Marshfield, WI  
Steven Radwany, MD FAAHPM, Summa Health System/NEOMED, Akron, OH  
Holly Yang, MD FAAHPM FACP, Scripps Mercy Hospital, San Diego, CA

**Objectives**

- Discuss the progress of the AAHPM Entrustable Professional Activities (EPAs)/Curricular Milestones Workgroup.
- Review the latest working draft of HPM EPAs.
- Provide input through a structured vetting process on how your own experience as an HPM clinician and/or educator is reflected in the EPAs.

The AAHPM Entrustable Professional Activities (EPAs)/Curricular Milestones Workgroup is tasked with leading a consensus process to define these key educational components for our field. These two educational frameworks will combine to define the critical tasks, competencies, and assessment methods for the HPM physician's role in the future. This session will provide an update from the workgroup on this process and invite input from attendees on how their experience as HPM clinicians/educators is reflected in the drafted EPAs. After a brief overview and update, the majority of time will be spent in a vetting process, during which small groups will review specific EPAs and have the opportunity to respond to formative questions from the workgroup. Attendee responses will impact the content of the EPAs going forward. This session will be interactive and allow attendees a glimpse of the future list of HPM EPAs to be released in June 2015.
Making Your Measurement Matter: The AAHPM & HPNA Measuring What Matters Project (TH336)

David J. Casarett, MD MA, University of Pennsylvania Perelman School of Medicine, Philadelphia, PA
Sally A. Norton, PhD RN FAAN, University of Rochester School of Nursing, Rochester, NY
Sydney Morss Dy, MD MSc, Sidney Kimmel Comprehensive Cancer Center of Johns Hopkins, Baltimore, MD
Keela Herr, PhD RN AGSF FAAN, University of Iowa College of Nursing, Iowa City, IA
Joseph D. Rotella, MD MBA FAAHPM HMDC
Katherine Ast, MSW LCSW, American Academy of Hospice and Palliative Medicine, Chicago, IL
Dale Lupu, PhD, American Academy of Hospice and Palliative Medicine, Chicago, IL

Objectives

• Describe the rationale and methods for the development of the AAHPM & HPNA Measuring What Matters (MWM) portfolio of hospice and palliative care quality measures.

• Identify three potential examples of implementing the MWM measures, with emphasis on both benefits and challenges of implementation.

• Describe next steps in the MWM project, including partnering with key stakeholders to develop a strategy for advancing measurement opportunities in our field and aligning with other national quality initiatives.

Leaders of AAHPM and HPNA's Measuring What Matters (MWM) project will address how hospice and palliative care providers can integrate MWM's measures into their quality improvement programs and use MWM results to promote hospice and palliative care as part of system innovation.

Because few of the national quality programs fit easily with palliative care concerns and goals, palliative care practitioners have been challenged to find applicable quality measures that can be benchmarked nationally. In 2013 and 2014, AAHPM and HPNA jointly undertook a consensus project to create a portfolio of recommended performance measures suitable across all hospice and palliative care settings. The resulting MWM measures ideally would be adopted by hospice and palliative care programs, health systems, and payers to enable comparison of quality data across settings. This workshop will describe the rationale and methods for the development of MWM, identify examples of implementing the MWM measures with emphasis on both benefits and challenges of implementation, and describe next steps in the project, including partnering with key stakeholders to develop a strategy for advancing measurement opportunities in our field and aligning with other national quality initiatives.
Supportive Care Tumor Board: Implementation and Impact for the Care of Patients with Advanced Cancer (TH340)

Leslie Blackhall, MD, University of Virginia School of Medicine, Charlottesville, VA
Linda Duska, University of Virginia, Charlottesville, VA
Robert Goldstein, MD, University of Virginia, Charlottesville, VA
Margaret Barclay, MSN RN ACNP, University of Virginia, Charlottesville, VA

Objectives

- Recognize how to develop and implement a cancer center–wide supportive care tumor board to facilitate the concurrent management of patients with advanced cancer by oncologists and supportive care services.
- Recognize the ways multidisciplinary care can improve symptom management and be able to identify how specific techniques, from radiation oncology, anesthesia pain, and other interventions, can aid the medical management of pain and other symptoms.
- Discuss how to use a supportive care tumor board to help facilitate transitions of care across different settings, including from hospital to outpatient and from aggressive care to home hospice.

Patients with incurable malignancies have high symptom burdens and complex care needs. Integrating palliative care services into the care of these patients is an important goal of AAHPM and ASCO, but it may be difficult to accomplish. In standard oncology care, tumor boards are used for treatment planning, as oncologists and other specialists review clinical data and discuss options regarding treatment options for patients with various types of cancers. However, these patients and their families often face complex challenges that cannot be resolved by disease-specific therapies alone. These include difficult-to-control symptoms (pain, nausea, fatigue, depression, and anxiety); psychosocial issues, such as poor social support and substance abuse; and end-of-life decisions. Efforts to integrate palliative care into standard oncologic approaches often meet with challenges due to institutional culture, misunderstandings regarding the nature of palliative care, and difficulties with coordinating care. As part of a Centers for Medicare and Medicaid Services (CMS) grant to improve the care of patients with advanced cancer, we implemented a weekly supportive care tumor board (SCTB) to facilitate the concurrent care of symptomatic patients with incurable cancer. This conference brings together medical, surgical, radiation oncology, and palliative care clinicians; anesthesia pain specialists; social workers; pharmacists; chaplains; and nutritionists to develop plans of care to address concerns in a timely, interprofessional, and multidisciplinary manner. This session will describe the development and implementation of an SCTB and how it changed the culture of clinical care at our institution. We will present data regarding its impact on patients, including changes in frequency and timeliness of referral to palliative and other supportive care services, effects on symptom burden, and effects on health resource utilization. We will illustrate the examples of this model with in-depth case reports of how an SCTB was used in treatment planning and care coordination for specific complex cases.
Symptom Management of Advanced Parkinson's Disease (PD) (TH341)
Shobha Rao, MD, University of Texas Health Science Center at Houston, Sugar Land, TX

Objectives
• Recognize common symptoms of advanced Parkinson’s disease.
• Discuss palliative approaches and symptom management in patients with Parkinson’s disease.

Palliative care physicians should have a good understanding of Parkinson’s disease (PD) because of its increasing prevalence as the population ages. Treatment of PD is mainly palliative. PD is the second most common neurologic diagnosis in hospice, behind only Alzheimer’s disease. Palliative care physicians provide psychological, social, and spiritual support as they work toward improving overall quality of life among patients with PD. In patients with advanced PD, disabling motor fluctuations and dyskinesias can occur. Depression, dementia, and psychosis are also common psychiatric problems associated with advanced PD.

This presentation will discuss evidence-based palliative approaches to the management of advanced PD. Strategies to treat motor fluctuations include adding a DA; increasing the levodopa dosage and/or frequency; starting a catechol-O-methyl transferase inhibitor, such as entacapone; and adding a MAO-B inhibitor. Indications for referral to deep-brain stimulation are advanced disease with severe motor fluctuations, dyskinesia, or disabling tremors that are not responding to adequate drug therapy. PD psychosis is usually drug induced and can be managed initially by reducing antiparkinsonian medications. The judicious use of psychoactive agents may be necessary. It is important to assess for caregiver stress as patients develop significant physical disability and cognitive decline. Patients often develop worsening of swallowing problems. Dietary modifications, such as honey-thickened fluids, is helpful to increase feeding efficiency and reduce the risk of aspiration. Pain may be a problem in all stages of PD. Pain can be due to musculoskeletal, neuropathic, or psychosocial causes. Successful pain management strategies include evaluation of the type of pain, careful adjustment of antiparkinsonian medications, judicious use of pain medications, and adjuvant therapy as needed.
Family Matters—Dealing with DNA Legacies: Integrating Genetics, Genetic Counseling, and Hospice and Palliative Care (TH342)

Thomas Smith, MD FACP FASCO FAAHPM, Sidney Kimmel Comprehensive Cancer Center of Johns Hopkins, Baltimore, MD
Joann Bodurtha, MD MPH FAAP FACMG, Johns Hopkins University, Baltimore, MD
Nancy Hodgson, Johns Hopkins School of Nursing, Baltimore, MD
Jennifer Axilbund, MS, Sidney Kimmel Comprehensive Cancer Center of Johns Hopkins, Baltimore, MD

Objectives

• Describe the frequent occurrence of genetic issues at the end of life.
• Identify tools that can help one recognize genetic issues, refer for counseling, and suggest DNA banking or testing.
• Recognize practical ways to donate a body to science in most states.

Genetics, epigenetics, and genomics all play an increasingly recognized role in disease causation and progression. While upstream recognition of genetic-related serious illness is always preferable, an estimated 10% of patients dying in hospice or palliative care will have previously unrecognized genetic causes. The benefits of timely recognition and appropriate action—often right before the person dies—include offer of discussion about at least one the following: (a) saving appropriate DNA or other specimens from the person with the condition for future testing, before that opportunity is lost; (b) genetic counseling and testing for changes such as BRCA, Lynch syndrome, or cardiomyopathy; (c) counseling of the remaining family; or (d) being part of legacy or life review.

We will illustrate the possible actions to take with three cases: a 41-year-old woman presenting near death with advanced colon cancer; a 53-year-old man with congestive heart failure, three of whose four siblings have died from heart failure or had heart transplants; and a 55-year-old woman with dementia.

We will illustrate how to take an intentional family history with “SIDES” questions: Ask both maternal and paternal SIDEs questions:

• Anything SIMILAR in the family?
• Anything INHERITED through the family?
• Any premature, unexplained DEATHS?
• Any EXTRAORDINARY events or lab results?

We will illustrate how to document in EPIC, as an example of an EMR, and consider the pedigree. All participants will have a useable list of available resources for DNA banking and testing.

In addition, we will illustrate the growing options for patients to donate their bodies to science at no cost to them through clearinghouses, such as LifeQuest Anatomical, MedCure, and the national registry of Body Donation Programs in the United States.
Steering Into the Skid: Utilizing the Dramatic Arts to Educate and Increase Awareness of the Impact of Dementia on Families (TH343)

John Morris, MD FAAHPM, Four Seasons Hospice, Flat Rock, NC
Margaret Noel, MD, MemoryCare, Asheville, NC

Objectives

• Recognize the growing need for caregiver education and support for families dealing with Alzheimer’s disease and related dementias.
• Recognize the use of an art form to provide education on how dementia impacts caregivers.
• Describe a readily available, affordable pathway to publish and use creative works to enhance professional and community understanding of the impact of illness.

As Alzheimer’s disease and other types of dementia become increasingly prevalent, the dramatic arts can help provide needed insight and understanding into this looming societal challenge. This concurrent session will illustrate how the dramatic arts can be used to educate medical professionals and the wider community in a creative way about the impact of dementia on family relationships. The presenters will perform a staged reading of a well-crafted one act play, *Steering Into the Skid*, by Deborah Ann Percy and Arnold Johnston. The play was written in response to a call for one-act plays that dramatize the full complexity and richness of the caregiving relationship, including its challenges and rewards.

*Steering Into the Skid* focuses on Amanda and Tim, both in their 60s, and in 12 short scenes set in their SUV, traces a year in their life together, from New Year’s Day to New Year’s Eve. As the months pass, the changes wrought by Alzheimer’s disease force each character to adjust to new demands on their imperfect but loving marriage.

The presenters will then lead a discussion to highlight how the play illustrates issues of impaired insight, the subtle line between normal aging changes and mild cognitive impairment, transitioning to dependence, and the unique challenges in communication presented by dementia. They will also discuss readily available and affordable tools that can help participants use creative works to educate and raise awareness regarding serious illnesses in their communities.

Alzheimer’s disease and other dementias demand the inclusion of caregivers to develop any form of effective care plan. Understanding the need to employ resources to train, educate, and prepare a caregiver for the role ahead can make a profound difference in the quality of life experienced by both patient and family in the face of a devastating illness.
Palliative Care in the US and UK: Similar Challenges, Different Responses (TH344)

J. Brian Cassel, PhD, Virginia Commonwealth University, Richmond, VA
Jane E. Seymour, PhD MA RGN, University of Nottingham, Nottingham, United Kingdom

Objectives
- Recognize differences and similarities between US and UK palliative care practices and policies.
- Discuss incorporating lessons learned from US and UK successes and failures into your own work.

Delivering optimal, equitable care to people with palliative care needs is an international challenge. Many assume that there are more differences than similarities between the United States and the United Kingdom regarding palliative care. Two researchers, one from each country, spent 4-6 months in the other country to evaluate the challenges and accomplishments of palliative care in the two countries. Data sources included interviews with experts and practitioners, articles, and policy documents.

The clearest difference is in the funding of hospice care. Payers in the United States have established separate hospice benefits but largely force patients and physicians to forego disease-focused care to access hospice. There is no “mutual exclusivity” provision in the United Kingdom. However, while almost all health services in the United Kingdom are funded and provided by the National Health Services, this is not true of hospice care, which continues to be funded and provided disproportionately by charities.

Overarching challenges today in both countries are taking palliative care into the mainstream and increasing access across a variety of settings. In the United Kingdom, this is being addressed through centralized policies and creating a funding mechanism for palliative care. In the United States, this is being addressed by the proliferation of outpatient palliative care services and experiments to offer hospice care concurrently with disease-focused care.

Hospital-based palliative care in the two countries is similar, but there are differences in what is provided in community-based settings, including long term-care facilities and family homes. Adapting existing models of palliative care to meet the needs of patients with multiple morbidities and frailty is required in both countries.

Despite fundamental differences in the financing and ownership of health care in the two countries, many policies, practices, and challenges for palliative care are comparable. Lessons learned can be applied not just in these two countries but for many others as well.
Lights! Camera! Feedback! Video-Based Coaching to Improve Teaching and Communication Skills (TH345)

Stephanie Harman, MD, Stanford Palliative Care, Stanford, CA
Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA
Elise Carey, MD FAAHPM, Mayo Clinic Rochester, Rochester, MN

Objectives
• Analyze a brief simulated coaching session that integrates video of the learner asynchronously.
• Describe an organized approach to receiving feedback on one’s teaching and communication skills using the Douglas Stone and Sheila Heen model.

Feedback is an essential part of the learning cycle at all stages of development for clinicians and academicians. Unfortunately, for most of us direct observation and formative feedback of our clinical work or teaching rarely occurs after our training is complete. This limits our ability to continuously improve our skills as we progress through our careers. Instead our skills can stagnate, and we are at risk of getting stuck in old habits, whether or not they are the most effective.

Time—and the cost of that time—is one of the major challenges in obtaining feedback on directly observed teaching and clinical encounters. Arranging for a colleague or mentor to observe one’s teaching or clinical work means that he or she must take time out of his or her busy day to come where you are and watch you. After that, you must designate a meeting time to discuss his or her observations and receive the feedback. And that is only stage one! Upon receiving feedback, one must decide how to integrate it, considering how it aligns with one’s self-assessment and, consequently, whether one wants to change. While there are many models to give feedback, far fewer exist on how to receive feedback.

In this workshop, we will discuss solutions to all of these barriers: How can we have people we respect and trust observe us and give us feedback? And how do we integrate that feedback into our ongoing work and professional growth? To achieve this, we will first discuss Web-based models for coaching and obtaining feedback. These models have been used to give frequent, rapid-cycle feedback to teachers. Second, we will present a model by Douglas Stone and Sheila Heen from the Harvard Law/Negotiation Project on how to seek and receive feedback.
To Begin at the Beginning: Determining Priorities for Pediatric Palliative Care Fast Facts with a Modified Delphi Study (TH346-A)

Michelle Freeman, MD, Penn State Hershey Medical Center, Hummelstown, PA

Objectives

• Describe the primary purpose of the modified Delphi technique in medical education research.
• Discuss the Fast Fact topics that pediatric palliative care physicians and pediatric residency program directors agree are most important for the education of pediatric interns.

Original Research Background: Palliative care Fast Facts—a collection of concise educational summaries on palliative care topics—enhance knowledge of internal medicine residents. There is no existing database of pediatric palliative care Fast Facts and no agreement on the core topics for which these summaries are needed.

Research Objectives: To determine the core topics for pediatric palliative care Fast Facts for the pediatric intern.

Methods: This study employed a modified Delphi technique—a multistage survey aimed at achieving agreement among a group of experts on an issue where none previously existed. We surveyed expert pediatric palliative care physicians and expert pediatric residency program directors to reach consensus on the highest yield topics for pediatric Fast Facts for the pediatric intern. In the first round survey, experts rated (1-5 Likert scale) a list of 93 pediatric palliative care topics identified via literature review to indicate the top Fast Facts that should be written for the pediatric intern and suggested additional topics. Topics were categorized according to criteria for consensus acceptance (mean rating ≥4), consensus rejection (mean rating ≤2), or equivocal (no consensus). The second round survey included the equivocal topics plus expert-identified topics from the first survey.

Results: 24 of 25 invited experts participated in the study with 75% and 96% response rates in the first and second surveys, respectively. Twenty-two of 93 topics met consensus for acceptance into the top Fast Facts on the first survey. Six additional topics met consensus for acceptance in the second survey.

Conclusions: This study identifies 28 Fast Fact topics that expert pediatric palliative care physicians and pediatric residency program directors agree are most important for the education of pediatric interns.

Implications for Research, Policy, or Practice: This study identifies the pediatric palliative care Fast Facts that should be written for pediatric interns as well as the content of a potential pediatric palliative care curriculum for pediatric interns.
Regoaling Over Time Among Parents of Children with Serious Illness: A Prospective Cohort Study (TH346-B)

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Objectives

- Describe prominent good parent beliefs among parents of children with serious illness.
- Describe the “regoaling” model of psychological adaptation to adversity and how this model is relevant to the good parent beliefs data and to palliative care practice.

Original Research Background: Parents’ beliefs about what they need to do to be a good parent when their children are seriously ill influence their medical decisions, and better understanding of how these beliefs change over time may improve decision support.

Research Objectives: To assess changes in parents’ perceptions regarding the relative importance of 12 good parent attributes during 12 months of follow-up.

Methods: Prospective cohort study, with baseline discrete choice experiment in a sample of 200 parents of children with serious illness treated at a children's hospital, and follow-up at 4, 8, 12, and 16 months, assessing whether parents had changed their beliefs about what they felt they needed to do to be a good parent for their child.

Results: At the baseline interview, the top ranking good parent attribute was “Making sure that my child feels loved,” followed by “Focusing on my child’s health,” “Making informed medical decisions,” and “Advocating for my child.” During the study 24 children died. By the 4-month follow-up, 40% of parents reported having a new goal among their top five goals, while 19% reported changing the order of their top five goals. During the interval from the prior assessment to 8-month follow-up, 27% reported new goals and 19% a new order; for the 12-month follow-up, 26% reported new goals and 24% a new order. Cumulatively, during the first 12 months of follow-up, 50% of parents reported new goals and 22% a different order of importance, while 28% of parents had not changed their beliefs about what the most important goals were for themselves.

Conclusions: Most parents of children with serious illness substantially change their beliefs of what they need to do to be a good parent over time.

Implications for Research, Policy, or Practice: Decision support for parents of children with serious illness should anticipate and accommodate shifting individual beliefs about being a good parent over time.
Evaluating Supportive Care for Children with Cancer: A Multi-Institutional Survey Study of Pediatric Oncology Patients and Parents (TH346-C)

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Objectives

• Discuss effective strategies and challenges for the delivery of early palliative care in pediatric oncology.
• Discuss parent/patient attitudes toward symptom burden and management and early palliative care integration from the time of diagnosis in pediatric oncology.

Original Research Background: Based on strong recent evidence, clinical consensus touts early palliative care (PC) integration in oncology as the optimal care model; however, PC remains underutilized in pediatric oncology (ped-onc), and little is known regarding patient and family attitudes toward early PC.

Research Objectives: We conducted a multi-institutional study of ped-onc patients and parents to determine perception of symptom burden and management early in treatment and assess views on early integration of PC.

Methods: Novel survey tools were developed using validated formats, when available. After IRB approval and pretesting, surveys were administered to 130 patient/parent dyads at three sites (NIH, JH, SJCRH). Eligibility criteria included patient age 10-17 at diagnosis, diagnosis date >1 month and <1 year, and English speaking. Preliminary analysis at 75% accrual was assessed for trends in response content frequencies, percentages, and degree of concordance between parent and child.

Results: Most children/parents (55%/49%) stated they would want to meet with PC around the time of diagnosis with only 2% of children and 6% of parents opposed. Seventy-nine percent of children/parents rated current quality of life (QoL) as good to excellent; 82%/84% considered QoL “somewhat important” or “very important” in decision making, yet 68%/83% prioritized cure over QoL when making treatment choices. Both anticipated improved health (96%) and elevated chance of cure (78%/86%) despite 13% of participants not evaluating expectations with their providers. Of parents whose perception of their child’s suffering from pain lacked concordance with that of their child (72.2%), 43.6% underestimated suffering and 58.7% overestimated their pain control; of those discordant with regard to nausea/vomiting (74.7%), 59.3% underestimated severity and 60.87% overestimated symptom control.

Conclusions: Interim analysis reveals tentative trends that suggest that early integration of PC would be welcomed by the majority of ped-onc patients and families and would likely improve overall care.

Implications for Research, Policy, or Practice: Our findings encourage improved care through early integration of PC in ped-onc and beyond.
Parent Outlook Regarding Their Child's Potential Health Outcomes During the Hematopoietic Stem Cell Transplant (HSCT) Course (TH346-D)

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Objectives
• Describe patterns of parent outlook regarding potential child health outcomes (future health and mortality) at baseline through 12 months post HSCT.
• Delineate factors associated with changes in parent outlook regarding potential child health outcomes during the first 45 days of HSCT.

Original Research Background: Hematopoietic stem cell transplant (HSCT) affords potential cure for some life-threatening conditions, but for families embarking on this intensive, high-risk therapy, their child’s outcome is uncertain. Parent outlook regarding potential child health outcomes during HSCT is unexplored.

Research Objectives: To evaluate parent outlook regarding child health and mortality during HSCT using data from two longitudinal health-related quality of life (HRQL) studies.

Methods: Parents of children undergoing HSCT (n=363) at eight US transplant centers completed the Child Health Ratings Inventories (CHRIs) measuring parent and child general health and HRQL at baseline (BL) through 12 months post HSCT. Main outcomes were responses to two CHRIs items developed to assess parent outlook regarding potential child outcomes, “might die” and “future health worse,” rated on a 5-point Likert scale ranging from worrying about the outcome none to all of the time, and transformed to 0-100 (higher, more worry). Analyses focus on BL to day +45 when improvement in parent outlook was pronounced. Clinical data were abstracted from charts. Personal, clinical, and HSCT course characteristics with p<0.2 on univariate analysis were entered into adjusted multivariable models, then eliminated by backward selection (p<0.1).

Results: Parents were 83% female, 77% white, mean age 38.6 years (SD=7.5). Child mean age was 9.6 years (SD=5.1). Most (72%) had cancer; 78% underwent allogeneic HSCT. By day +45, 33% had systemic infection, 33% acute graft versus host disease, and 20% intermediate/poor Bearman toxicity score. Mean parent “might die” worry decreased from BL (41.9, SD=8.3) to day +45 (26.6, SD=24.6, p<0.001). “Health worse” worry similarly decreased. For both outcomes, identified risk factors for ongoing parent worry at day +45 include younger child age (p=0.03) and malignancy (p<0.001) but not actual clinical outcomes.

Conclusions: Some parents remain at risk for unmitigated worry about their child’s health, largely irrespective of the HSCT course.

Implications for Research, Policy, or Practice: Enhanced clinician awareness of parent outlook and augmented support may benefit parents during HSCT.
Derivation and Validation of a Risk Model for Emergency Department Palliative Care Needs Assessment Using the Screen for Palliative and End-of-Life Care Needs in the Emergency Department (SPEED) (TH347-A)

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Objectives
• Identify a risk model.
• Recall predictors of needing a palliative care consult.

Original Research Background: A key setting for the provision of palliative care is the emergency department (ED), where important decisions regarding patient treatment and next site of care are determined. One barrier to the provision of palliative care in the ED is identifying patients who would benefit from a palliative care consult.

Research Objectives: To derive and validate a risk model to predict a palliative care event (PCE; palliative care consult, discharge to hospice, or in-hospital death) for cancer patients with an ED visit and subsequent hospital admission using data available upon arrival, including the five-question Screen for Palliative and End of Life Care Needs in the Emergency Department (SPEED).

Methods: We performed a retrospective derivation and temporal validation of a risk model for a palliative care event among cancer patients with an ED visit and subsequent hospital admission using data available upon arrival, including data from the SPEED tool. We developed a multivariate logistic regression model to predict PCEs. We assessed model performance using a receiver operating characteristic curve and visual inspection of quintile plots.

Results: Eleven factors were identified as predictive of a PCE, including SPEED score, proxy SPEED informer, age, EMS arrival, emergent or immediate ED acuity, the number of ED visits within the last 90 days, metastatic cancer, cardiac arrhythmias, coagulopathy, depression, and weight loss. In validation the risk model had an area under the curve of 0.72, and calibration showed an underestimation of risk in the second and third quintiles.

Conclusions: A risk model based on SPEED score has been successfully derived but needs a larger dataset for additional validation.

Implications for Research, Policy, or Practice: If the predictive ability of the model is confirmed, a risk model can efficiently identify cancer patients arriving to the ED who may benefit from early initiation of a palliative care consult.
Examining Emergency Room and Observational Stay Visits During Medicare Hospice Election (TH347-B)

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Objectives

- Understand the prevalence of emergency room and observational stay utilization during Medicare hospice election.
- Describe provider characteristics associated with high rates of emergency room and observation stay utilization during Medicare hospice election.

Original Research Background: Patients enrolled in the Medicare hospice benefit may occasionally use emergency room (ER) and observational stay (OV) services during a hospice election. Little is known about the extent and reasons behind use of these services.

Research Objectives: To examine the frequency and reasons why ER and OV visits occur during hospice elections.

Methods: We used Medicare hospice, Part A, and Part B claims to analyze the research question.

Results: We identified a cohort of 999,711 hospice enrollment periods with admission dates in 2010; of these, 64,239 enrollments (8.8% of the cohort total) were associated with 87,720 total ER/OV visits on days in which the beneficiary elected the hospice benefit. OV visits were a relatively small fraction of observed visits (2,225 visits were OV-only visits and 3,990 were both OV followed by an ER admission). Medicare was collectively billed $268.4 million for these visits, of which $189.4 million (70% of total) was attributable to inpatient ER payments. The most frequently appearing ER diagnostic resource group (DRG) category was septicemia/severe sepsis (1,460 visits, or 5.8% of total; associated with $15.8 million in ER payments), followed by kidney and urinary tract infections (947 ER visits) and hip and femur procedures (795 ER visits). ER/OV visit rates were higher in recently certified hospices (13.1 visits per 100 hospice enrollments in hospices certified 2005-2010 vs 7.3 visits per 100 enrollments in hospices certified in the 1980s; AIRR, 1.37; 95% CI, 1.32-1.41).

Conclusions: Only a small percentage of hospice enrollment periods had an ER or OV visit. ER visits occurred for a variety of reasons and weren’t clustered on a particular DRG.

Implications for Research, Policy, or Practice: While ER and OV visits are rare, Medicare pays a substantial amount for these services. We recommend ongoing data analysis, oversight, and monitoring to ensure that covered hospice services are not inappropriately billed to nonhospice parts of Medicare.
Randomized Controlled Trial of ED-Triggered Palliative Care in Patients with Metastatic Solid Tumors (TH347-C)

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Objectives

- Describe the methods of this randomized controlled trial of palliative care in the ED.
- Understand the difference between the significant and nonsignificant results from the trial.

Original Research Background: The delivery of palliative care is not standard of care in most EDs. Preliminary data suggest that early palliative care consultation can decrease hospital length of stay and costs for select patients with advanced illness and may extend life.

Research Objectives: To compare quality of life, depression, healthcare utilization, and survival for ED patients with advanced cancer randomized to ED-initiated palliative care consultation versus care as usual.

Methods: Randomized controlled trial of ED-initiated palliative care consultation for patients with solid metastatic tumors versus usual care. Adult patients with solid metastatic tumors who were able to pass a cognitive screen, had never been seen by palliative care, spoke English or Spanish, and presented to the ED from June 2011-March 2014 met eligibility criteria; eligible patients were approached and enrolled in the ED and randomized via balanced block randomization. Intervention patients received a comprehensive palliative care consultation by the inpatient team.

Results: 134 patients were enrolled and randomized. The intervention group received palliative care consultation 92% of the time, compared with 17% in the control group. Quality of life, as measured by a change in FACT-G score from enrollment to 6 weeks, was significantly higher in patients randomized to the intervention group, who demonstrated an increase of 9.2 points, compared with only 2.7 in controls (p<0.05). Median survival was longer in the intervention group—280 days versus 114 days in controls—but this did not reach statistical significance in the Kaplan-Meier analysis. The number of ICU stays at 180 days was 0.10 in the intervention group, compared with 0.08 in control; discharge to hospice within 180 days occurred in 24% of intervention patients and 20% of controls.

Conclusions: ED-initiated palliative care consultation in advanced cancer improves quality of life in patients with advanced cancer. More research needs to be done to evaluate the impact on healthcare utilization and survival.
Identifying Common Screening Criteria or “Triggers” for Palliative Care Consultation: A Systematic Review (TH347-D)

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Objectives

• List at least three common screening criteria for palliative care consultation in the acute care setting.
• Discuss the diversity among palliative care referral criteria in the acute care setting.

Systematic Review Background: Experts and professional societies in both palliative care (PC) and critical care have developed strategies aimed at improving the implementation of PC in the acute care setting. A recent focus of these groups is on the development of clinical screening criteria, or “triggers,” alerting clinicians to the palliative care needs of hospitalized patients. While many publications recommend tailoring screening criteria to individual acute care settings, common or foundational screening criteria for universal adoption have not been described.

Aims: The aim of this systematic review is to identify common screening criteria for palliative care consultation in the acute care setting.

Methods/Session Descriptions: CINAHL, The Cochrane Library, PsychINFO, SocINDEX, Web of Science, and PubMed databases were searched using terms “screening criteria,” “triggers,” “palliative care,” and “acute care.” Two reviewers independently conducted searches, selected articles, and extracted data. Each stage was discussed until consensus was reached. A third reviewer was available if consensus was not achieved. Investigators included (a) articles with specific triggers or screening criteria for palliative care, (b) articles focused on the acute care setting, (c) studies of adults (aged 18 and older), and (d) publications in English from 1995-2014. The search strategy yielded 1,878 references, of which 10 articles were analyzed.

Conclusion: Various screening criteria as well as methods to generate and evaluate criteria for PC consultation were reported in the literature, however some common themes were identified including length of hospitalization and mechanical ventilation, neurological status, age in conjunction with comorbidities, multisystem organ failure, and stage-IV malignancy. The identification of common screening criteria for PC consultation may serve as a foundation for clinicians aiming to develop or advance the presence of PC in rural, community, and academic hospital acute care settings. Further research is needed in determining universal or appropriate screening criteria for PC consultation in the adult acute care setting.
Hidden in Plain Sight: Palliative Care for Undocumented Immigrants (TH348)
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Objectives
• Describe three unique barriers that undocumented immigrants face when they are diagnosed with a serious illness.
• Identify successful strategies for increasing access to hospice and palliative care services for undocumented immigrants.
• Discuss how to anticipate common concerns and requests made by undocumented immigrants who are approaching the end of life.

Currently more than 11 million undocumented immigrants live in the United States. Although they are able to receive emergency and some primary care services, undocumented and recent immigrants are unable to purchase health insurance and cannot access Medicaid or Medicare benefits, including hospice. Patient concerns regarding their immigration status and economic, cultural, and linguistic barriers may further limit access to medical care. Therefore, undocumented immigrants may only seek care when they develop refractory symptoms of advanced illness. In caring for recent or undocumented immigrants, palliative care providers often have to address a wide range of cultural, economic, linguistic, legal, and ethical challenges. In this session, an interdisciplinary team of presenters will illustrate these challenges and describe how each member of the interdisciplinary team can help to address them. We will provide practical suggestions for eliciting undocumented immigrants’ unique concerns and facilitating access to critical services. Through case examples, we will demonstrate how to address common end-of-life concerns, including repatriation to countries of origin and/or facilitating contact with family members living abroad; how to provide care to immigrants who are marginally housed or have limited caregiver support; and how to obtain palliative and hospice care for these patients. Presenters from different geographic regions will address state-specific barriers to quality end-of-life care and provide successful strategies for overcoming them. We will also discuss the unique losses and sense of isolation experienced by undocumented immigrants, as well as the ethical dilemmas faced by the providers who care for them.
The Practice of Palliative Medicine in Developing Countries—Part One (FR400)

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Ganesh Dangal, MD, Kathmandu Model Hospital, Kathmandu, Nepal

Objectives

- Learn how physicians in specific countries provide palliative care to their patient populations often with limited resources
- Understand 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.
Training Fellows to Be Leaders: Ensuring the Future of Palliative Care (FR401)

Jennifer Kapo, MD, Yale University, Bethany, CT
Elise Carey, MD FAAHPM, Mayo Clinic, Rochester, MN
Vyjeyanthi Periyakoil, MD, Stanford University, Palo Alto, CA
Jane deLima Thomas, MD FAAHPM, Dana-Farber Cancer Institute, Boston, MA
Laura Morrison, MD, Yale University, New Haven, CT

Objectives

• Define essential leadership skills that every successful palliative medicine faculty member needs upon leaving training.
• Describe manageable and effective strategies for integrating leadership content into fellowship training.
• Discuss challenges for teaching this content and reflect on strategies for incorporating leadership training content into participants’ own educational programs.

As the field of palliative medicine expands and evolves, the need to develop strong and effective interdisciplinary leaders to direct clinical, research, and educational programs is essential. Junior faculty members are frequently asked to head programs within years of training, often before they have benefited from experiences that help them gain leadership skills. Although many individuals who are currently leading palliative care programs have benefited from formal leadership skills training by participating in the AAHPM LEAD program and the Macy Foundation as part of their early career paths, many more have not had the opportunity to receive this training. Ideally this training would be initiated during residency and fellowship programs to maximize the development of a mature skill set before physicians and nurses are asked to lead institutional programs. During this interactive program, four experienced palliative medicine leaders who have benefited from leadership training through the AAHPM LEAD program will describe the leadership skills training content and methods they have found to be personally effective as well as strategies they have successfully implemented into their programs. Key topic areas will include addressing interdisciplinary team dynamics, optimizing team health, skillfully resolving conflict, developing skills in negotiation, fostering effective mentor-mentee relationships, and self-care. Participants will have the opportunity to interact in the large group to share ideas and challenges with each other. Materials used to teach these skills will also be distributed to allow participants to incorporate them into their curricula. At the end of the session, participants can reflect individually and together on strategies for translating this content into an action plan to incorporate and expand individual and programmatic strategies for effective leadership.
Law and (Getting Things in) Order: How to Effectively Bring Lawyers into the Palliative Care Team (FR402)

Arif Kamal, MD, Duke Cancer Institute, Durham, NC
Chrissy Liu, JD, Seattle Cancer Care Alliance, Seattle, WA
Richard Bain, MD FAAHPM, Duke Medical Center, Durham, NC
Tomas Bednar, JD MA, Legal Clinic for the Disabled, Inc., Philadelphia, PA
Jodi Schur, JD, Chapel Hill, NC

Objectives

• Describe three types of collaborations with palliative care clinicians and attorneys.
• Recognize strategies to start a medical-legal team or collaboration at their own institution, based on examples from national experts.

Partnerships between legal professionals and clinicians are growing rapidly to meet the legal needs of patients with serious and advanced illness. Three prevailing models exist for collaborative care to address medical-legal needs. These include medical-legal programs (MLPs), consultation services, and ad hoc use of hotlines. In the MLP model, attorneys provide on-site legal assistance to address a variety of needs, ranging from advance care planning through financial distress to guardianship and custody issues. In consultative approaches, legal professionals may regularly meet with palliative care teams during interdisciplinary meetings or offer support through a co-rounding model. In addition, and also quite valuable, is engagement of legal services when certain needs are identified, either through community resources, hotlines, or one-to-one consultations. These alliances can be extremely valuable in complex medical cases and for those with serious illnesses, where palliative care clinicians themselves could benefit from an extra layer of legal support.

In this concurrent session, we will introduce the principles of medical-legal partnerships utilizing a team of palliative care and legal experts, including three attorneys representing academic and community organizations. Using case studies of actual patients, we will highlight typical legal needs of patients with complex illnesses and various ways for lawyers to become engaged members of the healthcare delivery team. We will introduce a legal screener tool, developed as a way to triage potential legal needs. We will then describe three different and unique medical legal partnerships from across the country that address the needs of cancer and HIV/AIDS patients. Lastly, we will provide audience members with lessons learned and tools to find local legal resources, engage community attorneys as part of the palliative care team, and establish a medical-legal program when ready.
Passing the Last Torch: Pharmaceutical Transitions at the End of Life (FR403)

Kathryn Walker, PharmD, University of Maryland School of Pharmacy and MedStar Health, Baltimore, MD
Mary Lynn McPherson, PharmD BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD

Objectives

• Describe symptoms commonly experienced by patients nearing the end of life and medications frequently used to control these symptoms.
• Describe specific medication considerations in patients who will be transitioning from an acute-care facility to home-based hospice care.
• Determine which medications are related to terminal and related conditions and must be provided by the hospice.

Patients nearing death have critically sensitive medication management issues, which must be managed seamlessly when transitioning care from inpatient to home, or “passing the torch.” Despite having similar goals of care, palliative care and hospice teams can work independently, often causing discord and confusion for patients and families. Common problems include selection of medications for symptom management that are not on the hospice formulary, inconvenience for the patient and family (e., parenteral), and/or continuation of nonessential medications. The optimal situation would be for both teams to work together hand-in-hand to ensure optimal drug therapy outcomes.

This program will illustrate the importance of selecting effective medications that are titrated under close supervision in the hospital and communicating that plan of care to allow for a smooth transition. Medications and selected routes of administration should be maximally convenient for patients and families and selected with consideration of the hospice formulary and cost-effectiveness. When transitions in care are not meticulously planned, patients suffer and practitioners often need to make amends as their first action step. Participants will leave this session with a firm action plan for implementing change in their own practice and a heightened sensitivity for issues faced by clinicians, patients, and families on both sides of the transition.
Understanding Death with Dignity Legislation: A Necessity for the Palliative Care Provider (FR404)

Frances DeRook, MD FACC, University of Washington, Seattle, WA
Stephen Kerner, DO CMD, Peace Health, Oregon Health & Science University, Portland, OR

Objectives

• Recognize the legal option of physician-assisted death and be able to describe the steps in the process and how it differs from assisted suicide and euthanasia, for which it is often confused by the public and healthcare providers.

• Recognize and describe the use of the Death with Dignity Act in Oregon and Washington, including number and demographics of participants, where death occurred, use of hospice and the most common patient-given reasons for use of the law.

• Describe the impact the legal option of physician-assisted death has had on the field of palliative care.

Oregon enacted the Death with Dignity Act in 1997; Washington passed an equivalent law in 2008 that went into effect in March 2009. Strict guidelines are published in both states to ensure compliance with the laws. Eligible patients must be adults, residents of the state, able to make and communicate informed healthcare decisions, and have a terminal illness that—in the judgment of two physicians—will result in death within 6 months. Patients must make voluntary oral and then written requests. Extensive documentation is required and collected by state agencies and compiled into annual reports. The collective 21 years’ experience in these two states confirms that, while rarely used, the laws function as intended, providing autonomy and comfort at the end of life to those with a terminal illness who seek this option. There has been no evidence of the “slippery slope” of abuse. To the contrary, there are data that legalizing physician-assisted death has resulted in improvements in end-of-life care. Similar legislation was enacted in Vermont in 2013, and in Montana the state Supreme Court ruled in favor of physician-assisted death. In early 2014, a court decision confirmed that New Mexico doctors can help terminal patients die. Given these developments and that Death with Dignity legislation is presently under consideration in at least seven other states, this is an increasingly important topic for palliative care providers who need to be prepared to answer questions from their patients.
Objectives

- Discuss PC-FACS processes and “vital statistics.”
- Discuss implications of cutting-edge research of clinical value to AAHPM members.

PC-FACS (Fast Article Critical Summaries for Clinicians in Palliative Care), one of the highest-rated member benefits of AAHPM, offers busy clinicians an efficient way to stay on top of pertinent literature in a rapidly evolving field. In its 10th year, PC-FACS provides electronic summaries of just-published research from more than 100 non-hospice and palliative care journals that might not otherwise be regularly reviewed by our readership. Editorial Board members, peer experts selected from the Academy membership, write succinct, thought-provoking commentaries that have practical implications for practice and for the field as a whole. Monthly issues offer commentaries on topics including basic science; bioethics, humanities, and spirituality; geriatrics and care transitions; hospice, hospice and palliative medicine interface, and regulatory issues; pediatrics; psychosocial issues; and symptom assessment and management. PC-FACS also offers special issues that provide more in-depth coverage of timely topics. In this session, Editor-in-Chief Donna Zhukovsky and Associate Editor-in-Chief Mellar Davis will provide an inside line to PC-FACS processes and an overview of content reviewed during the past year. Using a variety of media and interactive techniques, they will then take session participants on a whirlwind tour of some of the most exciting topics reviewed during the past year.
Home Is Where the Care Is: Bringing Palliative Care Expertise into the Community (FR411)

Meng Zhang, MD, Mount Sinai Visiting Doctors Program, New York, NY
Thomas Cornwell, MD, Cadence Health Care System, Wheaton, IL
Deanna Bower, DO, Housecall Providers, Portland, OR
Brook Calton, MD, University of California, San Francisco, San Francisco, CA
Ania Wajnberg, MD, Icahn School of Medicine at Mount Sinai, New York, NY
Elizabeth McCormick, MD, Icahn School of Medicine at Mount Sinai, New York, NY

Objectives

• Discuss the literature and evidence regarding home-based primary and palliative care.
• Describe and contrast several established models of home-based primary and palliative care in both academic and community-based settings (Mount Sinai Visiting Doctors Program, New York, NY; Housecall Providers, Portland, OR; Cadence Health Care System, Wheaton, IL; and the University of California, San Francisco, San Francisco, CA).
• Discuss how to present core components and recommendations for those seeking to implement similar programs.

As the population ages and more people live with multiple chronic illnesses, the number of patients with functional limitations grows. Palliative care and primary care services overlap when caring for this complicated and fragile population with a high symptom burden and unpredictable prognoses. Care must emphasize quality of life, complex decision-making, coordination of care, family involvement, and individualization of patient care.

Home-based primary and palliative care has been shown to be associated with a reduction in symptom burden, increase in patient and caregiver satisfaction, and decrease in utilization. Various models of home-based palliative care exist around the country. We will present four different models in order to illustrate how palliative care services can be expanded into the community: 1) An academic home-based primary and palliative care program, 2) a community-based, freestanding practice providing primary care and hospice care, 3) a community hospital-based primary and palliative care program affiliated with a healthcare system, and 4) an academic consultative home-based palliative care service.

Session participants will understand each program's structure, detailed demographic and clinical data on our populations, and the benefits and challenges of each model. We will review ongoing research and quality measures we are collecting within our programs to better elucidate the benefits from these services and how the needs of this vulnerable population are addressed. We will summarize key components of program implementation and recommend core services and outcome measures that will facilitate integration of new home-based programs into practices and larger health systems.
Life After Death: What Every Palliative Care Provider Should Know About Organ and Tissue Donation (FR412)

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Michael Frankenthaler, MD FCCP, North Shore-LIJ, Great Neck, NY

Objectives

• Describe the process for organ donation following cardiac death.
• Identify best practices for brain-death discussions and distinguish brain death from coma and persistent vegetative states.

Hospital-based palliative care teams are becoming increasingly involved with the care of critically ill patients for whom organ donation is being considered. The two types of deceased donors include brain-dead donors and donors with cardiac arrest for whom life-sustaining therapies have been withdrawn.

Families have a difficult time understanding the concept of brain death, and healthcare providers have misconceptions about brain death; therefore, effective communication is essential. Palliative care providers can use best practices in communication and avoid the pitfalls that are common in brain-death notification. Effective communication and education have been shown to help family members process complex medical information and also help with the bereavement period. Recent studies with bereaved family members of patients diagnosed with brain death show that there are still major gaps in palliative care services offered to this group. Media attention on famous cases creates further confusion regarding coma, brain death, and persistent vegetative states.

We will explore the process of organ donation after cardiac death and the special communication issues around this process when life-sustaining treatments are being withdrawn and death is expected in a short time. We will discuss donor suitability and common barriers to donation after cardiac death.

Honoring patient and family preferences regarding organ donation requires knowledge of the options available. This session will provide participants with the skills needed to understand all forms of organ and tissue donation.
Grief and Bereavement: Updated Theories and New Tools for Providers (FR413)
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Objectives
• Describe updated theories on grief, loss, and bereavement.
• Describe ways in which providers can engage patients and families in legacy work.
• Recognize provider grief and identify ways to prevent compassion fatigue.

As palliative care and hospice providers, we are often witnesses to patients and families struggling with grief and loss. Historically, Elizabeth Kubler-Ross’s five-stage model has helped providers and individuals understand the grieving process in an accessible and intuitive manner. However, updated theories are emerging that describe the grieving process as “tasks” instead of “stages.” Reframing the grieving process as tasks allows providers to better understand how they can serve bereaved patients and families who are working through these tasks. Providers can be particularly instrumental in encouraging legacy work that allows patients to support their family and friends by leaving a legacy and provides the bereaved with a tangible way to remember their deceased loved one. Examples of legacy work as well as practical tools for patients and providers to engage in legacy work will be discussed. Healthcare providers caring for seriously ill and dying patients often feel grief as well. Learning to grieve is a coping skill. Similarly to the tasks that grieving patients and families are facing, providers can also use this new framework to do their own grief work. Recognizing and understanding our own grief can help prevent compassion fatigue and burnout.
Hannah's Questions: A Teenager Confronts Her Death with Candor, Faith, and Marching Orders (FR414)

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Objectives
- Recognize how to talk to a teenager about dying, the obstacles to those conversations, and how to overcome those obstacles.
- Appreciate the empowerment and healing aspects of end-of-life conversations when they are fully engaged.
- Recognize the scope of the issues a teenager confronts in dying through the specifics of Hannah’s questions; fears that are not expressed cannot be addressed. Hannah’s physician, mother, and chaplain will explain how these medical, spiritual, and psychological questions were addressed and how they impacted those who engaged in the conversations with her.

Hannah Duffy was a star soccer player, honor student, wonderful big sister, and adored daughter with many friends when she was diagnosed with anaplastic astrocytoma and gliomatosis cerebri in October 2012. She was 13. When her brain was biopsied, 30% of the tumor was removed; the rest was inoperable. Hannah and her family were told she had 6 months to 2 years to live. Despite beginning chemotherapy and radiation, Hannah was back on the soccer field in concussion gear 2 weeks after her surgery. Family and friends mobilized into an army of “Duffy’s Tuffys.” Everyone went to war with her against her cancer. Hannah was stable for almost 10 months. But then a scan showed her tumor was progressing rapidly. Hannah said, “I’m going to die.” Her mother and physician said, “Yes,” beginning a long and wrenching conversation over the final weeks of her life. Hannah asked if she was letting people down by dying. She feared being forgotten. She asked about heaven, dying, and pain. As those questions were answered, Hannah felt at peace and started issuing marching orders to those she loved. Her to-do list ranged from having her friends wear pink stilettos to her wake after gluing a big glittery “H” to the sole of their shoes, to asking her mom to hang her picture above her baby brother’s crib so he’d always remember her. She also asked her teenage friends to embroider her name in their prom and wedding dresses. Her ultimate wish was that she never be forgotten. On September 26, 2013, Hannah Rose Duffy died at home, surrounded by her family. As one of her friends said, speaking for many, “We cried a lifetime of tears, but nothing was left unsaid” because of the power and courage of Hannah’s questions.
Objectives

- Understand that POLST is appropriate for patients with advanced illness and frailty, not for all patients.
- Understand that POLST orders can and should change as health status changes.

Original Research Background: The Physician Orders for Life-Sustaining Treatment (POLST) paradigm allows healthcare professionals to document the treatment preferences of patients with advanced illness or frailty as portable and actionable medical orders.

Research Objectives: The study objective was to ascertain when POLSTs are completed in proximity to death, the resuscitation and scope of treatment preferences recorded, and whether diagnosis or demographic factors influenced timing or order changes.

Methods: The POLST registry is a prospective cohort of Oregon residents with POLST forms. POLSTs completed within 2 years of death were linked to Oregon death certificate data. 18,285 Oregon POLST registrants were matched to death certificate data for 2010 and 2011. Time between POLST completion and death, POLST orders and order changes, demographics, and cause of death.

Results: 89% of initial POLSTs were completed in the last year of life. The median interval from POLST completion to death was 6.4 weeks (range, 0.14-102.6 weeks). Those dying of cancer had POLST completed nearer death (median 5.1 weeks) than those with organ failure (10.6 weeks) or dementia (14.5 weeks). For individuals with multiple registered POLSTs (11%; n=2,004), their earlier form was more likely to have an attempt resuscitation order (32.0% vs 7.3%) and less likely to have comfort-measures-only orders (13.3% vs 69.4%).

Conclusions: Over half of sampled POLSTs were completed in the final 2 months of life. Diagnosis influences when POLSTs are completed. Among registrants who had multiple POLSTs, the later form usually, but not always, had fewer life-sustaining treatment orders.

Implications for Research, Policy, or Practice: Our data show that most final POLST forms are completed during the last year of life and support that POLST is being used in the intended patient population.
Physicians’ Understanding of Patient Autonomy and Choice in Discussions Surrounding the Do-Not-Resuscitate Order (FR415-B)

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Objectives
• Define three criteria necessary for a decision to be autonomous and determine whether these criteria have been fulfilled in the quotations in the presentation.
• Describe ideal forms of persuasive communication and contrast that with less desirable communication strategies.

Original Research Background: Physician paternalism has given way to the primacy of patient autonomy. Challenges occur when patients request potentially nonbeneficial interventions, resulting in ethical conflicts between respecting autonomy and acting with beneficence.

Research Objectives: To explore physicians’ conceptualization of patient autonomy and choice and how that affects physician communication strategies in conversations where do-not-resuscitate (DNR) status is discussed.

Methods: Semistructured in-depth interviews were conducted with 29 internal medicine doctors across two sites in the United States who were routinely involved in DNR conversations with patients at the end of life. Participants were purposely sampled by stage of training and medical subspecialty to provide a wide range of perspectives and contribute to understanding emerging patterns and themes. Interviews lasted 60 minutes on average and were audiotaped and transcribed. Transcripts were analyzed and double coded using thematic analysis with an interpretive approach.

Results: Experienced doctors at all sites generally felt comfortable engaging in shared decision making and, when clinically appropriate, making more paternalistic recommendations against resuscitation. However, residents and fellows felt less comfortable restricting choice and felt compelled to offer choice even if the chance of successful resuscitation was negligible, often without explaining the likelihood of survival, its consequences, or in the overall context of goals of care.

Conclusions: Inexperienced doctors often interpreted hospital policies promoting autonomy to mean that they should not provide clinical recommendations, even in situations where they feel it would not be in a patient’s best interest to offer resuscitation. This obscures truly autonomous informed decision making by offering choice without providing the tools and knowledge necessary to make the decision.

Implications for Research, Policy, or Practice: To truly empower patients to participate and make decisions, shared decision making should be encouraged in which doctors impart their medical knowledge to guide informed decisions.
Comparison of Patients' Practices and End-of-Life Outcomes with Use of Advance Directives and the Physician Orders for Scope of Treatment Program: Insights from a Statewide Registry (FR415-C)

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Objectives
• Report the rate of advance directive and POST form completion in West Virginia.
• Compare out-of-death outcomes by type of form submitted, advance directive versus POST form.

Original Research Background: Over 90% of West Virginians would prefer to die in an out-of-hospital (OOH) setting. Nearly half have completed advance directives (AD), but in most studies ADs have not impacted end-of-life care (EOLC), whereas the POLST form (POST in West Virginia) has.

Research Objectives: To determine the practices of West Virginians with regard to AD and POST form completion and compare the outcomes between AD and POST forms on EOLC quality measures: OOH death, and hospice enrollment more than 72 hours before death.

Methods: The deaths of West Virginians who had submitted an AD or POST form to the online West Virginia e-Directive Registry between 2010 and 2013 were reviewed. Chi-squared testing was used to compare proportions of OOH deaths by type of form completed and submitting facility. Hospice deaths were reviewed for time of form submission prior to death. Z-tests compared the registry sample to a national sample. Logistic regression was used to predict out-of-hospital death by type of form submitted.

Results: There were 23,953 forms submitted and 5,651 adult deaths in the registry during the study period. Patients who had completed an AD were more likely to die in the hospital than those who had a POST form ordering comfort measures (44.7% vs 10.7%, p<.001). Enrollment in hospice more than 72 hours prior to death occurred in 78.2% of registry patients, compared with 71.6% of a national sample (p<.001). Of the 2,478 nonhospice patient deaths, the odds of having an OOH death with a POST form ordering comfort measures were 5.2 times those with an AD (p<0.001).

Conclusions: This study supports the advantage of a statewide system including the POST program and an end-of-life registry to ensure that patients’ end-of-life treatment preferences for OOH deaths are respected.

Implications for Research, Policy, or Practice: The challenge is to create similarly effective systems in other states.
I Don’t Want to Make My Own Decisions: Decision-Control Preferences Among Diverse Older Adults, Advance Care Planning, and Satisfaction with Communication (FR415-D)

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Objectives

- Learn about the level of control diverse older adults prefer to have over their medical decisions.
- Understand what patient characteristics are associated with a preference for wanting to relinquish control over medical decisions to their doctor, and whether decision-control preferences are associated with advance care planning, decision making, and communication.

Original Research Background: Older adults from diverse cultures may prefer varying control over medical decisions. Decision-control preferences (DCPs) may profoundly affect decision making and communication.

Research Objectives: To determine the DCPs of diverse, older adults and whether DCPs are associated with participant characteristics, advance care planning (ACP), question-asking behavior, and satisfaction with communication.

Methods: 146 participants were recruited from clinics, senior centers, and cancer-support groups in San Francisco. We assessed DCPs using the Control Preference Scale: doctor makes all decisions (low DCPs), shares with doctor (medium), or makes own decisions (high). We assessed associations between DCPs and participant characteristics, prior advance directives, ability to make in-the-moment goals-of-care decisions (e.g., comfort care), question-asking behaviors (self-efficacy, readiness [5-pt Likert], and prior asked questions), and satisfaction with patient-doctor communication (5-pt Likert) using Chi-square and Kruskal-Wallis analysis of variance.

Results: Mean age was 71 ±10 years, 53% were nonwhite, 47% completed an advance directive, and 70% made a goals-of-care decision. Eighteen percent wanted their doctor to make decisions, 33% to share, and 49% to make their own. Older age was the only characteristic associated with DCPs (75 years ±11 low, 69 ±10 medium, 70 ±9 high; p=0.003). DCPs were not associated with ACP, in-the-moment decisions, or communication satisfaction. Readiness was the only question-asking behavior associated with DCPs (3.8 41.2 low, 4.1 41.2 medium, 4.3 41.2 high; p=0.05).

Conclusions: Nearly one-fifth of diverse, older adults wanted their doctor to make their medical decisions. Low DCPs were associated with older age and lower readiness to ask questions but not race/ethnicity, yet older adults with low DCPs still engaged in ACP, made goals-of-care decisions, asked doctors questions, and reported communication satisfaction.

Implications for Research, Policy, or Practice: Regardless of DCPs, clinicians can encourage ACP, goals-of-care decision making, and questions from all patients. However, clinicians need to ask about DCPs to provide the desired amount of decision support and ensure informed decision making.
A Survey of Moral Distress Across Nurses in Intensive Care Units (FR416-A)

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Objectives
• Describe the moral distress of critical care RNs.
• List interventions to address moral distress in critical care RNs.

Original Research Background: In 2008 the American Association of Critical Care Nurses (AACN) published a position statement on moral distress that included a call to action for nurses to recognize and name the experience of moral distress and as commit to using professional and institutional resources to address it.

Research Objectives: This study meets this call to action by examining the level and frequency of moral distress in critical care registered nurses (RNs) working in an urban, academic hospital in Pennsylvania and identifies strategies to address this distress.

Methods: A descriptive, questionnaire study was used. RNs completed the 21-item Moral Distress Scale-Revised (Cronbach’s alpha=0.89) and indicated their preferences for institutional support in managing distressing situations (Hamric, Borchers, & Epstein, 2012). Survey questions were administered electronically via Qualtrics Survey Software. IRB approval was gained before administration.

Results: Preliminary results (N=102) show that situations creating the highest levels of moral distress were those related to futile care. Three-quarters of RNs surveyed are involved in goals-of-care conversations more than half of the time. Chaplaincy/pastoral care and palliative care consults are the top two resources employed by RNs surveyed. Over 40% of RNs surveyed have considered quitting or have left a position because of moral distress, while 16% are considering leaving their current position.

Conclusions: RNs report experiencing moral distress and identified specific resources that they would find helpful to alleviate such distress, including debriefing sessions, ethics committee meetings, and talking with patients and their families.

Implications for Research, Policy, or Practice: There is a large body of evidence documenting the incidence of moral distress in nurses, but few studies explore interventions to address moral distress. This study identified nurse preferences for lessening the impact of moral distress, which will guide institutional initiatives to alleviate distress.

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Objectives

• Describe parent-clinician decision-making in the NICU.
• Describe factors associated with parent-clinician consensus about decisions for critically ill infants.

Original Research Background: We know little about how parents and clinicians collaborate to make decisions for critically ill infants in the neonatal intensive care unit (NICU). Existing data are retrospective or hypothetical, emphasizing clinicians’ over parents’ perspectives. These studies suggest parents and neonatologists leave conversations with different perceptions about which decisions were discussed.

Research Objectives: To observe and analyze parent-clinician decision making in the NICU.

Methods: A mixed-methods study at an urban academic medical center. We audiotaped family conferences about life-sustaining therapies and/or “difficult news.” Families, physicians, and nurses completed surveys about meeting content. Transcripts were analyzed using the Informed Decision-Making Tool (IDMT) and qualitative analysis using a priori coding techniques.

Results: We audiotaped 19 conversations between 31 family members and 37 clinicians. In 58% of conversations, the primary clinician was meeting the family for the first time. When asked about their preferred decision-making role, 8/31 parents wanted to make decisions after clinician recommendations, 15/31 wanted to partner equally with clinicians, and 8/31 wanted clinicians to make decisions after hearing parent’s opinions. Physicians correctly judged parents’ desired decision-making role 20% of the time, typically overestimating their desired independence. Nurses were correct 57% of the time. Parent-clinician consensus about which decisions were discussed existed after 8/19 conversations; the remaining participants variably perceived that a decision was discussed and variably characterized the identified decisions. Conversations with consensus had higher IDMT scores and were more likely to be about end-of-life care.

Conclusions: Clinicians often overestimate parents’ desire to assume primary responsibility for decision making in the NICU. Decision-making clarity seems greatest when it involves forgoing therapies.

Implications for Research, Policy, or Practice: Training of NICU clinicians should include communication strategies to better actualize parent autonomy. Clinicians should recognize that they may be clearer about decisions to forgo life-sustaining therapies than they are about other types of decisions.
Effects of a Nurse-Led Primary Palliative Care Bundle on Specialist Palliative Care Consults in the ICU (FR416-C)

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Objectives

• Describe the primary palliative care model as implemented by ICU nurses and physicians.
• Discuss the potential impact of primary palliative care on specialty palliative care consult services.

Original Research Background: Specialist palliative care consults (SPCCs) in intensive care units (ICUs) reduce lengths of stay and nonbeneficial intensive care treatments, improve family satisfaction, and better manage symptoms of seriously ill patients. However, palliative care specialists are in scarce supply and not available in all hospitals. It is essential that primary palliative care (PPC) be incorporated as a core ICU service.

Nurse-led PPC in the ICU—implemented by an ICU nurse and physician team—is growing in popularity. PPC is protocol driven and adheres to the IPAL-ICU’s care and communication bundle. Limited evidence characterizes the effect of PPC on palliative care consultations.

Research Objectives: Describe the effects of a nurse-led PPC protocol on SPCCs in the ICU.

Methods: Two 20-bed ICUs of a large academic medical center participated in a PPC project. The unit leadership team implemented a PPC bundle which included (a) identification of surrogate decision-maker (first 24 hours), (b) advance directive and resuscitation status (first 24 hours), (c) social work and chaplain support (within 72 hours), and (d) structured family meeting (no later than ICU day 5). PPC and palliative care consults were analyzed as proportions of eligible patients (ICU patient with stay of 5+ days) pre- and post-bundle implementation. We used interrupted time series analysis to evaluate the effects of the PPC bundle implementation on specialist palliative care consults.

Results: A total of 1,145 patients were admitted to the ICUs during the study period. There was a significant (p<0.05) decrease in the proportion of eligible patients who received an SPCC decreased from 45.7% to 30.7%.

Conclusions: Implementation of a PPC bundle led to a decrease in SPCCs.

Implications for Research, Policy, or Practice: Increases in PPC may lead to a decrease in SPCCs. Further research is needed to characterize the effects of shifting palliative care from specialists to the primary team.
An Algorithmic Approach to Terminal Ventilator Withdrawal: Pilot Testing (FR416-D)
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Objectives
• Describe a terminal ventilator withdrawal algorithm.
• Describe the outcomes of a pilot clinical trial of a terminal ventilator withdrawal algorithm.

Original Research Background: Terminal ventilator withdrawal entails the cessation of invasive mechanical ventilation to allow a natural death. There is little empirical evidence to guide the conduct of this common procedure. If the process is not well conducted, patients undergoing ventilator withdrawal are at very high risk for experiencing significant respiratory distress.

Research Objectives: (1) To establish the feasibility of a nurse-led algorithmic approach; (2) To demonstrate that the algorithm ensured greater patient comfort compared with usual care; and (3) To determine differences in the use of opioids and benzodiazepines.

Methods: A two-group, repeated measures observation design was used with one medical ICU (MICU) conducting the algorithm and a second MICU providing usual care. Patient respiratory comfort/distress was measured with the Respiratory Distress Observation Scale (RDOS). The algorithm guided three process decisions: (1) premedication, (2) withdrawal method, and (3) extubation decisions.

Results: MICU nurses and respiratory therapists from the intervention unit were trained to follow the algorithm in educational sessions of 1-hour duration; fidelity to the algorithm was subsequently confirmed. Fourteen patients evenly distributed by ethnicity and gender were enrolled, with 8 in the control ICU and 6 in the intervention unit. No significant differences in age, gender, ethnicity, consciousness, illness severity, or baseline RDOS were found. All patients in the control unit underwent a one-step terminal extubation process. There were no incidences of postextubation stridor in the intervention group, and three (38%) control patients experienced stridor. Patients in the intervention group had greater respiratory comfort compared with the patients in the control group (p < .05). Differences in medication use were found with the control unit favoring benzodiazepines, while the algorithm promotes morphine.

Conclusions: Feasibility and proof of concept were established in this pilot study. A powered, randomized controlled trial is planned.

Implications for Research, Policy, or Practice: An algorithmic approach to terminal ventilator withdrawal is a feasible means of ensuring patient comfort.
Giving Them the Words: Rational Conversations About Drug Therapy at the End of Life (FR417)

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Objectives

• Explain the Centers for Medicare and Medicaid Services’ (CMS’s) expectations for increased medication oversight in hospice patients.
• Describe a template for evaluating and explaining the benefits and burdens of individual drug therapies at the end of life.
• Demonstrate effective communication skills regarding medication management negotiation, given an actual or simulated patient admitted to hospice.

In 2014 the Centers for Medicare & Medicaid Services (CMS) began requiring hospice programs to provide increased oversight, evaluation, and provision of medications used to manage the admitting diagnosis and related conditions. Specifically CMS has asked hospice programs to determine which medications the patient is taking are medically necessary versus unnecessary and which medications are related to the patient’s disease processes (which the hospice must provide). This increased scrutiny often leads to recommendations to discontinue medically unnecessary medications (eg, statins, vitamin supplements, dementia medications, riluzole). However, conversations about stopping medication therapy frequently make staff, patients, families, and caregivers feel uncomfortable and often even threatened. Taking this a step further, CMS has stated that hospice programs are certainly allowed to have a medication formulary or preferred drug list, and the hospice is not required to provide a nonformulary medication (however, the patient cannot use their Medicare Part D benefit; they would have to pay out of pocket). These conversations also make staff very uncomfortable and can result in confrontational conversations with patients and families. The purpose of this session is to give staff the words to have these often difficult conversations. Using a variety of case examples, the speakers will illustrate a process for presenting the benefits and burdens of drug therapy in scenarios where medications are medically necessary and related (formulary versus nonformulary); medically necessary but unrelated; not medically necessary but related; and neither medically necessary nor related. Participants will leave with a solid skill set that will empower them to have these sensitive conversations with patients and families that reflect clinically defensible and equitable decisions that meet CMS expectations.
Swimming Upstream: “I Have a Patient I'd Like You to See...Today...in Clinic" (FR418)

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Objectives
• Identify one model you can employ at your organization for a new outpatient program.
• Describe one potential financial alignment for an outpatient palliative care model.
• Identify “next steps” for developing an outpatient program at your institution.

Palliative care services in outpatient clinics, at home, or by telemedicine are increasing to meet the needs of patients throughout their illness trajectory. Moving palliative care services upstream allows better continuity and consistent care for patients with serious illnesses before and after inpatient encounters. Outpatient palliative care is poised for growth in the changing landscape of healthcare delivery.

Palliative care programs, newly established or mature, are often hospital based with consult services directed at inpatients with serious illness. Palliative care programs will be quickly asked to see patients outside the hospital walls. This poses real-world challenges with staffing, effort, opportunity costs, and meeting the needs of referring physicians and health systems.

This session will explore opportunities and pitfalls of starting a new outpatient program. The format will be a brief introduction of several established outpatient programs followed by a moderated panel discussion with ample opportunity to learn from established leaders and meet peers with similar challenges and concerns.
Where's the Family? Successfully Bringing the Family into Hospice IDG (FR430)
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Objectives
• Demonstrate the technical steps required to bring family into IDG using webconferencing technology.
• Discuss the benefits and challenges of involving family in IDG meetings.
• Problem solve potential changes to the IDG meeting that might better facilitate shared decision-making with family members.

Hospice principles define patients and family members as one unit of care. Although empowered to make decisions regarding care, patients and family members are routinely absent from the interdisciplinary group meetings where key decisions are made. Given the lack of direct patient and family input, care plans can suffer from incorrect assumptions about the patient and family perspectives and experiences.

We have been testing the use of webconferencing to bring family members into the hospice interdisciplinary group meeting to share in decision-making related to care. Caregivers have reported that this virtual team meeting is beneficial and that they feel as though they are sitting at the table with the team. They feel better informed and a part of the care process. Our research has found that there are clinical benefits to caregivers who are involved and informed as a result of participating in this decision-making experience. Hospice staff, while supportive, have identified challenges with the time shared decision-making requires.

This session will demonstrate how to actively involve family in the hospice interdisciplinary group meeting and share the benefits and challenges from several perspectives. We will demonstrate with webconferencing technology the steps involved in bringing a family into a group setting. Actual videorecorded encounters will demonstrate the technical ease and operational challenges with the patient and family membership in the interdisciplinary group. Hospice caregivers, medical directors, and nurses will share their experiences with this process. We will outline lessons learned from the experience and share a cost-effectiveness analysis. Finally, we will facilitate discussion with participants on ways to overcome obstacles and facilitate the shared decision-making with families and patients within the hospice interdisciplinary group structure.
**Cannabinoids: Now and in the Future (FR431)**

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**Objectives**
- Recognize the evidence for benefit of commercially available cannabinoids and their limitations.
- Recognize the diverse nature of cannabinoid pharmacology.
- Recognize why CB2r agonists are being rapidly developed and placed in clinical trials.

Cannabinoids target orphan receptors GPR-55 and GPR-18, ion channels, monoamine receptors, and mu receptors. Cannabinoids have labeled indications for chemotherapy-induced nausea and vomiting but are reported to improve appetite in patients with AIDS, central pain from multiple sclerosis, and neuropathic pain. The benefits of cannabinoids for cancer pain are mixed. Commerially available cannabinoids are subject to psychotomimetic and addiction (cannabinomimetic) adverse effects largely through activation of the cannabinoid 1 receptor (CB1r). The number needed to treat (NNT) to benefit a single individual with either THC or THC-CBD ranges between six and nine. In a systematic review of cannabis studies (vaporized cannabis, THC, THC-CBD), the standardized mean difference in pain intensity is -0.61 (95% CI, -0.84 to -0.37). However, the number needed to harm (NNH) was five for motor dysfunction, seven for altered perception, and eight for cognitive dysfunction. Although the present commercially available cannabinoids have modest benefits, they also have a narrow therapeutic index. Recently developed peripherally restricted cannabinoids; regionally administered cannabinoids; bifunctional cannabinoid ligands; cannabinoid enzyme inhibitors; endocannabinoids such as palmitolethanolamine (PEA), which do not interact with classic cannabinoid receptors (CB1r and CB2r); cannabinoid receptor antagonists; and selective CB1r agonists hold promise as future analgesics. Regional and peripherally restricted cannabinoids reduce cannabinomimetic side effects. Spinal cannabinoids increase the therapeutic index by minimizing drug exposure to supraspinal sites. Bifunctional ligands amplify analgesia or block side effects. Combinations CB2r agonists with TRPV 1 antagonist improve the therapeutic index of the CB2r agonist. Limitations include development of analgesic tolerance with enzyme inhibitors and pronociceptive effects of prostamides and certain cannabinoids. Most clinically important developments over the next 5 years will be in selective CB2r agonists. These agents are being tested in various inflammatory, osteoarthritis, and neuropathic pain phenotypes.
Putting the “I” back in “QI”—Teaching Lifelong Skills in Clinician-Directed Quality Improvement (FR432)

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Objectives

- Describe the relevance of a strong understanding of quality improvement (QI) from an educational, clinical care, and national policy perspective.
- Evaluate QI projects using a standard tool and example projects from three institutions.
- List and describe at least three methods used to integrate QI into the longitudinal curriculum of hospice and palliative medicine fellowship and/or interdisciplinary teams.

Several recent reforms in healthcare signal a shift towards assessing and improving quality of care as part of the overall demonstration of value. Most of these efforts target resource-intensive, low-value services that often do not meet the goals of patients or caregivers. Increasingly, palliative care clinicians, who are well versed in counseling patients regarding goal setting and avoiding unnecessary care, are asked to lead, design, implement, and evaluate QI initiatives to reduce costs and demonstrate improved outcomes. Additionally, with implementation of the Next Accreditation System (NAS), the ACGME is increasingly emphasizing the teaching of patient safety and QI in training programs. It is critical that palliative care practitioners of all disciplines have an understanding of QI processes and the ability to implement these processes in the clinical setting.

Using a multiinstitutional, interdisciplinary team of quality experts and education leaders in palliative care, we aim to demonstrate how audience members can incorporate novel teaching methods into QI for their own learners. We will introduce a tool for reporting and assessing QI projects. Then, using this tool, we will review three examples of QI projects from several institutions in a small-group format, inviting open conversation regarding their strengths, weaknesses, and applicability. This will spur lively discussions on the challenges and barriers of QI initiatives within our field or those that integrate with other disciplines. Lastly, we will review successful methods from our own experience of integrating QI into the longitudinal curriculum of our palliative care fellowships and interdisciplinary teams, such as risk evaluation and mitigation strategies (REMS) for buprenorphine, extended-release and long-acting opioid analgesics, and transmucosal immediate-release fentanyl products; institutional risk reporting systems; and patient safety committees. Overall, we aim to provide audience members with an implementable action plan to take home that inspires lifelong QI.
Integrated Palliative Care for Management of Elderly Patients with Advanced Chronic Kidney Disease (FR433)

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Objectives
- Apply a model of integrated palliative medicine and nephrology care in the decision-making process of an elderly patient with advanced renal disease to identify palliative care needs in this population.
- Apply prognostic models of end-stage renal disease (ESRD) to various patient populations.
- Describe and contrast the effects of dialysis and conservative management on functional status and prognosis in an elderly population.

Integration of palliative care services with standard nephrology practice for elderly patients with advanced kidney disease can be beneficial in the shared decision-making process regarding management options for the patient’s kidney disease and its associated symptoms, as well as in facilitating transition planning during a patient’s clinical course. Patients older than 75 are the fastest growing ESRD population. These patients are often burdened by multimorbidity, frailty, and other geriatric syndromes, all of which should be considered in the discussion of renal replacement therapy (RRT) versus conservative management (CM). Models of integrated palliative care and nephrology in clinical settings will be described as well as an approach to decision making. This approach includes evaluating patient and family preferences, factors important to one’s quality of life, and identification of contextual features that may be important. Reviewing models of prognostication in ESRD and comparing outcomes, in terms of morbidity, mortality, dialysis, and conservative management, will be helpful for the healthcare provider in informing the patient and family about treatment options, as well as in developing a medical recommendation.
Universal Precautions for Drug Misuse and Diversion in Hospice and Palliative Care—Could an Ounce of Prevention Be Worth a Pound of Cure? (FR434)

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Objectives

• Recognize the national epidemic of misuse and diversion of controlled substances and the federal and state initiatives compelling hospice and palliative care programs to implement policies for safe management of scheduled medications.

• Create universal precautions for drug safety policies and procedures for one’s hospice and palliative care organization.

• Describe outcomes measurement of improved patient, family, staff, organization, and community safety and satisfaction.

Drug diversion and misuse in hospice and palliative care are exhausting and demoralizing for staff. As the epidemic of opioid abuse and misuse increases on a national level, government and consumer organizations are increasing scrutiny of all prescribers. Hospice and palliative medicine are at risk of stringent legislation that will make our mission of relieving terminal suffering more difficult to achieve. The presenters of this concurrent session have developed and implemented a proactive approach to management of scheduled medications that is effective in minimizing the risk of misuse. Participants in this session will review the current standards for medication safety of their accrediting organizations, learn how to implement “universal precautions,” and review the components of a drug diversion toolkit. There will be an opportunity for audience discussion and questions as case scenarios are presented.
Managing Symptoms When “the First Step or Two Isn’t Working”: Provider and Patient Perceptions of the Role of Specialty Palliative Care in Symptom Management in Gynecologic Oncology (FR435-A)

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Objectives

- Identify patient- and provider-perceived barriers to the integration of specialist palliative care within gynecologic oncology.
- Identify patient- and provider-perceived facilitating factors for the integration of specialist palliative care within gynecologic oncology.

Original Research Background: Despite recommendations to integrate palliative care (PC) within the management of patients with gynecologic cancers, research describing provider and patient factors that may influence PC uptake is missing.

Research Objectives: Describe gynecologic oncology (GO) providers’ and patients’ knowledge, attitudes, and preferences related to utilization of specialist palliative care (SPC) for symptom management.

Methods: Semistructured interviews with 19 GO providers (7 physicians, 2 nurse practitioners, 4 physician assistants, 6 nurses) and 30 patients with advanced or recurrent gynecologic cancer from an academic medical center. Interview domains included perceived role of oncology team in symptom management, familiarity with SPC, and barriers and facilitators to SPC for symptom management. Two investigators independently coded and analyzed data in NVivo10, using template analysis, a qualitative thematic technique.

Results: Findings indicate shared beliefs between providers and patients, including an interest in involving SPC in symptom management. Although providers feel comfortable initially managing common symptoms, they expressed interest in involving SPC for complex or multiple symptoms. Patients do not expect GO providers to manage severe symptoms, expressing concerns that complex symptom management may be burdensome to the GO team. Barriers to involving SPC include patients’ perceptions of SPC as synonymous with end-of-life care, financial issues (eg, additional out-of-pocket expenses), and logistical issues (eg, scheduling). When a distinction was drawn between SPC for symptom management and end-of-life care, patients were open to seeing SPC for symptom management.

Conclusions: GO patients’ and providers’ perception of the role of oncology providers in symptom management reflects the concept of a primary PC provider, delivering initial management of common symptoms. SPC is seen as complementary to the GO provider’s skill set and particularly useful for severe or multiple symptoms.

Implications for Research, Policy, or Practice: Our research underscores the importance of ensuring that oncology provider training includes dedicated attention to symptom management to enable them to optimally function as primary PC providers.
Improvement in Symptom Burden Within One Day After Palliative Care Consultation in a Cohort of Gynecologic Oncology Inpatients (FR435-B)

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Objectives

- List three symptoms that were statistically significantly improved within one day of PC consultation for symptom management in our cohort of gynecologic oncology inpatients.
- Synthesize the results of this study into one or two sentences that could be used to advocate for greater integration of specialty palliative care consultation into the care of gynecologic oncology inpatients.

Original Research Background: The impact of inpatient palliative care (PC) on symptom burden in the gynecologic oncology (GO) population has not been evaluated.

Research Objectives: Evaluate the magnitude and time course of change in symptom burden after PC consultation in a cohort of GO inpatients.

Methods: Women with a gynecologic malignancy and a PC consultation for symptom management between 3/1/12 and 2/28/13 were identified. Charts were reviewed for demographics and disease characteristics. PC provider reports of symptom intensity on a modified Edmonton Symptom Assessment System (ESAS) scale were retrospectively reviewed for the following symptoms: pain, fatigue, anorexia, depression, anxiety, nausea, and dyspnea. Prevalence of moderate to severe symptom intensity on D1 ranged from 4% (dyspnea) to 52% (pain). There was statistically significant improvement in moderate to severe symptom intensity between D1 and D2 for the following symptoms: pain, anorexia, fatigue, and dyspnea (all p<0.05). There were no statistically significant differences in symptom burden between D2 and the last ESAS completed before discharge.

Conclusions: PC consultation is associated with significant improvements in symptom burden, and the majority of that improvement occurs within one day of consultation.

Implications for Research, Policy, or Practice: PC consultation may be an effective tool for symptom management in GO during even very brief hospitalizations and should be considered early in the hospitalization to effect timely symptom relief.
Lower Patient Ratings of Physician Communication are Associated with Greater Unmet Need for Symptom Management in Lung and Colorectal Cancer Patients (FR435-C)

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Objectives

• Understand prevalence of unmet needs of symptom management in a cancer population.
• Understand physician communication and its importance for high quality symptom management.

Original Research Background: Little is known about how often patients’ needs for symptom management are met.

Research Objectives: Identify prevalence of and factors associated with unmet needs for symptom management.

Methods: Patients with lung and colorectal cancer from the diverse nationally representative Cancer Care Outcomes Research and Surveillance cohort completed a survey approximately 4-6 months following diagnosis (n=5,422). We estimated the prevalence of unmet needs for symptom management during the 4 weeks prior to the survey, with unmet needs defined as patients reporting that they wanted but did not receive help for at least one symptom (pain, fatigue, depression, nausea/vomiting, cough, dyspnea, diarrhea). Using a prespecified conceptual model, we identified patient factors associated with unmet need using multivariable logistic regression with random effects (fixed slopes model with random intercepts for each primary data collection research site). We also tested whether clinical visits before the interview were associated with unmet need.

Results: Overall, 15% (791/5422) of patients had at least one unmet need for symptom management. Adjusting for patient sociodemographic and clinical factors, African American race, being uninsured or poor, having lung cancer versus colorectal cancer, early- vs late-stage disease, and the presence of moderate to severe symptoms were associated with greater unmet need (all p<.05). Patients who rated their physicians communication score below 80 (on 1-100 scale) had adjusted rates of unmet need that were more than twice those of patients who rated their physicians with a perfect communication score (23.0% vs 10.0%, OR=3.05, p<0.001). Neither visits with specialty physicians (medical oncology, radiation oncology, surgery, or primary care) nor the total number of outpatient visits in the 28 days before the interview were associated with unmet need (all p>.05).

Conclusions: A significant percentage of newly diagnosed lung and colorectal cancer patients report unmet needs for symptom management.

Implications for Research, Policy, or Practice: Interventions to improve symptom management should consider the importance of physician communication.
Symptom Clustering Among Patients Visiting a Supportive Oncology Clinic (FR435-D)

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Objectives

• Describe a supportive oncology clinic and its patient population.
• Identify symptoms that compose psychological, treatment-related, and gastrointestinal clusters within a supportive oncology population.

Original Research Background: Multiple symptoms are common and often severe in patients with cancer. Identification of symptoms that cluster may serve to elucidate the pathophysiology of the disease and aid in symptom management.

Research Objectives: Our aim was to define symptom clusters occurring among cancer outpatients receiving chemotherapy.

Methods: New and returning patients referred to a supportive oncology clinic (SOC) from our health system’s oncologists from November 2011 through May 2014 completed the Condensed Memorial Symptom Assessment Scale plus a sexual dysfunction structured assessment. Data were collected prospectively from 323 consecutive initial visits. Patients rated from 0-4 how bothersome 15 cancer symptoms were; symptoms were then graded as present (1+) or absent (0). Hierarchical cluster analysis with average linkage was used to identify symptom clusters. The absolute value of the correlation between symptoms was used as the measure of similarity between pairs of symptoms. A correlation of ≥0.6 was used to define the final clusters. A symptom cluster was defined as two or more symptoms that predictably occur together.

Results: Three clusters were identified: (1) psychological (worrying, feeling sad, feeling nervous), (2) treatment related (lack of energy, feeling drowsy, difficulty concentrating, dry mouth, constipation), and (3) gastrointestinal (weight loss, lack of appetite, nausea). Pain, difficulty sleeping, shortness of breath, and loss of interest did not cluster with any symptom. Gastrointestinal symptoms are important within the clusters. The prevalence of worrying, feeling sad, and feeling nervous did not cluster with lack of energy or difficulty in sleeping, nor pain with worrying or feeling sad.

Conclusions: Three symptom clusters were identified as showing high absolute correlation: a psychological cluster, treatment-related cluster, and gastrointestinal cluster.

Implications for Research, Policy, or Practice: Identifying symptom clusters may promote our understanding of the pathophysiology of cancer, help prioritize effective pharmacotherapies, and identify drugs likely to help more than one symptom.
Palliative Care Outcomes of Minority Patients Receiving Home-Based Primary and Palliative Care (FR436-A)

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Objectives
- Describe racial and ethnic differences in patients receiving home-based primary and palliative care.
- Discuss differences in palliative care outcomes among minorities and non-minorities receiving home-based primary and palliative care.

Original Research Background: Data suggest that minority patients use healthcare resources at a higher rate than nonminorities and have documented preferences for more aggressive care at the end of life. There is a paucity of information on the effects of home-based primary and palliative care (HBPC) on symptom management, advance care planning, and healthcare utilization among minority patients with serious illness.

Research Objectives: Compare the palliative care outcomes of nonminority versus minority patients (black and Hispanic) with serious illness receiving care from the Mount Sinai Visiting Doctors Program (MSVD), a HBPC model.

Methods: We performed retrospective chart reviews of all MSVD patients who died in 2012. We performed bivariate analysis comparing differences in outcomes among minority and nonminority patients.

Results: We identified 189 patients. Six patients (3.17%) died in nursing homes and were excluded because we could not access their care patterns. Of those remaining, 95 (52%) were nonminorities, 42 (33%) black, and 46 (25%) Hispanic. Minority patients were younger (p=0.003), insured by Medicaid (<0.001), had higher rates of home nursing services (p<0.001), had poorer performance status on the Karnofsky scale (p=0.007), were less likely to have MD visits in the last month of life (p=0.04), and were more likely to die in the hospital (p<0.001). There were no statistically significant differences in rates of DNR (p=0.31), rate of healthcare proxies (p=0.77), the use of opioids for symptom management (p=0.28), or rates of hospice enrollment (p=0.41).

Conclusions: There were no differences detected in advance care planning, symptom management, DNR orders, and enrollment in hospice among minorities receiving HBPC. However, even with the support offered by HBPC, minorities still had higher rates of healthcare utilization.

Implications for Research, Policy, or Practice: Future efforts should focus on minority patients’ preferences and the role of HBPC to decrease hospitalizations among minority patients with limited prognosis.
The Nurse Work Environment and Delivering Culturally Sensitive Perinatal Hospice Care (FR436-B)

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Objectives

• Discuss research background and significance.
• Describe the nurse work environment factors related to delivery of culturally sensitive care for families receiving perinatal hospice care.
• Based on analysis of research findings presented, create innovative approaches clinicians and administrators can implement to meet patients’ and families’ cultural needs.

Original Research Background: Perinatal hospices offer end-of-life care for families and infants diagnosed with a life-limiting condition either in utero or shortly after birth. Despite the increasing multicultural composition of these infants and families, little is known about whether culturally sensitive care is delivered and how the nurse work environment may influence the delivery of perinatal hospice care that is culturally sensitive.

Objective: The purpose this study was to evaluate the relationship between the nurse work environment and the delivery of culturally sensitive perinatal hospice care.

Methods: Using a correlational design, a sample of 995 hospices from the 2007 National Home and Hospice Care Survey was analyzed. Measures of the nurse work environment (ie, hospice environment, nursing unit environment, nursing unit structure) and characteristics of culturally sensitive care (ie, interpreter service, material translation, multilingual staff) were created. Separate multivariate logistic regression analyses were conducted for the characteristics of culturally sensitive care.

Results: Eighty-eight percent of hospices offered interpreter services, 68% provided translated materials, and 47% had multilingual staff. Accredited and teaching hospices were more likely to offer interpreter services, and accredited and teaching hospices with a technology climate were more likely to provide translated materials. BSN nursing staff and a technology climate were positively associated with having a multilingual staff; however, hospices with a nurse director were negatively related in multilingual staff.

Conclusions: This study suggests that the hospice and nursing unit environments may be important contributors to the delivery of culturally sensitive care. Future research is needed to examine the experience and attitudes of families receiving culturally meaningful perinatal care.

Implications for Research, Policy, or Practice: Understanding the nurse work environment and the relationship to providing culturally sensitive perinatal hospice care assists clinicians and administrators in addressing gaps in care and planning new approaches to meet patients’ and families’ cultural needs.
Disparities in Hospitalized Cancer Patients Receiving Palliative Care Consultation (FR436-C)

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Objectives
• Describe the baseline differences in symptoms and healthcare utilization among minorities and nonminorities with advanced cancer.
• Compare the outcomes of minority and nonminority patients receiving inpatient palliative care consult.

Original Research Background: Racial and ethnic disparities in health care have been documented among minority groups. As a result, minorities are diagnosed with late-stage cancer and have inferior outcomes likely leading to increased suffering. Little is known, however, about disparities in access to and outcomes of patients receiving specialty palliative care (PC).

Research Objectives: Evaluate outcomes among minority patients (black and Hispanic) receiving palliative care consultation.

Methods: We used data from the Palliative Care for Cancer Patients study (PC4C), a multisite observational study of the effect of inpatient PC on patient health outcomes and utilization among advanced cancer patients. We limited our sample to patients receiving PC from established, interdisciplinary teams. Univariate analyses and multiple regression analyses compared differences in outcomes among minority and nonminority patients.

Results: 583 (19%) patients received PC. Of those, 166 (28%) were minorities and 418 (72%) nonminorities. Mean days to PC was 4.4 versus 3.2 for nonminorities and minorities, respectively (p=0.65). At baseline, minorities reported a higher burden of symptoms on the Condensed Memorial Symptom Assessment Scale (CMSAS). Similarly they were less likely to have discussed their wishes with their doctor (p=0.04), were less likely to have completed a living will (p<0.001) or have a proxy (p<0.001), and had no difference in pain but were less likely to be taking pain medications (p<0.001) or report relief from pain medicines (p=0.05). After PC, all CMSAS symptoms improved for minority patients (except worry; p=0.03). In addition, after PC there were no longer any significant differences among minorities with respect to discussing their wishes (p=0.27), DNR completion (p=0.72), proxy assignment (p=0.22), and taking pain medications (p=0.22) when compared with nonminorities.

Conclusions: PC is associated with improvements in symptom control and discussions of care goals among minority patients who have worse baseline health assessments.

Implications for Research, Policy, or Practice: Future efforts should focus on increasing availability and use of PC for this at-risk population.
Silos of Care: How Unit Cultures Shape End-of-Life Experiences for Patients and Families (FR436-D)

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Objectives
• Define culturally competent care.
• Define unit culture.
• List ways in which provider/institution culture influence patient care at end of life.

Original Research Background: In response to widely documented racial and ethnic disparities in health, US medical providers are encouraged to exercise “culturally competent care” (ie, practicing in a way that is sensitive to the needs of patients from a wide range of racial, ethnic, and cultural backgrounds). Although the push for cultural competency is justified, there is little consensus in the literature about what culture is and how it operates in clinical encounters (Lo & Stacey, 2008). Given this lack of conceptual clarity, it’s not surprising that culture is operationalized as a set of beliefs and behaviors uniquely associated with patients. Rarely is culture understood as something healthcare providers and healthcare institutions also possess.

Research Objectives: Define culturally competent care, define “unit culture,” and recognize ways in which provider/institution culture influences patient care at end of life.

Methods: 7 months of ethnographic observations in a US hospital and 42 in-depth interviews with the families of deceased patients.

Results: Results suggest that not only do patients have racial/ethnic, religious, and cultural backgrounds that shape interactions with providers but also that hospital floors/units constitute cultural spaces. Looking specifically at end-of-life services, we argue that “unit cultures” (defined as beliefs, practices, and assumptions shared by units or specialization) profoundly influence how providers think about death, their role in end-of-life care, and what information they impart to patients.

Conclusions: Provider/patient interactions are frequently a combination of cultures, beliefs, and orientations. We suggest these interactional moments—during which provider cultures and patient cultures meet—play a significant role in determining what dying patients and families understand about impending death, how they make decisions about curative and palliative services, and how survivors feel in the months and years after a loved one has passed.

Implications for Research, Policy, or Practice: Recognizing the effect of unit culture in delivering culturally competent care can improve end-of-life services.
Building Resilience: An Innovative Reflective Writing Method for Clinical Palliative Care—the 55-Word Story (FR437)

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Objectives

• Describe a novel, effective, and brief framework for the use of medical narrative as a reflective exercise for increasing resilience within the larger literature of narrative medicine methods.
• Demonstrate and experience the 55-word medical narrative as a brief but effective reflective exercise.
• Integrate the 55-word story narrative method into various clinical care and teaching settings in palliative care.

Finding innovative, reflective self-care techniques reduces the potential for burnout and the stress associated with attending to the needs of the very ill and the dying. Time is often a barrier to self-care, and narrative methodologies often seem to require too much time or writing ability. We offer a novel, time-efficient, and practical approach for debut at this conference that is useful to almost everyone.

The 55-word medical narrative about clinical encounters from the perspective of the clinician is the self-care therapeutic tool offered during this session. Participants will experience and leave empowered to approach the medical narrative in a brief but meaningful way. In this workshop session, participants will be introduced to pertinent research and content on narrative medicine, and will participate in writing a 55-word story about a personal or professional encounter in hospice and palliative care, or about a topic that they want to explore in palliative care, such as hope, compassion, doubt, or guilt.

Participants will share their 55-word story in dyads, give feedback on this method and its impact on resilience and reflection, and explore its utility on palliative care services, such as palliative care rounds, in large group discussion.
Quality of Life for Children Living with Severe Neurological Impairment and Their Families: How Can We Understand It Better, and Whose Lives Are We Talking About? (FR438)

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Objectives

• Recognize symptom scales and other instruments used in clinical care and empirical research to describe quality of life (QOL) in pediatric patients; appreciate their varied focus on emotional, physical, and interpersonal dimensions of daily life; and identify their optimal applications and limitations.

• Recognize how attention in the medical literature to QOL emerged around care for neonates who were critically ill and has since been focused on a range of different clinical contexts, including the lives of children with severe neurological impairment.

• Discuss and distinguish between (a) informing, framing effects, shared decision making, and the influence of implicit bias; and (b) the subjective experiences of those whose “lives” are being discussed—the child’s and the family caregivers’.

Describing, discussing, and contemplating quality of life (QOL) is central to developing treatment plans in the practice of hospice and palliative care. Family caregivers assess and act on the subjective experiences of their children living with severe neurological impairment (SNI). Health professionals integrating principles and practices of hospice and palliative care into treatment for children with SNI can enhance the services by achieving deeper understanding of the concept of QOL—its assessment, its history in the United States, ways to discuss it explicitly with family caregivers, and strategies for incorporating values into decision-making.

This session will include an innovative exploration into QOL for children with SNI and their families in three parts. Participants will

1. gain familiarity with symptoms scales and other instruments used in contemporary clinical care and empiric research to describe QOL in pediatric patients; appreciate their varied focus on emotional, physical, and interpersonal dimensions of daily life; and identify their optimal applications and limitations

2. review how attention to QOL in the US medical literature emerged in the 1970s around care for neonates who were critically ill and has since been focused on a range of different clinical contexts, including the lives of children with SNI

3. focus on distinctions between (a) informing practices, framing effects, shared decision-making, and the influence of implicit bias; and (b) the subjective experiences of those whose “lives” are being discussed—the child’s and the family caregivers’—in the course of conversations about QOL for children with SNI and their families.

Through a combination of case-based illustration, didactic presentation, and interactive audience discussion, seminar faculty will help participants reach a new and deeper understanding of QOL for children with SNI and their families.
Breathe Easy: Facilitating Ethical Decisions About Noninvasive Ventilation (NIV) in Advanced Illness (FR450)

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Objectives

- Identify the ethical and legal constructs related to the provision and the discontinuation of NIV in advanced illness and at end of life.
- Describe the use of the Four Box model to facilitate decision-making related to NIV in a case discussion.

Making decisions regarding the use of life-sustaining therapies can be very difficult for patients with advanced illness and/or their surrogate decision makers. Clinicians are often asked to facilitate this decision-making process and express concerns about how to best counsel others. Decisions that are inconsistent with ethical principles may result in moral distress and untoward outcomes. This session will discuss the use of the Four Box model for facilitating ethical decision making. Although the method can be applied in many scenarios, the discussion will focus on decisions related to the use of noninvasive ventilation in advanced cardiac, pulmonary, and neuromuscular disease.
Demystifying Nutritional Support in Cancer (FR451)

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Objectives

- Describe the pathophysiology and stages of the cancer-related anorexia-cachexia syndrome.
- Describe methods to assess cancer-related anorexia-cachexia at the bedside.
- Describe the interventions according to stages of cancer-related anorexia-cachexia.

Central to managing nutrition in the cancer patient is recognizing and managing the anorexia-cachexia syndrome. Research characterizes the anorexia-cachexia syndrome as a metabolic syndrome associated with advanced cancer producing loss of muscle with or without the loss of fat mass. Its development is a turning point in the disease trajectory of a cancer patient, with continued weight loss associated with a shorter survival time, and it is responsible for death in up to 20% of cancer patients. Anorexia-cachexia is a significant cause of morbidity that manifests as weight loss, asthenia (loss of energy and strength), anemia, and alterations in immune function. Research now recognizes anorexia-cachexia as a continuum consisting of three stages, defined as precachexia, cachexia, and refractory cachexia. Not all patients traverse the entire spectrum. Interventions potentially modifying the effect of anorexia-cachexia differ according to stages. Patients are often inappropriately recommended extreme types of nutritional support according to the stage of cancer and extent of the metabolic syndrome. Patients also experience messages that force them to adhere to therapies that are no longer appropriate for the stage of anorexia-cachexia. From presenters with diverse backgrounds in oncology, nursing, cachexia research, and community palliative care, and through didactics, case presentations, and audience participation, the session will accomplish four major goals for the attendees: (1) enhance knowledge of the basic pathophysiology of the anorexia-cachexia syndrome, (2) improve clinical assessment of anorexia-cachexia with a focus on clinical bedside assessment and technological advances, (3) characterize interventions according to stage of anorexia-cachexia, and (4) develop attendees’ skills at communicating with patients and families about cancer and nutrition. When this session is completed, palliative care specialists will walk away better equipped to participate in complex nutritional decision making for cancer patients.
Palliative Care in the Seriously Mentally Ill (FR452)

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Objectives

• Discuss existing literature on the integration of palliative care into care of people with mental illness.
• Discuss strategies that the practitioner can incorporate into practice to assist the seriously mentally ill in navigating the healthcare system, maintaining a therapeutic relationship with the patient, and helping staff cope with the person’s behavior.

The seriously mentally ill (SMI) remain an underserved population in palliative care. The relationship between SMI and poor physical health is well documented. SMI have double the risk of dying from natural causes at any given age than the general population. They are at a higher risk of death from comorbid conditions such as cancer, cardiovascular disease, and respiratory and gastrointestinal illness, leading to an average reduced life expectancy of 8-15 years. Individuals with a psychiatric disorder are at increased risk for having a comorbid substance abuse disorder. The 2009 Survey on Drug Use and Health found that 26% of all persons with mental illness meet the criteria for substance disorder. This is even higher in patients diagnosed with schizophrenia and bipolar disorder. Engaging people with co-occurring disorders in treatment can be extremely difficult. Psychiatric patients often deny their mental and physical illnesses. Physical illness, especially cancer, compounded with mental illness can be extremely challenging for both patient and provider. Using a case-based approach, we will explore the interdisciplinary approach to assisting this population into treatment, helping them navigate the healthcare system and continuity of care. The case will focus on strategies that the practitioner can incorporate into practice to address behavioral issues that may arise, advance care planning and decision making, and collaboration with mental health specialists to ensure that pain and other symptoms are controlled.
Paying Homage to Unsung Heroes: Understanding and Honoring Military Service at the End of Life (FR453)

Kelly Cooke, DO, Pro-Health Care, Eagle, WI
John Franklin, MD, Ralph H. Johnson VA Medical Center, Charleston, SC

Objectives
- Recognize the meaning behind military awards and decorations (medals and ribbons).
- Utilize that understanding to gain insight to the psychosocial impact of the military experience.
- Describe a variety of ways to honor military service at the end of life.

Ninety-six percent of dying veterans are cared for outside of the VA Healthcare System. One way to understand military service is to understand the significance of military awards and decorations (medals and ribbons). There is a hierarchy of awards and decorations for each branch of the service as well as some that represent joint service. Understanding medals will allow you to ask insightful questions, facilitating trust and providing an opportunity for the veteran to share, while you gain insight into the psychosocial impact of the military experience. There are a variety of ways to help veterans process their experiences and their impacts at the end of life. Furthermore, by thanking veterans for their service and finding creative ways to recognize and honor their service, you may create a legacy for their families for generations to come.

Being able to reframe the military experience around valor rather than trauma will help highlight the courageous rather than the tragic and may help elucidate survivor guilt. Each veteran has a personal story, as well as a collective memory. Military medals are often very important at the end of life for the patient and family. Understanding them improves end-of-life care through life review and legacy making. There are a variety of ways to honor military service. We will share the VA tradition of the final salute and flag ceremony as well as rituals done in civilian hospices.

Everyone deserves to have their life celebrated. Veterans have unique experiences that may provide for unique opportunities to honor them. This session will highlight the significance of military awards and decorations and how that understanding can lead to creative ways to honor veterans. While the session is specific to veterans, some of the psychological support tools and ways to honor them are universal.
California: Creating a Palliative Care STATE of Mind (FR454)

Helen McNeal, California State University, San Marcos, CA
Judy Citko, JD, Coalition for Compassionate Care of CA, Sacramento, CA
Michael Rabow, MD FAAHPM, University of California, San Francisco, San Francisco, CA

Objectives

- Recognize the multidimensional challenges facing palliative care in creating comprehensive access to services.
- Identify the individual organizations collaborating and their roles in addressing these challenges.
- Identify a variety of strategies for improving collaboration across programs and geography to enhance access to palliative care in one’s own state and community.

In California three organizations have come together to create an environment that fosters the growth of palliative care availability at both the state and local level. With this collaboration, a climate is being created that facilitates the growth of palliative care in hospitals, the movement of palliative care into the community, and the strengthening of both the generalist and specialist palliative care workforce, now and in the future. Success in palliative care at the local level is ultimately predicated on the creation of a larger climate that engages not only healthcare professionals, but also policy makers, payer sources, health systems, and consumers. This session will provide insights into a statewide model that has evolved in California and that is accelerating the pace of palliative care change across the state. It will provide information and strategies for collaboration that can be implemented in states and communities across the country, thereby supporting expanded palliative care access for all Americans.
Integration of CAM and Conventional Therapies into the Palliative Care of Patients with Advanced Cancer (FR455)

Lucille Marchand, MD BSN, University of Washington, Seattle, WA
Gabriel Lopez, MD, MD Anderson Cancer Center, Houston, TX
Steven Rosenzweig, MD, Drexel University College of Medicine, Philadelphia, PA

Objectives

• Identify common, challenging symptoms in cancer patients for which conventional medicine has limited effectiveness.
• Discuss selected evidence-based complementary therapies that can be readily incorporated into palliative care practice with cancer patients.
• Create therapeutic care plans for challenging cancer-related symptoms that incorporate safe, effective, and often cost-efficient CAM therapies that, when combined with conventional therapies, empower and improve the quality of life of patients with advanced cancer.

Many clinical issues in the care of advanced cancer patients do not have optimal conventional solutions. Integrative palliative medicine, which incorporates CAM and conventional therapies, serves to use the best evidence-based research in the creative pursuit of symptom control and improved quality of life, upstream from end-of-life care. Almost all patients with advanced cancer can benefit from the broader therapeutic repertoire of integrative palliative care, and many of our patients sustain hope and empowerment using CAM therapies with conventional therapies. This session will review the latest research findings of CAM therapies that palliative care clinicians can incorporate effectively into plans of care, especially for those symptoms that are most difficult to relieve with conventional approaches alone, such as mucositis, fatigue, and anxiety. Recent evidence-based guidelines from the American Cancer Society, the Society for Integrative Oncology, and Cochrane reviews will be highlighted. Therapies specifically addressed will include nutrition and supplements, movement and exercise, acupuncture, and mindfulness-based therapies. During the presentation, the audience will be asked to comment on CAM modalities and resources they have found most useful in their palliative care practices for these difficult cancer-related clinical issues. A case presentation will be incorporated to lead discussion on the challenging symptoms that arise in the palliative care of cancer patients.
Palliative Care Gets Hip: Hip Fracture Management in Patients with Advanced Disease (FR456)

Ursula McVeigh, MD, University of Vermont Medical Center, Burlington, VT
S. Elizabeth Ames, MD, University of Vermont Medical Center, Burlington, VT

Objectives
• Recognize the surgical and nonsurgical treatment options for patients with hip fractures.
• Recognize how goals of care impact treatment decision about hip fracture management in patients with advanced disease.
• Identify a model for successful collaboration between orthopedic surgery and palliative care.

Hip fractures affect 340,000 patients per year and can signal a significant decline in health status, as one in five patients dies within 4 months of a hip fracture. Clarification of a patient’s goals and prognosis beyond quantifying surgical risk is an important perioperative step, as a hip fracture may be occurring during an end-of-life trajectory.

Operative management has traditionally been chosen for this injury, but identifying instances in which operative treatment may not be desired or beneficial is important. Current literature suggests that less than 10% of hip fractures are managed nonoperatively, and there is a significant deficit within the literature examining how these decisions are made or descriptions of optimal care when not pursuing surgery.

A multidisciplinary task force including palliative care and orthopedic surgery worked together at our academic institution to develop a clinical pathway for identifying patients with hip fractures who would benefit from a palliative care consult. The palliative care consultant worked to assess prognosis from underlying disease, delineate goals of care, coordinate multidisciplinary discussions to consider both operative and nonoperative management, and attend to the psychosocial and spiritual needs of patients and families.

Fifty-eight patients with hip fractures were managed with nonoperative care in a 2-year period following the start of the collaboration. A retrospective descriptive analysis of these patients, including qualitative analysis of reasons for nonoperative decisions, was performed and identified that treatment decisions fell grossly into two groups—those with restorative goals but wishing to avoid perioperative risk of surgery and those with comfort-directed goals in facing the end of their lives from underlying illness.

This session will review both surgical and nonsurgical management for hip fracture, explore the impact of goals of care on treatment decisions, and provide a guide for developing effective palliative care and orthopedic collaborations.
From Silos to Synergy: Results of the Interdisciplinary Curriculum in Oncology Palliative Education (iCOPE) on Student Learning Outcomes (FR457-A)

Tara Schapmire, CCM LCSW MSW OSW-C PhD, University of Louisville School of Medicine, Louisville, KY
Barbara Head, PhD CHPN ACSW FPCN, Louisville, KY
Mark Pfeifer, MD, Louisville, KY

Objectives
• Understand the rationale and design of a research study to test an innovative interdisciplinary palliative care curriculum, with applicability to attendees’ own institutions.
• Name components of a plan to evaluate the outcomes of the innovative interdisciplinary palliative care curriculum.
• Summarize the impact of iCOPE on learner outcomes.

Original Research Background: Interprofessional education (IPE) is essential to prepare a practice-ready workforce equipped to provide team-based, holistic patient and family centered palliative care. This abstract describes an interdisciplinary model for a mandatory, centrally driven, and sustainable curriculum in palliative care and presents results from a study including students of social work, medicine, nursing, and chaplaincy.

Research Objectives: In 2010 the University of Louisville received funding from the NCI (NIH-1-R25-CA-148005) to develop and test the impact of an interdisciplinary palliative oncology curriculum on learners.

Methods: A pre/post mixed-methods research design was used to evaluate the impact of the curriculum on 391 students from chaplaincy, nursing, medicine, and social work over five semesters beginning in fall 2012. Participants completed four online case-based learning modules, a clinical rotation, a critical reflection assignment, and an interdisciplinary case management experience. Pre/post measures included the End-of-Life Professional Caregiver Survey (EPCS), evaluating palliative care–specific educational needs related to all eight domains of the consensus guidelines; and the Self-Efficacy for Interprofessional Experiential Learning Scale (SEIEL), measuring student self-efficacy perceptions related to learning collaboratively in interprofessional teams. Pre/post interdisciplinary palliative care knowledge questions were developed and administered. Students completed postcurriculum evaluation of the learning modalities and participated in focus groups to provide feedback on overall content, process, outcomes, and logistical considerations.

Results: Increases occurred in attitude and skill (EPCS, t(390)=-16.0, p<.001; d=0.81; SEIEL, t(385)=-30.6,p<.001; d=1.55); and a summation of correct knowledge-based questions (t(218)=13.3, p<.001; d=.89). Student ratings of high effectiveness and quality ranged from 89%-91%. Qualitative feedback revealed the following themes: high satisfaction with case-based interdisciplinary learning, clinical experiences; interdisciplinary team learning was new for most students.

Conclusions: The iCOPE curriculum significantly improves interdisciplinary palliative care practice, knowledge, and skills, and is a highly valued experience for learners.

Implications for Research, Policy, or Practice: The obstacles to IPE can be overcome to provide learners with the knowledge, attitudes, and skills essential for interdisciplinary practice in palliative care. Students can be significantly impacted when taught the principles of palliative care and teamwork using interdisciplinary, case-based, learner-centered approaches.
A Review of Clinical Practice Guidelines for Palliative Nursing (FR457-B)

Karen Kehl, PhD RN ACHPN FPCN, University of Wisconsin, Verona, WI

Objectives

- Recognize and locate at least three clinical guidelines that are relevant to palliative nursing.
- Identify domains of quality palliative care that are in need of nursing clinical practice guidelines.

Systemic Review Background: Clinical practice guidelines are meant to provide evidence-based recommendations that can optimize care. While the National Consensus Guidelines for Quality Palliative Care have provided an excellent foundation of understanding for the interdisciplinary practice of palliative care, clear practice guidelines for nurses can improve patient and family outcomes and guide nursing education. Practice guidelines concerning palliative care have been developed by various organizations and groups, but it has not been clear which of these are relevant to the clinical practice of palliative nursing.

Aims: The aims of this review were to (1) Identify existing clinical practice guidelines with relevance to the practice of palliative nursing and (2) Identify gaps in the existing guidelines that require additional research or guideline development.

Methods/Session Descriptions: Searches were conducted in the National Guidelines Clearinghouse, PubMed, and websites of professional nursing organizations using terms including palliative, nursing, symptoms, end-of-life, and hospice. Inclusion criteria included guidelines that were (a) specifically directed at nursing practice or that included nursing as one of multiple disciplines, (b) published, (c) evidence-based, and (d) included references. There were 25 appropriate guidelines, including the Oncology Nursing Society’s Putting Evidence Into Practice, which includes 20 topics. The National Consensus Guidelines for Quality Palliative Care were used as an organizing framework. The quality of the guidelines was assessed using AGREE II.

Conclusion: Some excellent, evidence-based guidelines are available that give clear direction for nurses’ clinical practice. The domains best represented include physical aspects of care, psychological and psychiatric aspects of care, social aspects of care, and structure and processes of care. There is a need for guidelines concerning spiritual, religious, and existential aspects of care; cultural aspects of care; care of the patient at the end of life; and ethical and legal aspects of care. Additional guidelines are also needed on specific aspects of some domains, including some common symptoms that are not represented and anticipatory grief.
**Beyond the Final Breath: Nursing Care at the Time of Death (FR457-C)**

Debra Rodgers, BSN RN CHPN OCN, Cottage Health System, Rosemead, CA  
Beth Calmes, MSN RN, Cottage Health System, Santa Barbara, CA

**Objectives**

- Explain three benefits to newly bereaved family members of a bathing and honoring practice.
- Plan implementation of a bathing and honoring practice in the clinical setting.

**Original Research Background:** Approximately one-third of the United States population dies in acute care hospitals. Although nurses are expected to give compassionate care around the time of death, the literature lacks specific evidenced-based interventions for care after death.

**Research Objectives:** We conducted a qualitative study to examine family members’ experience of a bathing and honoring practice as part of nursing care after patient death.

**Methods:** Following a patient death, all families on the oncology unit at Santa Barbara Cottage Hospital were offered the opportunity to participate in bathing their loved one and reciting nondenominational honoring words. This was called the bathing and honoring practice (the practice). Of 149 patients who died, 89 (60%) of the family members chose to participate in the practice. Three months after the patient's death, we interviewed 13 family members by telephone using a semistructured qualitative interview script. Interviews were recorded, transcribed, and verified. Three investigators analyzed the interviews independently and then collectively using conventional and summative qualitative content analysis methods. We coded emergent themes and grouped them into categories of superordinate themes, ranking them by number of times mentioned and number of interviews in which they occurred.

**Results:** Eleven superordinate themes emerged from the data. The top five themes were (1) positive experience, (2) supported grief process, (3) meaningful experience, (4) honored loved one, and (5) ritually and spiritually significant.

**Conclusions:** A bathing and honoring practice is a beneficial intervention for families after a patient dies in an acute care setting. The practice is a “caring moment, caring occasion” as defined by Jean Watson in her Nursing Theory of Caring and meets criteria in domain 7 of the National Consensus Guidelines for Palliative Care.
Timing of Survey Administration After Hospice Patient Death: Stability of Bereaved Respondents (FR457-D)

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Joan Teno, MD MS, Brown University, Providence, RI
Melissa Clark, PhD, Brown University, Providence, RI
Carol Spence, PhD, National Hospice and Palliative Care Organization, Alexandria, VA
David Casarett, MD MA FAAHPM, University of Pennsylvania Health System, Philadelphia, PA

Objectives

• Discuss the types of hospice quality measures that are most and least susceptible to instability between 3 and 9 months after death when bereaved family members are surveyed.

• Discuss the types of hospice quality measures that are most and least susceptible to instability due to changes in grief when bereaved family members are surveyed after death.

Original Research Background: The Affordable Care Act requires the public reporting of hospice quality of care using a bereaved family member survey. However it is not known what time point after death offers the most stable, reliable responses.

Research Objectives: To examine the stability of bereaved family members’ survey responses when administered 3, 6, and 9 months after the death of the hospice patient.

Methods: Bereaved family members from six hospice programs from diverse geographic regions were interviewed at 3, 6, and 9 months after the death of the hospice patient. All respondents completed a core survey. Those who died at home, free-standing inpatient unit, or nursing home completed a site-specific module. Stability of response was based on proposed top-box scoring of each survey item with kappa statistics, and multivariate regression models were used to assess directionality and predictors of change.

Results: We had a total of 1,532 surveys returned by 643 respondents (17.4% black, average age 61.7, 50.5% a child respondent) about decedents who used hospice services (55.3% female, average age 78.6, 57.0% noncancer, 40.0% died at home). There were no significant differences in decedent or respondent characteristics across time points. The average kappa between 3 and 9 months was 0.54 (range: 0.42-0.74) for core items, 0.58 (0.41-0.69) for home-specific items, and 0.54 (0.39-0.63) for nursing home items. To analyze the effects of grief, we assessed the stability of responses from respondents with improvement or worsening of their grief scores by 1 standard deviation from the mean change in grief between 3 and 6 months. Even among individuals who demonstrate large grief changes, core survey items demonstrate moderate to high stability over time.

Conclusions: Bereaved family member responses are stable between 3 and 9 months after the death of the patient.
Palliative Sedation: Emerging Challenges and Controversies (FR458)

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Donna Zhukovsky, MD FACP FAAHPM, MD Anderson Cancer Center, Houston, TX
Jessica Moore, DHCE, MD Anderson Cancer Center, Houston, TX

Objectives

• Discuss the spectrum of usages of the term palliative sedation in clinical practice.
• Evaluate the scientific evidence regarding the effects and efficacy of palliative sedation to relieve suffering.
• Discuss the ethical claim that sedation to unconsciousness is inherently questionable.

Palliative sedation is widely practiced as a method of last resort to alleviate intractable suffering at the end of life. Recently concerns have arisen over whether the procedure creates suffering or does irreparable harm to the integrity of the dying person. The two goals of this workshop are to (a) consider the different understandings of palliative sedation common in clinical practice and (b) examine the validity of the scientific and ethical objections to palliative sedation.

The questions we will address include the following: Can we reliably identify those people for whom palliative sedation may be useful? Is it ever harmful? Can we effectively mitigate that harm, if it exists?

We will begin with a summary of the definitions of palliative sedation by professional bodies and a review of how providers in clinical practice operationalize those definitions. Next we will review the scientific claim that we lack the clinical and radiologic tools to determine whether noncommunicative people remain in pain and the ethical claim that sedation to unconsciousness is inherently questionable. Case studies will be used to determine the clinical relevance of these challenges and the difficulties encountered in clinical practice when faced with intractable suffering.

By the end of this session, it is anticipated that participants will be able to provide a definition of palliative sedation and discuss some of the more recent ethical and scientific objections to the practice identified in the literature.
Development of an Integrated EMR Across Multiple Hospitals to Meet The Joint Commission’s Standards for Inpatient Palliative Care (FR460)

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Maria Gatto, APRN, CHE Trinity Health, Livonia, MI
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Objectives

- Define the need for an effective EMR to improve patient care and meet industry standards.
- Describe the elements needed for The Joint Commission’s accreditation for palliative care.
- Identify measureable operational, clinical, and financial outcomes.

The Joint Commission (TJC) established advanced certification for palliative care programs. The electronic medical record (EMR) provides an opportunity to meet these standards. There are multiple delivery systems that hospital programs use to deliver palliative care. CHE Trinity is the second largest Catholic healthcare system in the country, serving 21 states nationwide, and is standardized using the Cerner EMR system of Powerchart. Palliative care was identified as a system-wide strategic initiative for FY 13-FY 16. The FY 13 focus was in the acute care setting, and two of three key deliverables were to standardize and centralize documentation and data reporting. It was determined to incorporate both TJC certification standards and NQF palliative care endorsed measurement standards in an effective and user friendly format that meets the need of the palliative care core team.

Two workgroups were initiated, documentation and metric, that would support the subsequent delivery system of each hospital (MD led, APN led, RN led). In addition to the initial consult and progress note development, separate standardized documentation was developed for psychosocial assessment, chaplaincy assessment, and interdisciplinary team note that met National Consensus Project palliative care quality practice guidelines. In March 2014 the process went live and is now being used in 28 different hospital systems across CHE Trinity. We will report lean strategic approaches; project details; successes; challenges; lessons learned; and measureable clinical, operational, and financial outcomes.
The LVADs Are Coming, the LVADs Are Coming! The Anticipated Growth of LVAD Use and the Role of the Hospice and Palliative Medicine Specialist in LVAD Patient Care (FR461)

Ellin Frair Gafford, MD, The Ohio State University, Columbus, OH
Kristen Schaefer, MD, Dana-Farber Cancer Institute, Boston, MA
Arden O’Donnell, MPH MSW LICSW, Brigham and Women’s Hospital, Boston, MA
Stephanie Cooper, MD FACC, University of Washington, Seattle, WA
Sherri Wissman, RN, The Ohio State University, Columbus, OH

Objectives

• Describe the existing evidence base and current guidelines for specialty-level palliative care for patients with mechanical circulatory support (MCS).
• Define an algorithm for shared decision making and advance care planning for patients being considered for a left ventricular assist device (LVAD).
• Recognize the role of the nurse VAD coordinator in the continuity of care for patients with VADs.

As the population of patients with mechanical circulatory support continues to grow dramatically, the role of palliative care for these patients is also evolving. Increasingly the benefit of palliative care support for these patients is being recognized, and palliative programs will need to anticipate these patients’ needs. Recently the Centers for Medicare and Medicaid Services began mandating that a palliative care expert be a part of the mechanical circulatory support team. In this session, participants will identify strategies to improve clinical and psychosocial care for this patient population from an expert multidisciplinary panel.
De“liver”ing Palliative Care to Patients with Advanced Liver Disease: Creating Collaborative Models Between GI and Palliative Medicine (FR462)

Cristal Brown, Duke University Medical Center, Durham, NC
Arif Kamal, MD, Duke Cancer Institute, Durham, NC
Andrew Muir, Duke University Medical Center, Durham, NC

Objectives

• Discuss common symptoms and psychosocial issues impacting the management of patients with advanced liver disease.
• Discuss medications and procedures frequently used to address symptom management issues to familiarize palliative care specialists with the “toolbox” of gastroenterologists.
• Discuss methods of creating a collaboration between palliative care specialists and gastroenterologists to improve the management of these challenging, chronically ill patients based on the experience of a combined palliative care and liver outpatient clinic that opened in July 2014.

End-stage liver disease (ESLD) is defined as chronic liver disease with a decompensating event, such as ascites formation, variceal bleeding, or hepatic encephalopathy, and is a leading cause of morbidity and mortality. Though its disease manifestations, symptoms, and effects on psychosocial distress are frequent and burdensome, few cooperative models between gastroenterology and palliative care have been reported. Further collaboration would provide an extra layer of support to this population through better understanding of unmet needs and unique perspectives for symptom management that leverages the expertise and resources of each service. Using a case-based format examining the management of patients experiencing uncontrolled symptoms of ascites and encephalopathy, a multidisciplinary panel including gastroenterology and palliative medicine specialists will provide actionable insights into how specialty palliative care services can better integrate into the care of advanced liver disease patients. We will review common sources of physical and psychosocial distress, such as ascites management, substance abuse issues, and caregiver fatigue. Further, we will explore traditional pharmacologic and novel interventional symptom management approaches from both the GI and palliative care literature. Lastly, we will describe our unique model with embedded specialty palliative medicine within an established liver disease clinic. Participants will leave with practical tips to better manage sources of distress in patients with advanced liver disease and engage local gastroenterology colleagues in parallel care models.
Recognizing and Responding to Moral Distress (FR463)

Elizabeth Vig, MD MPH, University of Washington and VA Puget Sound Health Care System, Mercer Island, WA
Lucia Wocial, PhD RN, Indiana University and Fairbanks Center for Medical Ethics, Indianapolis, IN

Objectives

• Define moral distress and identify individual, case-specific, and institutional risk factors for developing it.
• Discuss the experience of moral distress and strategies for identifying and managing it in ourselves and others.
• Explain how facilitated ethics conversations can address moral distress at an institutional level.

Moral distress occurs when you can’t do what you believe is right because of institutional barriers and feel forced to act contrary to your core values. Although moral distress has been studied most in nursing, it has been documented in numerous healthcare professions and in healthcare managers. Palliative care and hospice providers may personally experience moral distress, and also may interact with colleagues who are experiencing it. “Untreated” moral distress can lead to burnout, to individuals leaving their positions, and even to individuals leaving their professions. This can be psychologically costly for individuals and financially costly for institutions. Members of the palliative care team may be able to recognize moral distress in themselves and their colleagues, and then may help institute interventions to prevent its adverse outcomes.

First, Dr. Vig, a palliative care specialist/ethicist, will provide an overview of moral distress through presentation and discussion of a case. She will define moral distress, review the disciplines at risk for developing it, and discuss risk factors (individual, clinical, and institutional) for developing moral distress in the context of the case. She will use an Internet-based poll embedded in the PowerPoint for audience participation.

Second, Dr. Wocial, a nurse/ethicist, will describe the experience of having moral distress and ways to identify it. She will explain the “crescendo effect” that moral residue builds over time and describe the consequences for institutions of having staff with moral distress.

Next, Dr. Wocial will discuss an intervention aimed at reducing moral distress. This program, titled Unit-Based Ethics Conversations, at Indiana University Health, provides a forum for hospital-wide discussion and awareness of moral distress. She will show a short video of this intervention.

This presentation is geared toward clinicians with a range of experience who practice palliative care and hospice in different settings.
What's in the Syringe? Why Does Early Integration of Palliative Care Work in Oncology? (FR464)

Eric Prommer, MD FAAHPM, Mayo Clinic Hospital, Phoenix, AZ
Esme Finlay, MD, University of New Mexico, Albuquerque, NM
David Hui, MD MSC FRCPC, MD Anderson Cancer Center, Houston, TX

Objectives

• Describe methods of palliative care involvement in published concurrent palliative care-oncology studies.
• Describe common methods of randomization, control arms, and clinical endpoint measures in published concurrent palliative care-oncology studies.
• Describe methods of communication used, with a focus on decision making and enhancing patient understanding of prognostic awareness, in published concurrent palliative care-oncology studies.

Recent clinical trial data show that introducing palliative care along with standard oncologic care in patients with advanced cancer is both feasible and acceptable among outpatients. This early pairing of palliative care and active cancer therapy has led to improved quality of life, better control of depressive symptoms, and improved survival compared with standard oncologic care alone. One important question is what in the palliative care intervention is responsible for the effects observed so far. Current published simultaneous-care studies involve differences in (a) cancer type, (b) method of randomization, (c) nature of intervention, and (d) postintervention care. Understanding components of the palliative care intervention leading to maximal benefit has important implications for future clinical trial design as well as the day-to-day interactions between oncology and palliative care teams. In this session, a panel of palliative care-oncology specialists will dissect and present an analysis of key simultaneous palliative care-oncology care studies, with a focus on the mechanics of the palliative care intervention. Key studies will be analyzed for (a) timing and setting of palliative care involvement; (b) intensity of symptom control; (c) communication practices, with a focus on decision making and enhancing patient understanding and prognostic awareness; (d) chemotherapy consumption and chemotherapy allowance at the end of life; (e) outcome measures; and (f) control arm. Interventions leading to important clinical impact will be identified and correlated to hypothetical models of palliative care-oncology intervention. Attendees will have the opportunity to discuss their own interactions with oncology and share with the panel and other attendees their experiences as to what seems to be the key ingredient in successful oncology-palliative simultaneous care. Hypotheses generated from the discussions will support or challenge current models attempting to clarify why the early palliative care-oncology interaction works.
The Art and Science of Paying Attention: Mindfulness for Clinicians Who Can’t Sit Still (FR465)

Denise Hess, MDiv BCC MFTI, Providence Little Company of Mary Medical Center, Torrance, CA
Glen I. Komatsu, MD, Providence Little Company of Mary Medical, Rancho Palos Verdes, CA

Objectives

- Self-assess one’s own mindfulness behaviors using the Mindful Attention Awareness Scale (MAAS).
- Assess research on mindfulness among healthcare professionals.
- Demonstrate the “Pause, Presence, Proceed” method of mindfulness meditation.

Currently hospice and palliative care physicians, nurses, social workers, and chaplains are under unprecedented pressure to do more with less and to stretch their time, talents, and resources over larger patient populations with more challenging issues. Added to these pressures are the insistent warnings about burnout, compassion fatigue, and secondary traumatic stress. Stories of committed, expert clinicians leaving healthcare abound.

From the cover of *Time* magazine to professional journals from multiple disciplines, mindfulness and mindfulness meditation are in the press. The body of scientific research on mindfulness is growing exponentially and demonstrating the positive effects of mindfulness practices on a variety of physical and psychological conditions, such as depression, high blood pressure, psoriasis, stress, chronic pain, and more. The newest research on mindfulness and neuroplasticity suggests beneficial brain changes from regular mindfulness practice. Mindfulness-based stress-reduction and other mindfulness meditation courses are being taught and practiced in many types of settings, from schools to prisons to medical schools to Fortune 500 companies. Recently, researchers have been investigating and introducing mindfulness practices in a variety of healthcare settings. The initial findings suggest that mindful clinicians have a lower incidence of burnout, depression, and anxiety and are more focused, efficient, and likely to have satisfied patients.

This concurrent session offers an introduction to the latest mindfulness research along with guided practice in formal and informal mindfulness experiences. Mindfulness is presented as a way of being that can be integrated into every aspect of personal and professional life. Participants will not only learn about mindfulness, but will also practice mindfulness meditation in several accessible forms and create their own personalized action plan for continuing practice in their professional setting. This session is designed to accompany and enhance the daily mindfulness meditation sessions held each day of the conference.
Playing Together in the Sandbox: An Interprofessional Simulation to Teach Collaborative Communication Skills in a Family Meeting (FR466)

Dorothy Wholihan, DNP ANP, New York University College of Nursing, New York, NY
Susan Cohen, MD, Bellevue Hospital Center, Bronx, NY
Robert Smeltz, MA NP RN ACHPN, Bellevue Hospital Center, New York, NY

Objectives

• Identify core competencies for interprofessional collaboration within the context of a family meeting simulation.
• Apply simulation strategies to teach collaborative communication skills to interprofessional palliative care trainees.

Simulation to teach communication has become established practice in palliative care education, but rarely are communication skills taught in interprofessional team settings, and rarely at the graduate level. Nurse practitioners (NPs) and medical residents frequently work in parallel fashion. However, the family meeting is a common encounter in which medical and advanced practice nursing providers must collaborate to ensure smooth, professional, and compassionate communication. An interprofessional simulation was developed that pairs 2nd-year residents and 2nd-year NP students and requires them to collaboratively lead a family meeting to establish goals of care for a patient with a poor prognosis. Details of the case are provided to students before the family meeting. Students then hold a prebriefing before the family meeting to articulate and negotiate their respective roles in the meeting. The MD/NP team is filmed as they lead a family discussion to communicate bad news and discuss goals of care in a seriously ill, intubated patient. This pilot program ran from May to July 2014.

Using established models for breaking bad news and the Core Competencies for Interprofessional Collaborative Practice, the following objectives were developed:

1. Students will articulate and negotiate interprofessional roles within a family meeting.
2. Students will demonstrate the skills needed for collaboratively breaking bad news and establishing goals of care with families of a medically complex patient.

Outcomes of the exercise will be measured by the Readiness for Interprofessional Learning (RIPLE) scale, an evaluation scale for standardized patients, and a faculty skills evaluation checklist. Quantitative data and subjective responses will be reported. Implications for future practice will be discussed. The program developers hypothesize that a graduate-level interprofessional communication simulation will enhance participants’ collaborative skills in leading family meetings to break bad news and establish goals of care.
Concurrent Urologic and Palliative Care after Cystectomy for Treatment of Muscle-Invasive Bladder Cancer (FR467-A)

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Carly Benner, MD, University of California, San Francisco, San Francisco, CA
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Objectives

• List the severity of baseline physical and emotional symptoms for patients preoperatively before cystectomy as definitive treatment for muscle-invasive bladder cancer.

• Describe the outcomes associated with the addition of palliative care offered concurrently in addition to usual care for muscle-invasive bladder cancer.

• Describe the impact on family caregivers of palliative care offered concurrently with usual care for patients with muscle-invasive bladder cancer.

Original Research Background: Bladder cancer and its treatment create significant distress, but symptoms often are not adequately assessed, and few interventions have been prospectively evaluated using validated instruments. In particular palliative care offered concurrently with surgical oncologic care for patients with bladder cancer has not been studied.

Research Objectives: To characterize the impact of palliative care concurrent with usual urologic care for bladder cancer patients undergoing cystectomy.

Methods: Prospective, 6-month, serial cohort study comparing 33 participants receiving usual care with cystectomy for muscle-invasive bladder cancer with 30 participants also receiving concurrent palliative care. Patients and family caregivers completed validated symptom assessment and satisfaction surveys preoperatively and 2, 4, and 6 months postoperatively.

Results: The intervention group saw improvements in most symptom measures over the 6 months following cystectomy compared with the control group. Depression and anxiety decreased over the 6-month period for intervention patients but increased over this time among controls (p=0.01). Fatigue fell to a minimum for intervention group participants at 4 months, while it peaked at this time for control participants (0.002). Quality of life and posttraumatic growth scores followed a similar pattern, with scores peaking at 4 months for the intervention group, while controls reported their lowest scores at this time (p=0.01 and p=0.03, respectively). Changes in pain scores did not reach statistical significance. Neither family caregiver burden nor patient satisfaction showed statistically significant changes over time.

Conclusions: Patients who received concurrent palliative care in addition to usual urologic care following radical cystectomy for muscle-invasive bladder had better outcomes compared with usual care alone, including improved fatigue, depression, quality of life, and posttraumatic growth.

Implications for Research, Policy, or Practice: While further research on this topic is needed, our results suggest that providing palliative care services in addition to usual urologic care for bladder cancer patients may significantly reduce postoperative symptoms and should become routine practice.
The Use of a Brief Five-Item Measure of Family Satisfaction as a Critical Quality Indicator in Advanced Cancer Care (FR467-B)

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Objectives

- Review psychometric properties of a brief scale to assess family satisfaction with advanced cancer care.
- Describe current guidelines/practices for assessment of family satisfaction with care for advanced illness.

Original Research Background: Family satisfaction is a critical indicator of quality of care for patients with advanced illness that is commonly measured in palliative care research. Yet the systematic assessment of family satisfaction as a quality indicator is rarely practiced despite an emphasis on the importance of family input and support for caregivers in advanced care for those with cancer and other serious illnesses. Measurement burden may be one barrier to widespread use of family satisfaction measures.

Research Objectives: To use a brief measure of family satisfaction to assess differences across sites.

Methods: We used data from the Palliative Care for Cancer Patients (PC4C) study, a multisite observational study of the effect of inpatient palliative care on patient health outcomes and health service use among patients with advanced cancer. Using Item Response Theory (IRT), we developed a shortened five-item version on the FAMCARE scale to measure family satisfaction with care. We used multivariate regression analysis to detect significant differences across five treatment sites controlling for patient demographics, cancer type, family relationship to patient, and use of inpatient palliative care.

Results: Family satisfaction data were available on 1,979 patients. The most common cancer type was gastrointestinal (28%) followed by lung (13%). Mean FAMCARE-5 score across sites ranged from 5.54-6.89 out of a possible score of 10 (highest level of satisfaction). Family members of patients at site five (n=783) were significantly (p<.01) less satisfied with their care than family members at other care sites.

Conclusions: Variability in family satisfaction with advanced cancer care across sites can be detected using a brief five-item questionnaire.

Implications for Research, Policy, or Practice: The development of less lengthy and burdensome measures for monitoring family satisfaction among patients with serious illness can facilitate the routine assessment of family satisfaction to maintain and promote high quality care across care settings.
Exploring the Meaning of Caregiving During Life-Limiting Illness: Qualitative Results of the Caregiver Outlook Trial (FR467-C)

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Objectives

• Learn approach to addressing caregiver’s existential needs during serious illness.
• Learn context for study results within larger literature.

Original Research Background: Research suggests caregiver’s subjective sense of burden appears to be influenced by the meaning caregivers ascribe to their role.

Research Objectives: Identify the role-related meaning expressed by caregivers of those with life-limiting illness participating in an intervention, called Caregiver Outlook, to address caregiver’s existential needs.

Methods: The study was a one-arm pilot feasibility and acceptability trial of the Caregiver Outlook intervention, a standardized, chaplain-led intervention to address caregiver existential needs. Structured interviews allowed participants to respond as desired with follow-up probes based on caregiver’s responses. This presentation is a qualitative content analysis of the three intervention sessions, focused on relationship life review, forgiveness, and relational legacy. Content analyses included manifest coding as well as latent coding of caregiver’s narrative themes, expressing their individual stories and meaning of caregiving experience. Caregivers were recruited from outpatient palliative care and ALS clinics at an academic medical center; English speaking; and spouses, partners, or close family members of those with serious illness.

Results: Of the 36 trial participants, we selected a purposive subsample (n=13, 36 sessions), seeking maximum variation. Four participants cared for those with cancer and nine with ALS (matching sample proportions); six were male, seven female; two African American, nine white; and four adult children and nine spouses or partners. Caregiver main themes included caregiving challenges, motivation for caregiving, learning from caregiving, grief and loss, and spiritual journey. Each main theme included subthemes expressed across caregivers with detail varying particularly by subgroups (eg, motivation by gender or caregiver challenges by level of patient dependence).

Conclusions: Caregiver Outlook themes offer areas of potential needs and resources as caregivers explored meaning making to buffer caregiving demands.

Implications for Research, Policy, or Practice: Caregivers noted the opportunity to engage in such conversations assisted in gaining perspective in the midst of significant challenges and often isolation.
**Hospice Quality and Grief: Honoring Patient Preferences Matters (FR467-D)**

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**Objectives**

- Identify important opportunities to improve the quality of hospice care.
- Understand association of bereaved family members’ perceptions of the quality of care and their self-reported level of grief.

**Original Research Background:** Few studies have examined predictors of grief among hospice primary caregivers.

**Research Objectives:** Characterize bereaved family members’ perceptions of the quality of hospice care with their level of grief.

**Methods:** Respondents from six hospices drawn from diverse regions of the country completed an interview (response rate 53%) at 6 months post death. Interview content focused on a core set of questions for all patients about unmet needs for symptoms, concerns with communication, emotional and spiritual support, problems with care coordination, adherence to patient’s goals of care, and sociodemographic characteristics. A multivariate linear regression model was used to examine predictors of the level of grief as measured by the Inventory of Complicated Grief—Revised Short Form (ICG-R) by Prigerson and colleagues.

**Results:** Interviews were conducted with bereaved respondents (32% spouse, 50.5% child) regarding the quality of hospice care in 537 decedents (mean age 78.5, 56.2% female, 18.9% black). The ICG-R mean score was 44.5 (SD 9.5), and varied from 11 to 55 (lower score indicating worse grief). A multivariate linear regression found the hospice primary caregiver’s perception that the patient’s wishes were not followed was associated with a 4.7 point lower grief score. Other measures associated with worse grief included concerns with coordination (4.1 points lower, 95% CI -7.0, -1.2), lack of spiritual support (3.7 points lower, 95% CI -6.9, -0.42), and no prior experience with hospice (2.7 points lower, 95% CI -4.6, -0.74). Persons with a formal advance directive had improved grief score by 2.3 points (95% CI, 0.2, 4.4).

**Conclusions:** Primary caregivers’ prior experience with hospice and their perceptions of concerns with the quality of care are associated with their level of grief 6 months after the death of the patient.

**Implications for Research, Policy, or Practice:** This cross-sectional study suggests that efforts to improve hospice quality may lead to diminished grief.
Depression Moderates the Positive Impact of Early Palliative Care on Survival Among Advanced Cancer Patients (FR467-E)

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Objectives

• Understand the complex relationships among palliative care, depression, and survival.
• Report the results of a secondary data analysis of 2 RCTs.

Original Research Background: We previously demonstrated improved depression and survival in advanced cancer patients participating in two palliative care RCTs. ENABLE II (EII; n=322) compared intervention versus usual care and ENABLE III (EIII; n=207) compared immediate versus delayed intervention. The interventions were similar (eg, in-person PC consultation, weekly phone sessions facilitated by a nurse coach, and monthly follow-up calls), except in EIII there was a delayed intervention group (beginning 12 weeks after enrollment) and a caregiver intervention. The Center for Epidemiologic Studies-Depression (CES-D) was collected at baseline and approximately every 12 weeks until death or study completion.

Research Objectives: To determine whether baseline depression moderates the effect of the intervention on survival in the combined RCTs’ sample (n=529; intervention n=368; usual care n=161).

Methods: A Cox proportional hazard analysis was conducted with (a) intervention (as a time-varying covariate), (b) baseline CES-D scores, and (c) their interaction, entered simultaneously.

Results: There was a significant effect of the interaction (intervention x CES-D) on mortality risk (p=.035), indicating a moderating role of depression. To clarify the nature of this interaction, we classified patients as depressed (baseline CES-D>16) or not and conducted a separate Cox analysis within each depression group that included intervention as the sole predictor variable. Among depressed patients, receiving the intervention was associated with lower mortality risk (HR = 0.65, CI: 0.44-0.95, p=0.29), but this relationship was not significant among nondepressed patients (HR = 0.89, CI: 0.65-1.21, p=45).

Conclusions: The ENABLE intervention effect of reduced mortality risk was moderated by baseline depression such that the magnitude of the intervention effect increased as baseline depression scores worsened. This finding provides initial insight into one mechanism of early PC.

Implications for Research, Policy, or Practice: This finding warrants further study; however, given limited PC resources, it may be most beneficial to target early PC for depressed patients.
Bringing It to the Streets: A Novel Approach to Improve Palliative Care for Homeless Adults (FR468)

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Objectives
• Identify specific challenges faced by homeless patients at the end of life in an urban setting.
• Recognize the scope of problems for providers who care for homeless patients at the end of life.
• Describe two different models for addressing the unique palliative care needs of homeless patients.

People who are homeless experience a disproportionate amount of serious illnesses early in adulthood and may more frequently experience violent deaths. Homeless adults often share end-of-life concerns reported by housed individuals, for example dying without suffering, being surrounded by loved ones, and dying in a location of their choosing. However, homeless individuals often face additional challenges, including identifying reliable caregivers, securing safe and stable housing, and establishing continuity and trust with medical and social services providers.

This population is notoriously difficult to engage in care for a variety of reasons, including limited access to phones and transportation, substance abuse, medical and psychological comorbidities, and limited income. In light of such significant challenges, hospice and palliative care providers often struggle to provide dignified and safe end-of-life care for their homeless patients. Providers may be unaware of available community services for homeless persons, or they may have difficulty coordinating care across fractured and often disconnected agencies and systems. In this session, we will outline the challenges faced by homeless people with serious illnesses, review existing literature related to caring for this population, and describe different models that enable high-quality palliative care for homeless individuals. We will specifically highlight a novel approach to providing patient-centered, coordinated palliative care services for homeless patients in Seattle. Using case examples from the pilot phase of the program, we will contrast standard outpatient palliative care clinic services with the new, patient-centered “care conference” model. Based on lessons learned from the pilot phase of this program, we will share best practices in palliative care for homeless persons, which can be applied in a variety of urban settings.
The Mock No-Code: Cases and Resources for Professionals in Pediatric ICUs (FR469-A)

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Objectives

- Anticipate areas of potential distress in patients, families, and the other team members.
- Recognize, assess, and treat symptoms of suffering and distress in the patient in ways that are effective, safe, and ethical.
- Articulate the advantages and disadvantages of different modes of withdrawal and nonescalation of life support.
- Use language and specific phrases that can help frame care decisions in ways that are helpful to patients and families.
- Adapt the learning tools for use in your own institution.

Background: In the last decade most children’s hospital deaths occur in intensive care units following orders to limit resuscitative efforts. Although physicians and nurses in pediatric ICUs are usually required to be certified in pediatric advanced life support, these professionals are less likely to participate in a “code blue” event than they are to be involved in caring for a child whose death is anticipated or will follow a planned withdrawal of care. Training for these expected pediatric ICU deaths is not required and rarely standardized in most children’s hospitals. This innovation addresses these gaps in training.

Methods: Each “Mock No-Code” begins with a case discussion that will highlight two or more learning objectives. A pocket card (downloadable to a smart phone) with algorithms and evidence-based guidelines is reviewed. The facilitator ensures that equal attention in end-of-life situations is placed on “what to be ready to SAY” as on “what to be ready to do.”

Results: Pilot data indicate that participation in this training increases confidence and lowers anxiety of both nurses and physicians. Physicians and nurses find the pocket card to be a useful resource when dealing with end-of-life care.

Discussion: The materials presented in this session can be adapted for use in any ICU. Sessions to highlight objectives can range in time from 20 to 40 minutes.

Conclusion: Increasing staff preparedness for anticipated pediatric deaths in children’s ICUs should be an important part of ongoing training. The Mock No-Code can be an important part of this curriculum.
Brief Mindfulness-Based Self-Care Curriculum for an Interprofessional Group of Palliative Care Providers (FR469-B)

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Objectives
• Describe and give examples of formal and informal mindfulness techniques.
• Demonstrate use of brief mindfulness-based exercises.
• Identify self-care strategies that they use to cope with work-stress.

Background: Studies demonstrating high burnout rates for clinicians in hospice and palliative care have raised awareness of the importance of provider self-care. Mindfulness-based interventions have shown self-care benefits, including improved quality of life, job satisfaction, and burnout symptoms. Established programs are time-intensive (most 18-52 hours of instruction) and target primary care physicians and nurses. This curriculum is a 5-hour mindfulness-based intervention targeting an interprofessional group of palliative care providers within the regular workday schedule.

Methods: The curriculum was executed in five monthly 1-hour sessions. The content was based on consultation with texts (primarily books by Jon Kabat-Zinn and Thich Nhat Hanh) and with experts (a mindfulness-based stress reduction teacher and a physician with experience designing and delivering a published physician mindfulness curriculum of longer length [see Krasner MS et al, JAMA, 2009]). Pre- and postintervention surveys were collected assessing participant mindfulness, burnout, and stress levels on validated scales and reported mindfulness practice frequency. Satisfaction and narrative data were also collected.

Results: Participants reported being very satisfied with the series and showed statistically significant improvements in mindfulness levels (3 of 5 subscales) and burnout scores (1 of 3 subscales) and increased frequency of self-reported informal and formal practice. Open-ended narrative evaluation also demonstrated retention of concepts presented during the series. Participants expressed a preference for continuing elements of the series in ongoing program activities.

Discussion: While mounting evidence suggests that mindfulness-based approaches may be useful for self-care, most of the formally evaluated curricula have not been directly applicable to a clinical work setting. This curriculum offers a brief intervention that was well-received by an interprofessional team of practicing palliative care providers. While the pre-/postintervention design prevents us from excluding confounding factors, participants did show improved mindfulness and burnout scores on postintervention evaluation. The curriculum was executed initially on a monthly basis; feedback from participants included requests for more frequent sessions, and it could be adapted to the team’s usual schedule as necessary.

Conclusion: Delivery of a brief, 5-hour mindfulness-based self-care curriculum within the regular workday was feasible, well liked, and associated with improvements in mindfulness and burnout levels.
Health Communication iOS APP: A Free Resource for Interprofessional Curriculum Training (FR469-C)

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Objectives
• Educate and support the communication training of palliative care team members.
• Provide skills-based guidance about relational communication in the clinical context.
• Identify concrete communication practices for challenging topics in palliative care.
• Disseminate evaluation findings of the Health Communication APP.

Background: With the influx of palliative education programs during the last decade, the inclusion of mobile device support remains limited, and the study of mobile app usability and feasibility is even more rare. To increase clinical communication training exposure to a variety of team members and expand palliative care training beyond health education, the Health Communication APP features over 100 specific communication strategies as well as a search by scenario menu. Two primary features are included: first, a quick reference guide for what to say and how to say it in a variety of circumstances, and second, a communication toolkit that helps clinicians effectively respond to difficult conversations with patients and caregivers. App content is derived from theory and evidence resulting from 10 years of research in a variety of healthcare contexts.

Methods: The content of the App is based on the COMFORT Communication Curriculum. The curriculum has been peer reviewed and tested among palliative care audiences (undergraduate and graduate education as well as clinical audiences); all studies have demonstrated significant change in communication confidence, comfort, knowledge, and efficacy.

Results: Findings from feasibility and usability tests of the APP will be presented. Results are based on feedback data from clinicians who have downloaded and used the APP. Initial feedback has demonstrated high satisfaction with APP content and ease of use.

Discussion: To meet the growing dependence on mobile devices for information and support, the Health Communication APP provides learners and clinicians with a resource for learning about palliative care communication. This educational tool can be used to provide interprofessional education, supplement communication instruction, and to guide clinical observations as well as curriculum development.

Conclusion: The Health Communication APP mobile content is an innovative tool for palliative care communication training. Clinicians and students find it easy to use and valuable to their practice.
Pilot to Design an Observed Structured Clinical Examination (OSCE) for the Communication Skill of Cultivating Prognostic Awareness (FR469-D)

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Objectives

• Discuss the developed case and scoring system that measures the skill of cultivating prognostic awareness.
• Discuss how we evaluated how well our program taught this skill to our interprofessional fellowship class.

Background: As palliative care develops as a field, palliative-care specific communication skills are becoming more clearly defined. Helping patients to cultivate prognostic awareness to make informed medical decisions is one such skill. This skill requires clinicians to disclose prognostic information honestly and empathically while titrating the disclosure to the patient's information preferences and enabling the patient to continue to hope.

Methods: We developed a case and scoring system for an OSCE. The OSCE was administered to 11 interprofessional fellows at the beginning and end of fellowship. The case and scoring system were adjusted based on our observations and fellow feedback during this pilot phase so that the scores captured the desired expertise. Statistical analysis was performed on a program level to evaluate the fellowship program's effectiveness in teaching this skill.

Results: The final version of the OSCE has three parts. Part 1 contains six communication steps to cultivate prognostic awareness. Part 2 contains one global rating of expertise. Part 3 is the NURSE scoring system for empathic communication.

Discussion: An OSCE provided a standardized measure for our fellowship's effectiveness in teaching the skill of cultivating prognostic awareness. In addition to being more likely to discuss prognosis, more expert communicators were observed to use more NURSE skills and to disclose prognosis iteratively, repeatedly titrating the prognostic disclosure to the patient's information preferences and ability to tolerate the discussion and integrate the information.

Conclusion: Formal validation of the OSCE will require a larger number of participants, which we are in the process of accruing.
**Death Cafes: A Tool for Teaching about End of Life in Both Academic and Community Settings (FR469-E)**

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**Objectives**

- Increase awareness of death with a view to helping people make the most of their (finite) lives.
- Create a safe and informal forum for health professions learners (medical and nursing students, residents, fellows) and community members to discuss EOL issues openly and authentically.
- Build a foundation for subsequent training in relationship-centered EOL care, contemplative care, and cross-cultural approaches to dying and death.

**Background:** Since 2011 over 1,000 Death Cafes have been held around the world. A Death Cafe is a casual group discussion of dying and death, typically hosted in someone's home. Participants, usually strangers, gather to eat cake, drink tea, and discuss death. The Death Cafe model was developed by Jon Underwood and Sue Barsky Reid (Great Britain), based on the ideas of sociologist Bernard Crettaz (Switzerland). We hosted the first Death Cafe in San Francisco as part of the UCSF 80-hour interprofessional course “Integrative Approaches to End-of-Life Care.” Over the past 2 years, UCSF and Zen Hospice Project have hosted regular Death Cafes in both academic and community settings as part of our end-of-life (EOL) educational partnership.

**Methods:** Each Death Cafe consists of a 2-hour meeting with 15-25 participants (typically talking in small groups of four to six people). One or two facilitators loosely structure the session through prepared discussion prompts or short exercises designed to encourage conversation.

**Results:** In written evaluations (responses to open-ended prompts regarding the nature and impact of the Death Cafe experience), participants note that discussing difficult or taboo subjects in a safe, informal context has helped to transform their attitudes toward death. People report being surprised at the ease with which they are able to discuss end-of-life issues in these settings; they emphasize that sharing personal concerns in a group of strangers is not only comforting, but also serves to normalize the death-related topics.

**Discussion:** Because Death Cafes provide a secure and casual context in which to explore one of the most challenging and fear-inducing topics, the discussions can be used strategically as points of entry for much-needed societal reappraisal of how we approach—and how we want to approach—the end of life.

**Conclusion:** We have found Death Cafes to be an extremely effective educational tool. We will share practical guidelines and suggestions for the use of Death Cafes in both academic and community settings.
“Flipping the Classroom” for Weekly Teaching Sessions: Create Your Own Low-Cost Website with Learning Resources for Fellows and IDTs (FR469-F)

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Objectives
• Create a comprehensive list of 45 topics pertinent to both adult and pediatric HPM fellowship training, including topics applicable to geriatric fellowship training and interdisciplinary team members to encourage their attendance to small group discussions.
• Develop a website that “flips the classroom” for individual study of content prior to each session, followed by weekly small-group discussion of practical application to patient cases.

Background: Creating a comprehensive set of engaging traditional PowerPoint lectures for a full year of fellowship training is a daunting task for a new program director. In a collaborative effort to combine and improve weekly classroom sessions for two small HPM fellowships (adult and pediatric), we “flipped the classroom” by creating a simple low-cost website to organize background materials for an annual series of 45 weekly small group HPM topic discussions.

Methods: We created a list of 45 HPM topics from 32 lectures in the 2012 AAHPM Board Review Course and chapters from two core related to communication skills and pain management. We created a simple password-protected website using an online service and uploaded background lecture MP3 recordings and PDF articles organized by weekly topic. Each week one HPM faculty member or fellow facilitated group discussion of patient cases related to the background content. Paper handouts were often distributed, but not a single PowerPoint slide was projected during the year.

Results: HPM fellows and faculty rated weekly sessions very highly and strongly encouraged continued use of the “flipped classroom” approach. Both the adult and pediatric fellows said the series was the single strongest teaching component of their fellowship year. They strongly endorsed the value of periodic attendance by geriatrics fellows and IDT members and suggested ways to increase their attendance.

Discussion: A simple website with weekly background content and small-group discussions of 45 core HPM topics were highly rated by both adult and pediatric palliative care fellows and faculty. Now that the website content is established, it is low cost ($18 per month) to maintain and improve in subsequent years.

Conclusion: This approach to classroom teaching is an efficient and engaging way for fellowship programs to organize and present weekly teaching topics and could be easily adapted by interdisciplinary teams for regularly scheduled professional development sessions.
Doing Quality Improvement Together: How to Participate and Benefit from Multisite Quality Collaborations in Palliative Care (SA500)

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Objectives

- Describe the successes and challenges of five regional and national quality improvement collaborations.
- Recognize ideas for quality improvement projects, including how to integrate local efforts with those of larger consortia.

Palliative care quality improvement efforts are accelerating, yet single-site efforts are limited in generalizability and sustainability. Collaborative initiatives are critical to achieving these goals.

We will present steps in creating, building, and sustaining palliative care networks for quality improvement alongside examples of successful and ongoing projects. Our panel includes physician and nursing leaders of five established collaboratives: the Palliative Care Research Cooperative Group (PCRC); the Palliative Care Quality Network (PCQN); the Carolinas Consortium for Palliative Care; the Center for Hospice, Palliative Care, and End-of-Life Studies at the University of South Florida; and the Virtual Learning Collaborative to Reduce Disparities for Advanced Cancer Patients and Family Caregivers. These efforts are diverse in purpose, geography, and size and represent some of the most ambitious, productive, and thriving consortia to study and improve palliative care.

First we will review our experiences in creating and sustaining multisite collaborations, including how to engage stakeholders, review goals, appraise resources and costs, and reconcile the varying interests of members. Next we will provide examples of quality improvement projects and share preliminary results that highlight how rapid assessment and development of best practices can thrive in palliative care. Such examples include a pain management program through the PCQN, a dyspnea and constipation project within the Carolinas Consortium, and implementing an evidence-based concurrent oncology-palliative care model in settings with a majority of minority.

During this session we will share our experiences, challenges, and lessons learned in establishing and sustaining five large quality improvement collaborations in palliative care. In addition, we will foster an open dialogue with the audience to promote development of similar programs in their local communities. Together we hope to build a mutual understanding of the power of quality improvement collaborations and a practical path forward so all may participate and benefit.
“There Is Going to Be a Miracle”—Decision-Making When Religious Beliefs and Medical Realities Conflict (SA501)
Christina Puchalski, MD FACP, George Washington University and the GW Institute for Spirituality & Health, Arlington, VA
George Handzo, MDiv, Healthcare Chaplaincy Network, Cos Cob, CT

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

One of the most challenging encounters in medicine for clinicians and families are the ones between healthcare providers whose reality is rooted in science and medical data and patients and family members whose primary reality is rooted in religious beliefs. Researchers have documented that spiritual beliefs are viewed as a key means of coping. Belief in a higher power with the ability to perform miracles is a very sacred aspect of life and spirituality. More than 50% of participants in most published studies believe in miracles. Thus conversations about goals of care and prognosis can become adversarial and cause stress to the healthcare team and perhaps undue suffering for the patient. Resolutions often require ethics and legal consults.

Many healthcare professionals believe that resolving these types of cases requires special skills and, most importantly, time that they do not have. It is true that the expressed belief that a miracle will or might occur can arise from several causes, not all of them rooted in religion or spirituality. Thus it is important for providers to first determine what “miracle” means to this particular family through a proper assessment and relationship building. Through didactics, discussion, and use of case examples, this workshop will present practical and time-efficient processes for forming positive alliances with families who hold strong religious beliefs and coming to decisions about end-of-life care that respect both the medical realities and the family’s religious beliefs. Important elements of this process are respectful, attentive listening; a thorough spiritual history; and specific practical communication strategies for aligning with the patient and identifying common goals of care. Differentiating situations truly based on religious issues and situations in which the issues are actually emotional but framed in religious language will be discussed.
The Practice of Palliative Medicine in Developing Countries—Part Two (SA502)
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Aleiya Virgo-Herron, MBBS, Ministry of Health, Hope Institute Hospital, Kingston, Jamaica
Anita Eseenam Agboko, MBChB, Komfo Anokye Teaching Hospital, Kumasi, Ghana

Objectives
• Learn how physicians in specific countries provide palliative care to their patient populations, often with limited resources.
• Understand specific cultural and political challenges to developing palliative care clinical, educational, and research programs.
• Describe roles of different healthcare 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.
"But the Family Is Asking for a Blood Transfusion": Managing the Hematologic Malignancy Patient in Hospice (SA503)

Rebecca Yamarik, MD, Providence Trinity Care Hospice, Cerritos, CA
Eric Prommer, MD FAAHPM, Mayo Clinic Hospital, Phoenix, AZ
Devora Green, MA, Providence Trinity Care Hospice, Cerritos, CA
Martina Meier, MD, Providence Trinity Care Hospice, Cerritos, CA

Objectives

• Identify certification/recertification issues in hematologic malignancies.
• Recognize when blood-product transfusion is consistent with hospice goals and how it can be achieved in a cost-efficient manner.
• Discuss how to enhance communication about continuing or discontinuing transfusion therapies.
• Discuss the identification and support of psychosocial and spiritual needs and concerns in the hematologic patient.

Hospice physicians are increasingly receiving referrals from hematologists. Hematologic malignancies are a challenging group of diseases because they are a heterogeneous group of cancers comprising more than 50 subtypes. Disease trajectories can be erratic. Patients with indolent diseases, such as primary myelofibrosis or chronic lymphocytic leukemia, often stabilize in hospice care and are challenging to recertify, while patients with acute leukemia are frequently admitted later in their clinical course and often live only hours to days in hospice. Patients with acute leukemias have often received frequent transfusions of blood products to control symptoms and prevent bleeding. Hospice physicians are often confronted with a patient who is deemed likely to die within 6 months yet requires costly, labor-intensive transfusions to benefit poorly categorized symptoms or ones requiring true interventions. Sorting out when to have the conversation about withholding blood products and recognizing when they are appropriate can be challenging for the hospice team. There are instances in which transfusions of blood products can be consistent with hospice goals of care. However, cost issues can make transfusions prohibitive without special relationships with transfusion providers. Decisions about transfusions require both knowledge of goals of care and specific knowledge about prognosis and cost-effective ways to handle blood product support. This session will, through the use of didactics, case presentations, and audience participation, enable attendees to walk away with (a) improved understanding of the prognosis of hematologic malignancies and certification/recertification issues associated with them, (b) enhanced understanding of blood product support needs for hematologic malignancies and how to provide them in a cost-efficient manner, (c) improved communication techniques when discussing discontinuation of transfusions, and (d) enhanced identification and support of psychosocial and spiritual distress needs and concerns in the hematology patient.
Health System–Wide Integration of Palliative Care and Emergency Medicine (SA504)

Jennifer Kapo, MD, Yale-New Haven Hospital, New Haven, CT
Kristin Edwards, MD, Yale University and Bridgeport Hospital, New Haven, CT
Karen Jubanyik, MD, Yale University and Yale-New Haven Hospital, New Haven, CT

Objectives
- Describe the key metrics to show improved quality of palliative care delivered in emergency departments.
- Identify key members of a steering committee for a system-wide palliative and emergency care collaborative initiative.
- Identify the challenges of facilitating change across a health system of three hospitals with different institutional cultures and hospital-specific goals.

There is growing recognition that the collaboration of palliative care and emergency medicine teams caring for complex patients facing serious illnesses not only improves the quality of care but also has potential financial benefits for institutions through cost avoidance and improved resource utilization. During this interactive session, palliative and emergency medicine physicians will describe the development of an integrated, health system–wide palliative and emergency medicine program to provide comprehensive, seamless palliative care to patients receiving emergency room care across three hospitals. Topics discussed will include (a) the creation of an interdisciplinary steering committee comprising key emergency medicine and palliative care clinical leadership as well as institutional leadership from each of the three hospitals; (b) business-plan development describing the value of potential cost avoidance; (c) the creation and pilot testing of a consult trigger instrument using the electronic medical record to identify patients who might benefit from palliative care intervention; (d) the identification of the key operational, financial, and care quality metrics to prove value of the program; and (e) the development of the key program components including education initiatives, care protocols, and physical space renovations. The opportunities and challenges of approaching change and standardization across three distinct hospitals with their individual institutional cultures will be highlighted.
State of the Science: Update in Hospice and Palliative Care (103)

Jay R. Horton, PhD FNP-BC ACHPN, Icahn School of Medicine at Mount Sinai, New York, NY
Kimberly S. Johnson, MD MHS, Duke University School of Medicine, Durham, NC
Nick Dionne-Odom, PhD RN, University of Alabama at Birmingham School of Health Professions, Birmingham, AL
Cardinale Smith, MD MSCR, Icahn School of Medicine at Mount Sinai, New York, NY

Objectives

- Summarize selected important, peer-reviewed articles from the last year.
- Critique the methodologies and understand the conclusions of these articles.
- Determine if the findings are relevant to the patients for whom attendees care.

The objective of this session is to review journal articles published during the last year 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 was 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 were reviewed for both study quality and potential for immediate impact on the field of hospice and palliative care. There was a selection bias against descriptive studies, pilot studies, preclinical studies, retrospective studies, open-label trials, case series, instrument validation studies, and confirmatory analyses.
Solving the Jigsaw Puzzle of Refractory Breathlessness (SA510-A)

David C. Currow, BMed MPH FRACP FACHPM, Flinders University

Objectives

• To understand the many research methodologies that are being employed to understand better refractory breathlessness.
• To be able to interpret the findings of research in refractory breathlessness with more confidence.
• To consider how to contribute to further improving the evidence base which informs the symptomatic treatment of refractory breathlessness.

Over the last decade there have been substantial steps forward in understanding refractory breathlessness—breathlessness that persists at rest or on minimal exertion despite optimal treatment of the underlying causes. At every level of scientific inquiry, this evidence base has moved forward in an increasingly systematic way.

At a population level, we have updated prevalence and severity across the whole population. This is complemented with data on breathlessness in the last 3 months of life in large numbers of patients with a range of life-limiting illnesses. The impact on patients and their caregivers is also far better understood individually and across the community.

The mechanisms that underpin breathlessness are far better understood as are the components that contribute to the sensation—both affective and intensity components. Using increasingly sophisticated neuroimaging and noninvasive processes, our understanding of breathlessness continues to improve so that treatments can be more targeted.

Increasingly, rigorously designed and conducted studies are exploring nonpharmacological interventions, and the work in pharmacological interventions has moved forward. The evidence base for opioids to safely reduce chronic breathlessness continues to strengthen. A number of other agents are being trialed.

The great frontier ahead is how we change established practice given the recommendations of major bodies such as the American College of Physicians, the American College of Chest Physicians, and the American Thoracic Society.
What Improves Quality of Life for Seriously-Ill Patients and Their Caregivers? From Observation to Intervention to Dissemination (SA510-B)

Karen E. Steinhauser, PhD, Duke University School of Medicine

Objectives

• Discuss approaches to defining, measuring, and intervening in quality of life for patients and families.
• Recognize that social, psychological, and spiritual aspects of quality of life have implications for how and who is best suited for intervention.
• Explore approaches to quality-of-life concerns, lessons learned, and implications for disseminating strategies to improve by reviewing data from different studies and control trials.

A primary goal of palliative care is to decrease suffering and increase quality of life. Yet defining what constitutes quality of life, measuring it, and intervening to improve it remain ongoing challenges for the field. The purpose of this presentation is to review progress in each of these three steps of definition, measurement, and intervention in patient and caregiver quality of life, with particular attention to the role of psychological, social, and spiritual care’s relationships to quality of life. While the National Consensus Project guidelines and National Quality Forum preferred practices dictate care in each of these three realms, much work is need to understand specifically how psychological, social, and spiritual aspects of care relate to quality of life and intersect and are distinct in the setting of serious illness. Understanding these relationships has implication for how to intervene and which interdisciplinary team members may be best suited for intervention. Data from cross-sectional and longitudinal observational and validation studies as well as findings from randomized controlled trials of quality-of-life interventions will be used to explore approaches to quality-of-life concerns, lessons learned, and implications for disseminating strategies to improve care.
Can You Hear Me Now?! A Palliative Care Telehealth Approach to Caring for Heart Failure Patients (SA511)

Christopher Kearney, MD, MedStar Health, Baltimore, MD
Kathryn Walker, PharmD, MedStar Health, Baltimore, MD
Rene Mayo, MSW LSWA, MedStar Health, Baltimore, MD

Objectives
• Discuss the process of integrating mobile tablet technology into caring for palliative heart failure patients after hospital discharge.
• Describe the clinical intervention using the tablet and how the patient will interface with the team from home.
• Discuss outcomes related to the use of technology in this setting.

We often lose the connection with our patients after spending a lot of time connecting with them during their inpatient stay. To prevent this lapse in care, we will describe how we harnessed the power of “telehealth” to redefine the boundaries of our team and provide effective and efficient patient care outside the walls of our hospital. Through the smart and appropriate use of mobile technologies, we aimed to improve patient/provider communication, facilitate a comprehensive approach to medication management, and enhance patient self-care education in a target population of urban-dwelling patients with advanced heart and lung failure admitted to our academic community hospital. After receiving a palliative care consultation in the hospital, wireless tablets were deployed to the homes of palliative care patients for 2 months. This allowed videoconferencing between patients and the palliative team after discharge, and the tablet was preconfigured with apps designed to facilitate personalized medication management, clinical and health status monitoring (e.g., medication adverse event reporting, symptom diaries), and patient education (e.g., resources relevant to the patient’s health status and condition). This project represents collaboration between palliative care, home health, and telehealth to extend palliative care outside the walls of the hospital and provide continuity of care.
Performing Compassionate Extubation: Cases, Pearls, and Pitfalls (SA512)

Eileen Rhee, MD, The Children’s Hospital of Philadelphia, Philadelphia, PA
Lynne Morrison, MD, The Children’s Hospital of Philadelphia, Philadelphia, PA
Joshua Kayser, MD MPH, University of Pennsylvania, Philadelphia, PA
David Munson, MD, The Children’s Hospital of Philadelphia, Philadelphia, PA

Objectives

- Identify three process questions that facilitate planning for a compassionate extubation in the ICU.
- Summarize the benefits to patients, families, and staff derived from the use of protocols or guidelines for compassionate extubation.

The removal of mechanical ventilation is a compassionate end-of-life option that requires a well-coordinated approach to appropriately prepare and ensure comfort for the patient and his or her family. This panel of dually trained intensivists and palliative care physicians will illustrate important concepts and choices though a series of case vignettes in both children and adults. We will facilitate discussion about the numerous issues that surround a planned extubation. Topics for discussion will include a historical analysis of the first recognition of the need for “terminal weaning” or “terminal extubation,” framing discussions regarding withholding or withdrawing life-sustaining therapies, determining the optimal location for extubation, the approach to patients with tracheostomies or long-term technology dependence, pharmacologic management to avoid suffering, and designing institutional protocols while recognizing a need to individualize the approach to the specific patient situation. The panelists will share clinical pearls based on their experiences and review the evidence that exists for best practices.
Why Do They Call It Special K? The How, When, Why, and What-Ifs of Using Ketamine in the Palliative Care Setting (SA513)

Shefali Parikh, MD, The Children’s Hospital of Philadelphia, Philadelphia, PA
Gina Santucci, MSN RN APRN-BC, The Children’s Hospital of Philadelphia, Philadelphia, PA
F. Wickham Kraemer, MD, The Children’s Hospital of Philadelphia, Philadelphia, PA

Objectives
• Identify three unique pharmacologic properties of ketamine.
• Identify three challenges and three benefits of the use of ketamine in the palliative care setting.
• Collect three tools to develop a protocol for ketamine use and implementation in one’s own palliative care practice.

The N-methyl-D-aspartate (NMDA) receptor is involved in both the sensitization of central neurons and the functioning of the opioid receptor, and there is evidence that one NMDA receptor antagonist, ketamine, has analgesic properties. At subanesthetic doses, ketamine may be used as a brief infusion for treatment of severe refractory pain or as a more prolonged infusion, typically at the end of life. Ketamine has also been delivered orally and intranasally to patients in the palliative care setting. The evidence to support the benefit of ketamine as an adjuvant to opioid therapy is quite limited. Nevertheless, this approach continues to be used by experienced pain and palliative care clinicians, particularly in the setting of otherwise refractory neuropathic pain at the end of life. The goal of this session is to review the literature involving ketamine use in the palliative care setting, review its pharmacokinetics and pharmacodynamics, relay case studies to delineate the challenges and benefits of ketamine use, and enable practitioners to implement the use of ketamine in both pediatric and adult palliative care settings.
Cultivating Resilience: Mindful Practice and Communities of Care (SA514)

Ronald Epstein, MD, University of Rochester, Rochester, NY

Objectives

• Define resilience and burnout and their effects on clinical care.
• Identify and create opportunities for enhanced self-care and resilience, and thereby achieve improved quality of care.

Resilience is the capacity to respond to stress in a healthy way such that goals are achieved at minimal psychological and physical cost; resilient individuals “bounce back” after challenges while also growing stronger. Resilience is a key to enhancing quality of care, quality of caring, and sustainability of the healthcare workforce. AAHPM prioritizes “identifying opportunities for enhanced self-care and resilience” as a key objective for its Annual Assembly sessions. Although it is known that people can enhance their capacity for resilience, addressing burnout and promoting resilience in healthcare settings have been elusive. Resilience is especially important in palliative care, where clinicians confront loss, grief, conflict, and difficult decisions on a daily basis.

In this workshop, we will focus on individual, team, and institutional factors. We will draw upon evidence about the effectiveness of individual and institutional approaches that promote empathy, quality of care, well-being, and resilience. Our approach is three-fold. First, resilience involves cultivating an “observing self”—a capacity for mindfulness, self-monitoring, limit setting, and attitudes that promote constructive and healthy engagement with (rather than withdrawal from) the often difficult challenges at work. We will introduce specific skills, habits, and attitudes that promote resilience using small group discussion, appreciative inquiry interviews, contemplative approaches and practices that clarify intention, presence, and attentiveness in the workplace. Second, resilience is facilitated by a strong sense of community, and we will explore ways in which communities of practice can promote resilience, analogous to efforts to promote patient safety and patient-centered care. Finally, it is in the self-interest of healthcare institutions to support the efforts of all members of the healthcare workforce to enhance their capacity for resilience; it will increase quality of care while reducing errors, burnout, and attrition. We will address institutional factors that promote individual and collective resilience.
Policies and Procedures of Pacemaker Deactivation: Opportunities and Pitfalls (SA515)

Adam Marks, MD, University of Michigan, Ann Arbor, MI
Lida Nabati, MD, Dana-Farber Cancer Institute, Boston, MA
Craig Blinderman, MD MA, Columbia University/New York Presbyterian Hospital, New York, NY

Objectives

• Recognize the practical and ethical controversies around pacemaker deactivation.
• Identify potential opportunities for collaboration, as well as potential conflict, when developing a policy for pacemaker deactivation.
• Review results of a national survey of hospital-based ethics committees regarding their experiences regarding pacemaker deactivation.
• Review proposed procedures for pacemaker deactivation as developed by a tertiary university-based hospital.

In the last several years, much has been written about the practical and ethical considerations regarding the deactivation of cardiac implantable electronic devices (CIEDs) in patients at the end of life. While deactivation of certain devices, such as implantable cardiac defibrillators, has become relatively common, other devices carry significantly more controversy and potential for conflict between patients and providers, as well as among medical professionals. Indeed, recent surveys have revealed that the majority of physicians remain uncomfortable discussing deactivate of CIEDs in general and pacemakers in particular.

We will begin this concurrent session with a case report of a family's distress when their request for pacemaker deactivation in a patient with terminal cancer was met with accusations of euthanasia, and then review the literature regarding consensus and opinions regarding pacemaker deactivation. We will detail the experiences of one university-based hospital's attempt to develop a policy for pacemaker deactivation with an emphasis on practical lessons learned. We will review the results of a national survey of hospital-based ethics committees regarding their experience with pacemaker deactivation. Finally, we will end with a proposed procedure to manage the potential symptoms associated with pacemaker deactivation in a patient at the end of life.
Care Quality and Cost Implications of the Timing of Palliative Care Consultation Among Patients with Advanced Cancer Treated at the UCSF Helen Diller Comprehensive Cancer Center (SA516-A)

Colin Scibetta, MD, University of California, San Francisco, San Francisco, CA
Kathleen Kerr, BA, Mill Valley, CA
Michael Rabow, MD FAAHPM, University of California, San Francisco, San Francisco, CA

Objectives

• Understand the role of early palliative care in the treatment of patients with advanced cancer at the end of life.
• Recognize that specialty palliative care services are underutilized in patients with advanced cancer.

Original Research Background: The American Society of Clinical Oncology (ASCO) recommends that palliative care (PC) be offered alongside standard oncologic care for patients with metastatic cancer and/or high symptom burden. There are limited data about how the timing of palliative care affects the quality, intensity, and cost of medical care at the end of life for patients with advanced cancer.

Research Objectives: To understand how timing of PC referral is associated with the quality and cost of medical care delivered to patients with advanced cancer at the end of life.

Methods: In this retrospective cohort study, we analyzed administrative and billing data to assess patterns of healthcare utilization of patients cared for at the UCSF Cancer Center who died from cancer between Jan 1, 2010, and May 31, 2012.

Results: Among 978 decedents who received regular cancer treatment at UCSF, only 298 (30%) had specialty palliative care referrals. Of these, 94 (31.5%) had early PC referrals (EPC) while 204 (68.5%) had late PC (LPC). Patients who received EPC had a lower rate of inpatient admissions (33% vs 66%, p=0.002), lower rates of ICU stay (5% vs 20%, p=0.0005), and fewer ED visits in last month of life (34% vs 54%, p=0.0002), as well as fewer instances of hospice service <3 days (7% vs 20%, p=0.0001) and a lower rate of inpatient death (15% vs 34%, p=0.0001). The direct cost of inpatient care in the last 6 months of life for patients with EPC was significantly reduced when compared with LPC patients ($19,000 vs $25,700), while the direct cost of outpatient care was higher in the EPC compared to LPC population ($13,000 vs $11,500).

Conclusions: EPC is associated with less intensive acute medical care, lower costs, and improved quality outcomes at the end of life for patients with advanced cancer.

Implications for Research, Policy, or Practice: Barriers to the early provision of specialist outpatient palliative care should be addressed.
Perceptions of Palliative Care Among Hematologic Malignancy Specialists: A Mixed-Methods Study (SA516-B)

Thomas LeBlanc, MD, Duke University School of Medicine, Durham, NC
Jonathan O’Donnell, BA, Duke University School of Medicine, Durham, NC
Yael Schenker, MD, University of Pittsburgh Medical Center, Pittsburgh, PA
Douglas White, MD, University of Pittsburgh Medical Center, Pittsburgh, PA
Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA

Objectives

• Describe differences in how hematologic oncologists view palliative care, compared to solid tumor oncologists
• Recognize opportunities to design targeted palliative care service delivery models for the unique situations faced in blood cancer care.

Original Research Background: Patients with hematologic malignancies have unmet palliative care needs but are less likely to receive specialist palliative care services than patients with solid tumors. This difference is poorly understood.

Research Objectives: We conducted a multisite, mixed-methods study to understand and contrast perceptions of palliative care among hematologic oncologists and solid tumor oncologists.

Methods: Between February and October 2012, oncologists at three academic medical centers with well-established palliative care services completed surveys assessing referral practices and in-depth, semistructured interviews about their views of palliative care. We compared referral patterns using standard statistical methods, then analyzed qualitative interview data using constant comparative methods to explore reasons for observed differences.

Results: Among 66 interviewees, 23 oncologists cared exclusively for patients with hematologic malignancies and 43 treated only patients with solid tumors. Seven of 23 hematologic oncologists (30%) reported never referring a patient to palliative care; all solid tumor oncologists had previously referred (p<0.001). In qualitative analyses, most hematologic oncologists viewed palliative care as end-of-life care, while most solid tumor oncologists viewed palliative care as a subspecialty that could assist with complex cases and/or offload burden in a busy clinic. Solid tumor oncologists emphasized practical barriers to palliative care referral, such as appointment availability and reimbursement issues. Hematologic oncologists emphasized philosophical concerns about palliative care referrals, including different treatment goals, responsiveness to chemotherapy, and a preference to control palliative aspects of patient care.

Conclusions: Most hematologic oncologists view palliative care as end-of-life care, while solid tumor oncologists more often view palliative care as a subspecialty for comanaging complex patients.

Implications for Research, Policy, or Practice: Efforts to integrate palliative care into hematologic malignancy practices will require solutions that address unique barriers to palliative care referral experienced by hematologic oncologists.
Care Management by Oncology Nurses to Address Palliative Care Needs: A Pilot Trial to Assess Feasibility, Acceptability, and Perceived Effectiveness of the CONNECT Intervention (SA516-C)

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Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA
Douglas White, MD, University of Pittsburgh, Pittsburgh, PA
Edward Chu, MD, University of Pittsburgh, Fox Chapel, PA
Margaret Rosenzweig, PhD CRNP, University of Pittsburgh, Pittsburgh, PA

Objectives
• Describe the components of an oncology nurse-led care management approach for improving provision of “primary” palliative care in oncology clinics.
• Understand data on the feasibility, acceptability, and perceived effectiveness of an oncology nurse-led care management approach for improving provision of “primary” palliative care in oncology clinics.

Original Research Background: Subspecialty palliative care is not an option for many patients with advanced cancer due to limited availability and practical barriers. There is a need to find alternative strategies to deliver palliative care in oncology clinic settings.

Research Objectives: To assess the feasibility, acceptability, and perceived effectiveness of an oncology nurse-led care management approach to improve provision of “primary” palliative care.

Methods: A single-site, single-arm trial of the CONNECT intervention, in which certified oncology nurses receive specialized training and work closely with oncologists to (a) address symptom needs, (b) engage patients and caregivers in advance care planning, (c) provide emotional support, and (d) coordinate care. Feasibility was assessed through enrollment rates, outcome assessment rates, and visit checklists to monitor protocol adherence. Patients, caregivers, and oncologists completed 3-month assessments of acceptability and perceived effectiveness.

Results: We enrolled 23 patients with advanced cancer (consent-to-approach rate 86% and enrolled-to-consent rate 77%), 19 caregivers, and five oncologists. CONNECT was implemented according to protocol for all participants. No participants withdrew after enrollment. Four patients died during the study; 3-month outcome assessments were completed with all remaining participants (83%). Patients and caregivers reported high satisfaction with CONNECT and perceived the intervention as helpful in addressing symptoms (85%), coping (91%), and planning for the future (82%). Oncologists unanimously agreed that they were comfortable working with the CONNECT nurse to manage symptoms (100%) and engage patients in advance care planning (100%) and that CONNECT improved the quality of care provided for patients with advanced cancer (100%).

Conclusions: An oncology nurse-led care management intervention is feasible, acceptable, and perceived to be effective for improving provision of primary palliative care in a community oncology clinic.

Implications for Research, Policy, or Practice: A randomized trial is warranted to assess whether CONNECT improves patient, caregiver, and healthcare utilization outcomes.
Palliative Care Referral Among Patients with Cirrhosis Is Infrequent and Primarily Utilized for Liver Cancer, Not Decompensated Cirrhosis (SA516-D)

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Anna Lok, MD, University of Michigan, Ann Arbor, MI
Betty Ferrell, PhD FAAN FPCN, City of Hope, Duarte, CA
Maria Silveira, MD MA MPH, University of Michigan, Ann Arbor, MI

Objectives

- Identify one factor associated with palliative care referral for patients with decompensated cirrhosis.
- List the three components of the Model for End-Stage Liver Disease (MELD) score.

Original Research Background: Decompensated cirrhosis is associated with substantial symptom burden and poor overall quality of life. Despite symptom burden and high mortality, palliative care (PC) consultation among patients with decompensated cirrhosis may be underutilized.

Research Objectives: To assess timing, utilization rate, and predictors of PC consultation among patients with cirrhosis.

Methods: This is a retrospective review of patients from Veterans Health Administration inpatient and outpatient files for VISN 11 from 2001-2011. Cirrhosis diagnosis was determined using a validated ICD-9 code algorithm and study cohort limited to those that died within 1 year of diagnosis. Primary outcome was receipt of PC consultation. Model for End-Stage Liver Disease (MELD), a widely used prognostic tool among patients with cirrhosis, was calculated using the first INR, creatinine, and bilirubin values after the diagnosis of cirrhosis.

Results: The cohort included 622 patients (mean age 59.5 years, 99.1% male, 70.9% Caucasian, 20.6% African American, 36.7% hepatitis C). A total of 47 (7.5%) patients received a PC consultation; median time from PC consultation to death was 32 days (IQR 18-118). Median survival was longer among those seen by a PC clinician versus not (156 vs 104 days, p<0.001). Presence of liver cancer was the only covariate associated with receipt of PC services. Age, decompensation symptoms (eg, encephalopathy, ascites), MELD score, and comorbidities were not associated with PC consultation.

Conclusions: Palliative care consultation occurred infrequently and late in disease course, especially for those with cirrhosis without cancer. Liver cancer was the only predictor of PC consultation, emphasizing the discomfort of physicians in referring patients with nonmalignant disease.

Implications for Research, Policy, or Practice: Guidelines are needed to help clinicians decide when and for whom to initiate end of life discussions and palliative care referral in this population. Prospective studies are needed to verify longer survival among those that received palliative care.
The Polypharmacy Police Versus the Patient Advocate: An Evidence-Based, Patient-Tailored Approach to Medication Simplification Strategies for the Palliative Care Patient (SA517)

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Rosene Pirrello, RPh, University of California, Irvine, Orange, CA
Eric Prommer, MD FAAHPM, Mayo Clinic Hospital, Phoenix, AZ
Mary Lynn McPherson, PharmD BCPS CPE, University of Maryland, Baltimore, MD

Objectives

• Define and describe polypharmacy and its specific challenges in the palliative care setting.
• Discuss the psychosocial issues associated with discontinuing medications and strategies for patient-centered communication regarding this issue.
• Discuss how to provide clear, concise, evidence-based, and patient-tailored recommendations for the top five medications likely to have minimal benefit or cause harm in the palliative care setting.

Across all palliative care (PC) settings, PC providers must constantly assess the risks and benefits associated with medications in advanced illness. Polypharmacy frequently occurs in the setting of multiple medical providers and patients with multiple comorbidities compounded by acute symptom management. This increases the risk for adverse drug reactions, drug-drug interactions, and drug-disease interactions. Moreover, PC patients and loved ones are often resistant to stopping medications, as the medications symbolize hope and a source of control in an uncontrollable situation.

We propose a clear, concise, evidence-based, and patient-tailored approach to discussing this often heated issue. We suggest framing medication reduction as a strategy to decrease patient burden and improve safety, rather than emphasizing cost savings, as this can be misinterpreted. Determination of when and what medications to simplify requires knowledge of the prognosis, risks and benefits, drug elimination, drug interactions, changing routes of administration, and consideration of tapering certain classes of medications to avoid withdrawal. We discuss the top five medication classes most likely to be of minimal benefit or cause harm in the PC setting: anticoagulants, appetite stimulants, antibiotics, dementia medications, and statins.

Through a case-based approach, this session will promote discussion among the multidisciplinary panel and audience members focusing on successful and collaborative solutions to addressing polypharmacy in the PC setting. Particular emphasis will be placed on supportive and patient-tailored communication and identification of key evidence-based decision-making tools available to the PC provider. This session will conclude with a robust question-and-answer period and forum for discussion to promote collaborative solutions to an increasingly prevalent issue faced by palliative care providers.
The Healing Power of Hope: For Patients and Palliative Care Clinicians (SA518)

Lucille Marchand, MD BSN, University of Washington, Seattle, WA
Cory Ingram, MD MS FAAHPM, Mayo Clinic, Rochester, MN

Objectives

• Distinguish between hope and hopelessness and false hope and false hopelessness, generate a list of attributes regarding domains of hope and hopelessness, and review the research on hope and how maintaining hope has important, positive clinical outcomes.

• Differentiate hope as a process with key communication facilitators versus hope as outcome.

• Discuss innovative strategies that foster hope, meaning, and resilience for palliative care clinicians in navigating challenging work situations and cumulative stresses in providing hopeful palliative care.

Hospice and palliative medicine clinicians struggle with maintaining hope in the face of life-threatening illnesses. Poor prognosis often highlights the dilemma of maintaining hope in the face of challenging illnesses with limited or no options for curative care. When hope is dependent on a specific health outcome, options may indeed be limited and hopeless. But if hope can be reframed as a dynamic process, then a patient has the potential to see hope and possibility even in the face of dying. Recent studies have demonstrated that the biology of belief and maintenance of hope have positive results for the patient by improving physical, emotional, and spiritual symptom management. Hope may also have positive effects for the clinician. How can we foster authentic hope and not false hope or hopelessness in our communications with patients and families? This session will explore the dimensions of hope, hopelessness, false hope, false hopelessness, and miracles and how they affect the care we provide for our patients. Inspiring hope in ourselves as clinicians also has a healing effect on us and can help prevent burnout and increase resilience to the stressors inherent in working with situations that are challenging. Techniques to foster hope in patients and ourselves will be explored including brief self-reflective exercises, mindfulness in practice, appreciative inquiry, writing, collage, and other narrative and debriefing methods. A brief reflective exercise will be included in the session with sharing in small groups.
The Practice of Palliative Medicine in Developing Countries—Part Three (SA530)

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Sushma Bhatnagar, MD, Institute Rotary Cancer Hospital, New Delhi, India
Clint Cupido, MBChB FCP SA, Abundant Life Palliative Care Victoria Hospital, Wynberg, South Africa
Folaju Olusegun Oyebola, MD, Federal Medical Centre Abeokuta, Abeokuta, Nigeria

Objectives

- Learn how physicians in specific countries provide palliative care to their patient populations, often with limited resources.
- Understand specific cultural and political challenges to developing palliative care clinical, educational, and research programs.
- Describe roles of different healthcare 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.
Facilitators and Barriers to Implementing Automatic Palliative Care Consultation for Hospitalized Patients with Solid Malignancies (SA531)

Cardinale Smith, MD MSCR, Icahn School of Medicine at Mount Sinai, New York, NY
Jay Horton, PhD NP, Icahn School of Medicine at Mount Sinai, New York, NY
Sara Johnson, MD, University of Wisconsin, Madison, WI
Gabrielle Rocque, MD, University of Alabama, Mountain Brook, AL

Objectives

- Describe two different models of integrated palliative care delivery for hospitalized cancer patients.
- Discuss barriers and facilitators to implementation of integrated palliative care delivery.
- Discuss the impact of integrated palliative care among hospitalized cancer patients at two different academic institutions.

Hospitalized advanced cancer patients have a high symptom burden and need for support. Successful integration of palliative care into standard oncologic care is becoming increasingly important as data demonstrates that it is associated with improved mood and better quality of life and possibly survival. As such, current oncologic guidelines suggest the early integration of palliative care, particularly for those patients with advanced malignancies. Despite this, palliative care consultation occurs late in the trajectory of illness, and this likely contributes to poor patient outcomes.

In this session we will compare and contrast two different delivery models implementing automatic palliative care consultations for hospitalized patients with cancer at two separate academic institutions. One program demonstrated improvement in healthcare utilization (30 day readmission rates, referral to hospice and observed/expected mortality) while the other did not. The session will be led by a multistitutional, multi- and interdisciplinary team of oncology and palliative care physicians and nurses. We will discuss the initiation and implementation of these programs focusing on hospital and oncology buy-in. We will describe the criteria used to identify patients and discuss the methods employed to ensure appropriate patients received a consult. In addition, we will discuss our results (healthcare utilization, symptom management, and patient satisfaction). Furthermore, the panelists will discuss mistakes and lessons learned in navigating this terrain. The session will conclude with specific recommendations to engage stakeholders and ways to measure outcomes.

In the current era of healthcare reform there has been a change in focus from volume to value with many hospitals and healthcare systems interested in growing and integrating palliative care into standard of care for patients with serious illness. The models described can be adapted to other patient populations and institutions. The implementation and results are important for palliative care experts to continue to delivery palliative care innovation.
Incorporating Palliative Care Principles in the SNF Rehab Setting: Understanding the Importance of Fatigue (SA532)

James Judge, MD, Optum Complex Population Management, Farmington, CT
Cary Schnitzer, MD, Optum Palliative Care and Hospice, Phoenix, AZ
Christopher White, MSN, Optum Complex Patient Management, Hamden, CT

Objectives
- Identify markers of advanced illness in the hospital medical record or discharge materials.
- Discuss how to elicit the patient’s and their family’s understanding of the disease status efficiently and the person’s goals—30-day goals and overall goals of care—and values at the time of admission.
- Identify nonspecific symptoms, such as fatigue, low food intake, lack of interest in rehabilitation, unexpected poor tolerance of rehabilitation, weakness, and shortness of breath.

In the evolving Medicare world, hospital care processes are transforming rapidly to achieve Medicare quality metrics, lower readmission rates, and lower overall cost of care in accountable care organizations, Medicare Advantage Plans, and Bundled Payment Demonstrations. The cost-saving strategies use a combination of shortening hospital lengths of stay and SNF lengths of stay, increasing discharge directly to home, and effective transitions in care to reduce readmissions. In this new world, many of the patients admitted for rehabilitation have very advanced illnesses.

In this evolving clinical landscape, the focus on the big picture of the patient may be lost in the push to reduce lengths of stay in the SNF. The patient with advanced heart, lung, liver, or kidney disease may not be recognized as a person who may not benefit from aggressive rehabilitation and complex medication regimens, and who will not respond to the positive attitude and expectations of the rehabilitation unit staff.

In many rehabilitation units, the patient who does not want to engage in rehabilitation activities is frequently labeled as “resistive,” “lazy,” or just not interested in rehabilitation.

Many of these patients have fatigue and/or cachexia associated with advanced disease. Families and patients are often in conflict because
1. the severity of the disease process was minimized by the physicians and practitioners in the hospital setting
2. the severity of the disease process was communicated to the person and their family, but was not incorporated into their understanding
3. there are inherent stresses in a person with an advanced illness having a second new environment and new healthcare team to work with.

The presentation will provide strategies that have been developed over the past 3 years by the Optum Complex Management Team in several states. The strategies are based on accepted palliative care principles and are applied in the SNF and the community. This presentation will focus on how to incorporate palliative care principles early in the postacute SNF stay.
Even Dying Children Can Be Victims of Abuse and Neglect (SA533)

David Korones, MD, University of Rochester Medical Center, Rochester, NY
Philene Cromwell, MS RN PNP, Lifetime Care, Rochester, NY

Objectives
- Define the challenges in communication between palliative care teams and child protective services.
- Discuss the stresses experienced by families, palliative care teams, and CPS staff when assessing for abuse and neglect of a dying child.
- Discuss barriers of medical teams, palliative care teams, and CPS to advocating for the potentially abused or neglected child.

Healthcare practitioners are mandated reporters when there is suspicion of child abuse or neglect. However, following through on the obligation to report can be a daunting challenge when it occurs in the care of a dying child.

We will discuss three cases of dying children whose families our pediatric palliative care team felt compelled to report for child abuse or neglect. One child had pneumonia and a neurodegenerative disorder, and her parents would not allow nurses in the home to assess for comfort. A second child was dying of leukemia; her father called the police to the home because he felt the mother was intoxicated while administering opioids. The mother of a third child with posterior urethral valves was suspected of Munchausen’s by proxy. In the first two cases, Child Protective Services (CPS) seemed uncomfortable with the tragic circumstances of the referral. The need for referral was seen very differently by CPS than by the palliative care team. The children were not removed from the home, and no changes were mandated by CPS. In the third case, the palliative care team worked collaboratively with CPS, and there was a positive outcome for the child.

There are significant barriers to reporting abuse or neglect of dying children. It is difficult for a palliative care team (whose members may be emotionally attached to a child and family) to assess objectively whether its suspicion of abuse or neglect is warranted. It is just as difficult for CPS, which may have little experience investigating abuse or neglect of a terminally ill child. The challenge for both teams is to sort out when the line between overwhelming stress and actual neglect or abuse is crossed. As difficult as referral to CPS may be when a child is dying, these children need a voice, and the palliative care team can be that voice.
From “NPO, Needs Feeding Tube” to Palliative Dysphagia Management: How to Collaborate with Speech-Language Pathologists (SA534)

Sarah Stranberg, University of Pittsburgh Medical Center, Pittsburgh, PA
Julie Childers, MD, University of Pittsburgh, Pittsburgh, PA
Paula Leslie, PhD, University of Pittsburgh, Pittsburgh, PA
Tamara Wasserman-Wincko, MS CCC-SLP, University of Pittsburgh Medical Center, Pittsburgh, PA

Objectives
• Describe a quality improvement initiative to maximize collaboration between speech-language pathology and palliative care.
• Describe three complex cases in which speech-language pathology and palliative care collaboration improved care.
• Create ideas for how speech-language pathology and palliative care could collaborate at your institution.

Clinical decision-making about dysphagia management is challenging when caring for complex and end-of-life patients. Palliative care and speech-language pathology are often the primary services that address these issues. As with many disciplines, speech-language pathologists’ academic training regarding the assessment and management of dysphagia in end-of-life cases is limited. This results in recommendations that may not be consistent with a patient’s goals of care, as well as an element of clinician distress. Speech pathologists’ training is targeted at “preventing aspiration” rather than how to address feeding/swallowing issues in complex cases. Mixed messages regarding perceived risks can result in primary services receiving conflicting information from speech-language pathology and palliative care consultations.

We developed a quality improvement initiative involving collaboration between speech-language pathology and palliative care services with the goals of providing clear, consistent recommendations to patients and their families regarding swallowing status as it relates to oral intake options, aspiration risks, and eating for quality of life. Discussion will include the joint development of written guidelines and standards of documentation that provide structure and a consistent means of communication between numerous palliative care and speech-language pathology staff across the continuum of inpatient care. This session will provide examples of typical speech-language pathology consults of clinically challenging situations that were occurring prior to this project and present case examples that demonstrate the enhanced patient care provided with implementation of this protocol. In conclusion, the session will detail means that were used to objectively measure staff opinions of and usage of these guidelines and goals for sustaining and improving this multidisciplinary collaboration. We will include small and large group discussions of ways that you could develop similar interventions at your institution, including identifying speech-language pathology and palliative care champions, education of both the speech-language pathology and palliative care teams, and methods for optimizing communication regarding shared cases.
All Bones and No Meat: Advances in the Management of Cancer Cachexia (SA535)

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Egidio Del Fabbro, MD, MD Anderson Cancer Center, Richmond, VA
Rony Dev, DO, MD Anderson Cancer Center, Houston, TX

Objectives
- Discuss the mechanisms of anorexia and cachexia.
- Discuss the evolving definitions of anorexia and cachexia and the assessment tools available for clinical practice and research.
- Summarize evidence-based treatment strategies, with particular emphasis on novel therapeutics.

The cachexia-anorexia syndrome (CAS) is a multifactorial syndrome characterized by involuntary loss of skeletal muscle and fat, decreased quality of life, and shortened survival. Although typically associated with cancer, CAS is also common in many chronic illnesses, such as heart failure, chronic obstructive pulmonary disease, human immunodeficiency virus infection, and renal and hepatic failure. Over the past few years, significant progress has been made toward our understanding of the pathogenesis of this syndrome, resulting in the development of novel therapeutics.

Anorexia can be classified as (a) primary anorexia, which is mediated by inflammatory cytokines, such as tumor necrosis factor, interleukin 1, and interleukin 6 and various anorexigenic factors, such as leptin, cholecystokinin, and peptide YY; and (b) secondary anorexia related to various comorbidities, such as mucositis, early satiety, nausea, taste alteration, and dysphagia. In addition to central effects on the hypothalamus causing loss of appetite, CAS is also a peripheral phenomenon characterized by wasting of muscle and fat due to an imbalance between the catabolic mediators (e.g., cortisol, glucagon, adrenalin, cytokines) and anabolic mediators (e.g., growth hormone, insulin, testosterone). Given the high prevalence of CAS, it is important to routinely assess common nutritional impact symptoms and to monitor body composition. Although megestrol acetate and corticosteroids have some activity against anorexia, they have significant side effects and limited effect on lean body mass. Emerging therapies for CAS include selective androgen receptor modulators, ghrelin analogues, and cytokine inhibitors that show preliminary evidence for improving appetite, lean body mass, function, and quality of life. In this session, we aim to 1) provide a better understanding of the pathophysiology for anorexia and cachexia, 2) review the latest consensus definition and assessment tools, and 3) discuss up-to-date therapeutic strategies in managing this devastating syndrome. The last 10 minutes will be available for questions and discussions.
An Exercise in Futility? Developing Policy and Shaping Practice to Address Demands for “Nonbeneficial Medical Treatment” (SA536)

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Jason Kallestad, MD, University of Minnesota Medical Center, Fairview, Minneapolis, MN
Denise Hess, Providence Little Company of Mary Medical Center, Torrance, CA
Bates Moses, MD, Kaiser Riverside Medical Center, Riverside, CA

Objectives

• Describe values conflicts that arise when patients or families demand treatments that clinicians deem medically nonbeneficial.
• Compare and contrast evolving notions of autonomy and paternalism.
• Apply concepts of patient autonomy and values conflict through interactive case presentation highlighting staff moral distress in the context of families hoping for a miracle.

Palliative care teams are often consulted when the primary clinical team feels further life-sustaining interventions are “futile” but patients or families demand the treatments be provided. Palliative team members also often have involvement in hospital ethics committees that review such cases. In this session, our overall goals are to increase knowledge about “futility policies,” increase awareness of competing ethical principles involved, address legal considerations that shape the clinical context in which such decisions are made, and stimulate healthy and open national discussion about this issue. For hospitals or health systems considering creating, implementing, or revising such policies, we aim to provide a framework upon which to do so. To these ends, faculty will explore values conflicts that emerge from inherent differences in how the “benefit” of a therapy is defined, staff moral distress that results from providing care that they perceive as futile or even harmful, and ways in which well-designed policies on medically nonbeneficial therapies can support families and clinicians. The session will include case study, audience surveys, and a high level of interaction between faculty and attendees.
Outlook: A Randomized Clinical Trial to Address Existential Needs during Serious Illness (SA537-A)

Karen Steinhauser, PhD, Duke University Medical Center and Durham VAMC, Durham, NC
James Tulsky, MD FAAHPM FACP, Duke Medicine, Durham, NC
Maren Olsen, PhD, Durham VAMC, Durham, NC
Karen Stechuchak, MS, Durham VA Medical Center, Durham, NC
Stewart Alexander, PhD, Purdue University, West Lafayette, IN

Objectives
• Learn the evidence regarding an RCT of an intervention to assess patients’ existential needs.
• Learn where findings rest within larger literature.

Original Research Background: The National Consensus Project on Quality Palliative Care called for interventions to address patients’ existential needs.

Research Objectives: Determine whether a brief intervention (Outlook) to address existential needs (including preparation, life completion) for patients with serious illness reduces anxiety and depression and improves quality of life.

Methods: A three-arm randomized control trial comparing (1) Outlook intervention—three facilitated visits discussing life review, forgiveness, and legacy; (2) attention control—three facilitated visits involving relaxation meditation; and (3) usual care. Measures, assessed at baseline and 5 and 7 weeks included quality of life (QUAL-E and FACIT), anxiety (POMS) depression (brief CES-D), and spiritual well-being (FACIT-sp). Enrolled patients were nonhospice eligible veterans with advanced cancer, CHF, COPD, ESRD, or ESLD living within a 35 miles radius of Durham, NC.

Results: 221 participants were randomized (59% enrollment rate); average age 67.8; 96% male; 46% with cancer, 33% COPD, 13.6% CHF, 6.8% ESRD and .5% ESLD; 58.4% married; 43.9% African American. As compared with usual care, intervention participants had higher preparation (QUAL-E) (p=.02) at the first postassessment and not the second, and improved social well-being at second postassessment (p=.05). As compared with relaxation, intervention participants did not have significant differences over time in outcomes. Participants with cancer or low sense of peace had improved preparation (p=.04; p=.02) at first post-assessment and not the second, as compared with usual care. Those with depression had higher QOL at the first assessment (p=.05), post-intervention, as compared with relaxation meditation.

Conclusions: Outlook had an impact on social well-being and preparation as compared with usual care. The lack of impact on and anxiety and depression differs from previous results among hospice patients. Intervention content may benefit from a behavioral activation component during the pre-hospice illness period.

Implications for Research, Policy, or Practice: The trial informs the small but growing evidence base evaluating interventions addressing palliative care patients’ existential needs.
Hospital-Based Chaplain Activities with Seriously Ill Patients and Adherence to Clinical Practice Guidelines for Spiritual Care in Palliative Care (SA537-B)

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Molly Perkins, Atlanta Veterans Affairs Medical Center, Atlanta, GA
George Grant, PhD, Emory University Hospital, Atlanta, GA
Ellen Idler, PhD, Emory University, Atlanta, GA

Objectives

- Identify National Consensus Project’s Clinical Practice Guidelines for Quality Palliative Care.
- Discuss chaplain adherence to the criteria in the Clinical Practice Guidelines.

Original Research Background: Clinical practice guidelines for quality spiritual care in seriously ill patients have been identified by expert review. Little is known regarding how the activities of hospital-based chaplains match with these criteria.

Research Objectives: To investigate how well chaplains adhere to the criteria in the Clinical Practice Guidelines.

Methods: Chaplains at an urban southern academic hospital completed computerized diaries immediately following patient encounters from January to October 2013. This instrument is grounded in chaplaincy education tools and was designed and piloted with chaplain input. Chaplains recorded observations regarding attendees, conversation topics, activities and interventions, and visit outcomes. We linked diary data with quality spiritual care criteria in domain 5 of the National Consensus Project’s Clinical Practice Guidelines for Quality Palliative Care. Analyses were at the patient level; the chaplain could meet the criterion during any encounter.

Results: We collected 1,140 diaries across 782 patients from four staff chaplains and five residents. Median visit length was 15 minutes (interquartile range [IQR] 10-30). 72.5% of diaries were the chaplain's first encounter with a patient; 14.0% were the second. The most common criterion met by the second visit was a regular assessment and documentation of spiritual issues (eg, guilt and forgiveness) and existential issues (eg, meaning and purpose), done for 54.9% and 49.9% of patients, respectively. A standardized instrument to assess religious background was used for 51.9%. Rituals including prayer were facilitated for 31.1% of patients. Contacting faith communities and religious symbol display occurred rarely (<5% of patients). We had insufficient data to address 5 other criteria.

Conclusions: Chaplains frequently addressed topics from the guidelines, but discrete activities such as referrals were less common. Findings suggest chaplains may address important needs that fall outside these criteria.

Implications for Research, Policy, or Practice: The guidelines for quality spiritual care provide a useful framework but may not provide a perfect recipe for all patients.
Discussions of Physical, Spiritual, and Emotional Needs during Home Hospice Care (SA537-C)

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Objectives
- Demonstrate knowledge of domains of care discussed during nurse home hospice visits.
- Identify the proportion and change over time dedicated to domains of care during nurse home hospice visits.

Original Research Background: Physical, emotional, and spiritual needs of cancer patients and their caregivers vary during the course of hospice care. However, little is known about communication between hospice nurses, patients, and caregivers regarding these needs during home hospice visits.

Research Objectives: To examine the amount and trajectory of physical, psychosocial/emotional, and spiritual care (domains of quality end-of-life care) between nurses and cancer patients/caregivers from hospice enrollment to patient death.

Methods: We conducted an observational, longitudinal, multisite study of hospice nurse home visits. Hospice nurses wore digital recorders to capture naturally occurring conversations in the home. Physical, psychosocial, and spiritual conversations were identified then examined by visit for proportion and change over time. Descriptive and linear mixed effects regression analyses were conducted.

Results: 65 nurses from 11 hospices recorded 463 visits to 123 cancer patients and their caregivers. Most nurses were female, M=44 years, averaging 13.4 (SD=12.6) years of hospice experience. Caregivers and patients tended to be partners (63%) with a mean age of 59.3 (SD=14.2), 71.7 (SD=12.9) respectively. Physical care discussions dominated visit communication (75%; SD=19.1), with psychosocial/emotional (4.1%; SD=7.7), spiritual (0.5%; SD=2.2), and other discussions (20.4%; SD=7.2) (eg, silence, family members talking to each other, chitchat) comprising the rest of the visit. No significant differences occurred in this distribution over the course of multiple home visits.

Implications for Research, Policy, or Practice: While the majority of communication between home hospice nurses, patients and caregivers addressed physical care, a portion of the visit was consistently dedicated to discussing psychosocial/emotional and spiritual issues, indicating the multifaceted approach of home hospice nurses to end-of-life care. Future research should examine communication exchanges between families and their hospice team, as well as determine how communication by team members such as aides, social workers, and chaplains contribute to optimal end-of-life care.
#mypatientisbloggingaboutme: The Influence of Social Media on Patient/Family Interactions and Care (SA540)
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Objectives

- Identify ways in which social media affects providers, patients, and families and their interactions with each other.
- Describe ethical considerations and guidelines for managing appropriate boundaries and therapeutic relationships with respect to social media.
- Describe three methods for talking with patients and families about social media use in the context of the healthcare setting.

In 2013, 73% of online adults in America used social media, and 90% of those ages 18 to 29 used it. Social media has become pervasive in healthcare, with patients and families using it for emotional support, to gather information, and to advocate for services denied by healthcare teams. Many healthcare providers are ambivalent about whether social media supports or undermines their relationship with families, but it is clear that it affects not only the ways in which we communicate with patients and families, but also how patients and families communicate with each other. For palliative care, in which communication is the cornerstone of interactions with patients and families and greatly influences decision-making and goal setting, the effects of social media can have a wide-ranging impact.

Using multimedia, lecture, and discussion, this session will provide an overview of social media and its distinct impact on the practice of palliative care, with an emphasis on its influence on communication and decision-making. Social media resources frequently used by patients and families will be reviewed, and their impact on healthcare providers and the medical care provided will be highlighted. Topics will include (1) how patient or family use of social media affects providers, including a review of the literature and cases (eg, how providers feel when they know patients and families are blogging about them and the effects this has on interactions and subsequent decisions regarding care); (2) the influence of social media on patients and families, including how patients gather information about available treatments, social media’s role in offering emotional support, especially when far from home, and how patients may begin to acquire a public persona that affects their flexibility in decision-making; (3) ethical guidance on setting appropriate boundaries and maintaining therapeutic relationships with patients and families who want to stay connected via social media; and (4) tips for talking with patients and families about their participation in social media and how it affects providers’ interactions with them.
The Trifecta of Community-Based Palliative Care: Preventing Hospitalizations, Improving Symptoms, and Timely End-of-Life Care (SA541)

Sumathi Misra, MD MPH, Vanderbilt University, Nashville, TN
Katsiaryna Khatsilovich, BA, Gentiva Healthcare, Nashville, TN

Objectives
• Identify three clinical interventions for use in the home setting that aid in prevention of hospitalization.
• Demonstrate knowledge of three tools for collecting multilevel metrics (operational, clinical, financial, customer satisfaction).
• Identify one intervention to assist patients and families with early decision-making and goals-of-care conversations.

Studies on the efficacy of home-based palliative care programs are sparse, as the bulk of research has been conducted on hospital-based consult teams. As the face of health care changes and hospitals receive more scrutiny over repeat hospitalizations for symptom-based admissions, attention is turning to home-based palliative care programs as a means to managing patients who fall “into the gap” between chronic care and hospice care. Very little research exists on the benefit of home-based programs in terms of outcomes; the first journal article addressing home-based palliative care program efficacy was published in the September 2013 issue of the Journal of Palliative Medicine. As evidenced in our program, a home-based program assists in symptom management, reduces hospitalizations, assists in completing goals of conversations earlier in the disease process (as opposed to a few days before death), and promotes a general increased feeling of patient well-being.
Speed Dating with the Pharmacy Ladies: Practical Medication Tips for End-of-Life Care (SA542)

Kathryn Walker, PharmD, University of Maryland School of Pharmacy; MedStar Health, Baltimore, MD
Mary Lynn McPherson, PharmD BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD

Objectives

• Discuss three pearls related to pharmacology of palliative medications.
• Discuss three pearls related to appropriateness of maintenance medications in end-of-life care.
• Discuss three pearls related to the use of palliative medications in a safe and effective manner.

Complex medication decisions are an integral part of treating palliative care patients. Pharmacists have a unique perspective on using these medications creatively and effectively. This one-hour session will address tips and tricks for using medications appropriately for patients facing advanced diseases. Whether debriding a medication profile, aggressively treating symptoms, or strategizing a dosage formulation, it can be hard to commit to medication decisions. Two pharmacists will speed-date their way through medication tips designed to highlight important and little known medication facts that are important in palliative medicine. Topics to be covered include determining appropriate maintenance medications; side effects of opioids, such as hypogonadism; alternate administration of oral medications; using topical products; tips for maximizing dosing of patches; buccal versus transmucosal administration; medications that you can crush versus dissolve; and more! Find a tip that you are compatible with and that may just change your life.
How to Help Patients Make Value-Based Medical Decisions: Promoting Adaptive Coing and Prognostic Awareness (SA543)

Juliet Jacobsen, MD, Massachusetts General Hospital, Harvard Medical School, Boston, MA
Joseph Greer, PhD, Massachusetts General Hospital, Harvard Medical School, Boston, MA
Vicki Jackson, MD MPH FAAHPM, Massachusetts General Hospital, Boston, MA

Objectives

• Discuss the role of the outpatient palliative care clinician as supportive psychotherapist.
• Identify and practice clinical skills from the positive psychology literature to help patients build resilience and adaptive coping in the face of serious illnesses.
• Discuss techniques to enable patients to tolerate greater discussion of prognosis and the possibility of death.

Continuity outpatient palliative care practice offers an opportunity for palliative care clinicians to support patients longitudinally through the process of medical decision-making. This session will discuss how clinicians can support patients in both living well and engaging in values-based medical decision-making using techniques from supportive psychotherapy within a medical framework. We will explore how palliative care clinicians can partner with the patient to engage in a fully emotional, encouraging, and supportive relationship. Participants will learn and practice techniques to reinforce patients’ healthy and adaptive patterns of thought and behavior in order to build resilience in the face of illness and maintain quality of life. We will also discuss how to help patients develop a deeper awareness of and ability to tolerate discussions of clinical decline and the possibility of death. By building prognostic awareness and resilience, clinicians enable patients to be more fully informed and cope more effectively when making decisions about medical treatment.
Advanced Management of Neuropathic Pain in Pediatric Palliative Care: The Concept of Multimodal Analgesia (SA544)

Stefan Friedrichsdorf, MD, Children’s Hospitals & Clinics of Minnesota, Minneapolis, MN

Objectives

- Recognize the high prevalence of neuropathic pain in children with advanced serious diseases.
- Describe the main causes of neuropathic pain in pediatric patients receiving palliative care.

The majority of children with life-limiting conditions experience pain during their last weeks of life. Clinicians need to differentiate between somatic/acute, visceral, chronic, and neuropathic pain, as the analgesic management for each pain type differs. Emerging data reveal that neuropathic pain in children with advanced cancer and other progressive serious diseases is common, underrecognized, and undertreated. This session will review the pharmacological and integrative (nonpharmacological) management of neuropathic pain. This presentation will address indications, dosages, side effects, and interactions of a miscellaneous group of pharmacologic agents used to manage neuropathic pain in children. Current multimodal analgesia approaches include pharmacological, anesthetic, rehabilitative, and integrative (nonpharmacological) therapies. A step-by-step approach for analgesic and adjuvant medications, including NSAIDs, opioids, alpha-agonists, corticosteroids, antidepressants, gabapentinoids/antiepileptics, NMDA-receptor-channel blockers, general anesthetics, antispasmodics, sodium channel blockers, and atypical antipsychotics, for pediatric neuropathic pain management will be suggested. The importance of nerve blocks and neuroaxial anesthetic approaches will be stressed. Rehabilitative treatments, especially physical and occupational therapy, as well as integrative treatment modalities, such as acupressure, acupuncture, biofeedback, hypnosis, diaphragmatic breathing, aromatherapy, progressive muscle relaxation, and their role in state-of-the-art pain management will be discussed. Differentiating neuropathic pain from neuroirritability in nonverbal children poses a particular challenge for the palliative care clinician, and this session will briefly introduce some assessment and management options for neuroirritability.
Preparedness Planning for Patients Receiving Left Ventricular Assist Device as Destination Therapy: How Best to Measure Change in Culture? (SA545-A)

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Keith Swetz, MD MA FACP FAAHPM, Mayo Clinic, Rochester, MN
Angela Luckhardt, RN CNS, Mayo Clinic, Rochester, MN
Shannon Dunlay, MD MS, Mayo Clinic, Rochester, MN

Objectives

• Articulate recent CMS and ISHLT guidelines for care of patients receiving DT and what palliative care-specific issues are in those guidelines.
• Define preparedness planning for patients who receive left ventricular assist device as destination therapy (DT) and describe four core elements.
• Explore rates of advance directive completion and preparedness plan documentation prior to DT implementation, and describe contents of such advance directive documents and PM consultations.

Original Research Background: Left ventricular assist device as destination therapy (DT) can improve survival, functionality, and quality of life in patients with advanced heart failure. However, advance care planning (ACP) is crucial to promote outcomes consistent with patient’s goals, as patients will have DT until their death. Preparedness planning (PP) refers to our proposed approach to such ACP.

Research Objectives: To describe our initial, 5-year, single institution experience with PP and DT.

Methods: Retrospective medical record review of 107 consecutive patients undergoing DT implantation between January 5, 2009, and August 19, 2013, with focus on advance directive (AD) content and palliative medicine (PM) consultation documentation (specifically seeking core elements of PP: device failure, post-DT quality of life, catastrophic complication, and comorbidity progression).

Results: Mean (±SD) patient age at DT implantation was 64.3 ±10.7 years, and 42 (43%) patients have since died. PM evaluated 86 (80.1%) patients preimplantation; 75 (87.2%) were able to complete PP preimplantation. Seventy-one (66.4%) patients had an AD at time of implantation, compared with 47% pre 2009 (p=0.01). Fifty-nine (68.6%) patients having PM consultation had an AD at implantation, while 12 (57%) patients without PM consultation had an AD (p=0.32). While PM consultation notes often documented core elements of PP, only 2 (2.8%) ADs specifically addressed LVADs, and no such document contained any of the core PP elements. Hospice utilization was rare (3/42 patients) and did not differ based on PM consultation or presence of an AD or PP.

Conclusions: PM consultation and ACP are integral to comprehensive DT care. While completion/availability of ADs prior to DT implantation has improved with PP efforts, ADs still rarely address LVAD-specific issues, and hospice utilization remains rare. Ongoing efforts at optimizing PP processes and measuring quality improvement are warranted.

Implications for Research, Policy, or Practice: Despite CMS and international organizations calling for palliative care specialist involvement with patients receiving DT, operationalization and measurement of successful integration is yet to be determined.
Preferences of Patients with Heart Failure for Discussing Prognosis and Advanced Care Planning (SA545-B)

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Objectives
• Describe Heart Failure (HF) patient’s preferences for discussing specific palliative care topics with their provider.
• Identify which populations of patients may warrant further attention when providing palliative care to HF patients.

Original Research Background: National guidelines recommend integrating palliative care into Heart Failure (HF) treatment. Few studies examine whether HF patients receive palliative care.

Research Objectives: Describe the characteristics and preferences of HF patient’s palliative care discussions with clinicians.

Methods: Patients diagnosed with NYHA class II-III HF were surveyed about whether they had discussed with their clinician what to expect in the future regarding their HF, prognosis, advanced care planning, and their surrogate choice, and if they had not, whether they wanted to have these conversations.

Results: Participants (n=102) were on average 53 years old, had HF for 7 years, were 66% male, and had either Class II (57%) or Class III (43%) HF. Most participants reported having had discussions with their provider about what to expect in the future regarding HF (76.5%), prognosis (68.0%), and their surrogate choice (63.4%). Half discussed advanced care planning (46.5%). Of those who reported not having these conversations, most wanted to discuss what to expect in the future with respect to HF (81.5%), prognosis (76.3%), and advanced care planning (56.4%). HF class was not associated with having had or desiring to have discussions on any issue. Men were more likely than women to report discussions about future expectations of HF (83.6% vs. 62.9%; p=0.02), prognosis (78.5% vs. 48.6% p=0.002), and advanced care planning (56.1% vs. 28.6%; p=0.008).

Conclusions: Most participants discussed palliative care issues with providers, and most of those who did not wanted to. Our data cannot explain why women are less likely to report these discussions but suggest that clinicians be mindful of this disparity. We cannot confirm the content or quality of the discussions.

Implications for Research, Policy, or Practice: These data should embolden clinicians to discuss patients’ prognosis, wishes for advanced care planning, and choice of a surrogate. Further research should examine the impact of these discussions on outcomes.
Integrating an Advance Care Planning Clinical and Education Intervention to Improve Patient-Centered Care and End of Life Care Planning among Chronically Ill Older Adults (SA545-C)

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Objectives
• Discuss how a patient-centered educational intervention may improve completion of advance directives.
• Demonstrate the impact of an outpatient-centered educational intervention in future decisions related to end-of-life care and acute services utilization.

Original Research Background: Early identification of advance care planning (ACP) preferences among older adults (OA) with advanced illness is critical to avoid the approximately 40% of all deaths which occur in acute care settings and 50% within intensive care units.

Research Objectives: To assess if educational interventions can demonstrate positive results in improving ACP/AD rates and influencing end-of-life future decisions.

Methods: Intervention targeted OA’s with chronic illnesses at a tertiary VA hospital. Veterans and their families were seen by interprofessional teams while waiting for clinic appointments, using a case-based low-level literacy bilingual video to facilitate ACP discussion.

Results: n=249, 91 ≥70 years, 158 <70 years old with similar number of chronic diagnoses. 195 (78%) OA completed AD after intervention. OA completed AD in geriatric (32%), cardiology (29%), oncology clinics (17%). 79% subjects <70 and 76% OA>70 completed AD either medical power of attorney (MPOA) and/or living will (LW). After prospective review, 59 AD completers were found to use their AD when hospitalized. 69% were used in the inpatient setting, 20% in surgery, 8% in the ICU and 2% in hospice. Of the AD used, 66% was used in subjects <70 and 34% was used in OA>70. When admitted, 35% subjects ≥70 changed code status during hospital stay from full code to DNR/DNI, while 5% subjects <70 were less likely to change code status after admission to the hospital (p<0.005).

Conclusions: Patient-centered educational interventions can improve ACP/AD completion rates, as demonstrated by high usage after completion, particularly in acute inpatient settings. AD completion also encouraged OA to clarify goals of care, causing a significant number to change code status.

Implications for Research, Policy, or Practice: Educational interventions can promote AD usage in acute inpatient settings, where crisis and high healthcare expenses usually occur. Further prospective studies could look at impact on quality of life, cost-effectiveness and healthcare outcomes.
Evaluating Prognostication Tools to Aid in Hospice Referral, Certification & Recertification Narratives of Patients Afflicted With Pulmonary Arterial Hypertension (SA545-D)

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Objectives
• Understand the utility of the REVEAL PAH risk calculator vs LCDs in prognostication of PAH.
• Understand how prognostication tools can enhance hospice certification and recertification narratives.

Original Research Background: Pulmonary Arterial Hypertension is a progressive and fatal disease with no cure. A recent small study suggests that a majority of patients with PAH die in the hospital (67%) and most in the ICU (83%). Research suggests that patients benefit most from receiving hospice care from 2-3 months. Local Coverage Determinations (LCDs) were created to assess whether patients are likely to be in their last 6 months of life. However, these LCDs have not been updated with recent disease-specific prognostication research. We asked whether there were newer disease-specific prognostication tools that could be compared to or used with the LCDs to better predict PAH survival time.

Research Objectives: To review the literature for PAH prognostication tools, then evaluate and compare prognostication tools for PAH as relevant to hospice referral, certification, and recertification narratives.

Methods: Phase 1: A review of the PAH-specific prognostication literature to identify target tools. Phase 2: A retrospective analysis of 100% sample of hospice patients with a diagnosis of PAH who received hospice services at one large nonprofit hospice and palliative care provider in the Mid-Atlantic region since 2010.

Results: Phase 1: 12 articles on prognostication of PAH were identified, of which one tool, the REVEAL, was the most highly regarded. Phase 2: A 100% sample (n=21) of charts from deceased hospice patients seen between 2010-2013 were selected for a retrospective analysis. The analysis will compare the LCDs against the REVEAL prognostication tool in predicting actual date of death and length of stay in hospice.

Conclusions: The REVEAL risk calculator is a prognostication tool that could aid hospice and palliative care physicians in more accurately predicting survival time as well as appropriate and timely referrals to hospice.

Implications for Research, Policy, or Practice: As therapies and treatment options progress, it is critical to continue to research prognostication measures. Up to date prognostication tools are required for improving clinical practice. Accurate prognostication allows appropriate plans of care.
Integrating Psychosocial Quality Indicators into Hospice and Palliative Care Programs (SA546)

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Objectives

- Identify the neuropsychiatric syndromes of distress, delirium, and depression as areas for psychosocial care quality improvement.
- Identify validated assessment and screening tools for core psychosocial quality indicators in palliative care.
- Select measures of quality psychosocial indicators based on research evidence, clinical setting demands, and results of community engagement feedback to facilitate implementation and evaluation.

As palliative medicine grows and matures, an increased focus on quality of care is needed to demonstrate the value of its services. Quality of health care is often evaluated through assessments of care delivery compared against published healthcare quality measures. Recently, the Centers for Medicare & Medicaid Services (CMS) announced the implementation of the Hospice Quality Reporting Program (HQR). The HQR calls for expanded quality measurement and uses the newly developed Hospice Item Set (HIS) for reporting data on quality to CMS. This is a remarkable leap forward in ensuring that all patients receive quality end-of-life care, yet some important areas for optimization of this quality improvement process remain. Despite many of the clinical domains for quality palliative care being addressed by the HIS, evaluation of the biopsychosocial component is conspicuously absent. Without addressing the high burden of neuropsychiatric illness in palliative care, we miss a major marker of quality end-of-life care.

Palliative care leaders, such as AAHPM, need to develop the metrics for identifying the domains for quality psychosocial care. We hope that AAHPM will become the cornerstone to developing future quality markers for psychosocial quality in palliative care. Thus, during this session, we plan to provide clinicians with the tools needed for the increased identification and assessment of three primary domains of psychosocial indicators of quality palliative care: distress, depression, and delirium. Several studies have shown that brief instruments of assessment for neuropsychiatric disorders, performed at the bedside and in the clinic, can provide valuable information for diagnostic assessment and thus treatment for patients with serious neuropsychiatric illnesses. This session will cover (1) areas for improvement and initial recognition of psychosocial distress, (2) tools for the diagnosis and assessment of these three psychosocial domains, and (3) tools attendees can use to assess these quality metrics in their programs.