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

March 9-12, 2016, Chicago, IL

Wednesday, March 9

AAHPM & HPNA Preconference Workshops

8 am—5 pm

Hospice Medical Directors Update and Exam Prep (P01)

Edward W. Martin, MD MPH FACP, Home & Hospice Care of Rhode Island, Cranston, RI. Shaida Talebreza, MD FAAHPM HMDC, University of Utah Health Care, Salt Lake City, UT. Ronald J. Crossno, MD FAAFP FAAHPM, Kindred Healthcare, Rockdale, TX. Kathleen Faulkner, MD FAAHPM, Good Shepherd Community Care, Newton, MA.

Objectives

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

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

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

Robert M. Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA. Anthony Back, MD, University of Washington, Seattle, WA. James Tulsky, MD FAAHPM FACP, 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—"Work With Me People!" Influence and the Art of Leading Teams (P03)

Dave Logan, PhD, CultureSync, Los Angeles, CA.

Objectives

- Establish more effective relationships with colleagues and patients.
- Define the essential behaviors and practices of good teamwork.
- Work better within teams and increase effectiveness as a team leader.
- Describe basic influence principles and use influence to motivate others and to resolve and/or prevent interpersonal and organizational conflicts.

Ignite your leadership potential. Influence and the Art of Leading Teams is designed to equip hospice and palliative medicine physicians with tools, techniques, and strategies to become more effective team leaders by recognizing the influence and accountability of physicians and understanding what drives performance and behavior at work. Effective physician leadership is instrumental to improved patient satisfaction, reduced length of stay, and better integration of clinical care across service lines. To be effective, physician leaders must master multiple clinical and leadership competencies, including interpersonal skills. When leaders learn to use interpersonal skills, they are able to apply them in a wide variety of specific activities, including leading teams, coaching, and managing conflict.

This preconference program is offered in partnership with the American Association for Physician Leadership. This session applies to all physician leaders and practice settings looking to increase their effectiveness as a team leader. Primary leadership competencies addressed in this program include interpersonal skills, communication skills, and the ability to convey a clear, compelling vision.

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/leadership.

Fellowship Directors' Program: Higher Ground—Helping Our HPM Fellowships Continue to Grow and Thrive in an Era of Rapid Change (P04)

Lori Earnshaw, MD, University of Louisville, Louisville, KY. Gary Buckholz, MD FAAHPM, University of California San Diego, San Diego, CA. Jane deLima Thomas, MD FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Jillian Gustin, MD, Ohio State University Medical Center, Columbus, OH. Stanley Hamstra, ACGME Senior VP, Milestones Research and Evaluation, Chicago, IL. Juliet Jacobsen, MD, Massachusetts General Hospital, Boston, MA. Stacie Levine, MD FAAHPM, University of Chicago, Chicago, IL. Sumathi Misra, MD MPH, Vanderbilt University School of Medicine, Nashville, TN. Laura Morrison, MD FAAHPM, Yale University School of Medicine, New Haven, CT. Steven M. Radwany, MD FAAHPM, Summa Health System, Akron, OH. Thomas Reid, MD MA, University of California San Francisco, San Francisco, CA. Michael David Barnett, MD MS, University of Alabama Birmingham, Birmingham, AL. Lindy Landzaat, DO, University of Kansas Medical Center, Kansas City, KS. Wayne McCormick, MD, Harborview Medical Center, Seattle, WA

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Objectives

- Describe the development of competency-based medical education and its impact on HPM fellowship training.
- Create and adapt assessment and evaluation tools.
- Discuss the impact of the NRMP Match on recruitment, interviewing, and candidate selection, as well as the process of filling unmatched positions.

Hospice and palliative medicine fellowship programs have faced the challenges of a new accreditation system, revised common program requirements, and entering the NRMP Match. Summer 2015 brings the first interview and recruitment cycle in the Match, and programs will have questions and lessons learned after experiencing the Match for the first time. Many programs will have also experienced ACGME self-study requirements and CLER visits, in addition to all programs having created new processes for program evaluation, clinical competency committees, and reporting milestones. In order to adapt to the new paradigm of training fellows, experts within the field have created Entrustable Professional Activities (EPAs), which must be reconciled with existing competencies and evaluation tools. Because the new accreditation system allows for flexibility and the field of hospice and palliative medicine demands innovation to address workforce shortages, program directors have a unique opportunity to develop or enhance pathways for training pediatricians in adult palliative care programs, mid-career fellows, and part-time fellows. The common program requirement changes demand that some programs create new curricula, expand protected time for program directors, and clinical rotations sites, all of which have funding implications in a time of sparse resources. This session will focus on helping program directors and coordinators implement these changes through expert testimony and small group exchanges of educational tools, evaluation forms, and innovation in curriculum development.

Smooth Sailing in Advanced Illness Transitions of Care: Optimizing Medication Management from Palliative Care to Hospice Care (P05)

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

Objectives

- Use evidence based practice assessment to determine optimal medication therapy in end of life diseases processes.
- Develop best practices for transitions in care and medication management from palliative care to hospice care in end of life disease processes.

- Utilize an evidence-based approach to medication prescribing process, including specifically how to discontinue medications for patients with serious illness.
- Integrate effective communication skills concerning medication management in patients with an advanced illness, with providers, patients, families and caregivers.

Medications play a very large role in the management of chronic illnesses in advanced illness. The purpose of this all-day preconference is to wrestle with optimizing medication management in the most common advanced illnesses at the end of life including metabolic syndrome, heart failure, COPD, dementia, ALS and other disease states. Particular attention will be paid to medication-related issues in transitions of care between palliative care and hospice care, including medication and dosage formulation selection, therapeutic goal setting, monitoring and dosage titration aimed at optimizing symptom control.

8 am—5:30 pm

ACHPN Certification Review: Advanced Practice Registered Nurse (P06)

Constance Dahlin, ANP-BC ACHPN FPCN FAAN, Hospice and Palliative Nurses Association, Pittsburgh, PA. Maureen Lynch, MS ANP-BC AOCH ACHPN FPCN FAAN, Dana Farber Cancer Center/Harvard Medical School, Boston, MA. Kerstin Lappen, MS RN ACHPN FPCN, Minnesota Oncology, Minneapolis Clinic, Minneapolis, MN. Bronwyn Long, RN DNP MBA, National Jewish Health, Denver, CO.

Objectives

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

The review course will provide a review of the content areas based on the Hospice and Palliative Credentialing Center (HPCC) detailed test content outline. This course may be used to increase the hospice and palliative advanced practice registered nurse's knowledge of general palliative nursing or to assist the nurse in self-identifying topics that require further review and study in advance of sitting for the specialty certification examination.

Attendees of this session will require the following materials: Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd edition (order online from the HPNA Shop) and the Hospice and Palliative Credentialing Center ACHPN Candidate Handbook (download and print for free at http://hpcc.advancingexpertcare.org/competence/aprn-achpn/).

CHPN Certification Review: Registered Nurse (P07)

Carma Erickson-Hurt, DNP ACHPN, South Coast Hospice, Coos Bay, OR. Bonnie Morgan, MEd RN-BC CHPN FPCN, IMS Oncology/Palliative Care Alliance, Mesa, AZ.

Objectives

- Provide participants with a framework to in which to prepare for Certified Hospice and Palliative Nursing (CHPN®)Examination
- Provide participants with a process to assess strengths and weaknesses of content for the CHPN® Examination

The review course will provide a review of the content areas based on the Hospice and Palliative Credentialing Center (HPCC) 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 self-identifying topics that require further review and study in advance of sitting for the specialty certification examination.

Attendees of this session will require the following materials: Core Curriculum for the Hospice and Palliative Registered Nurse, 4th edition (order online from the HPNA Shop) and the Hospice and Palliative Credentialing Center CHPN Candidate Handbook (download and print for free at http://hpcc.advancingexpertcare.org/competence/rn-chpn/).

8 am—11:45 am

Pairing Palliative Care with Cutting-Edge Oncologic Care: Challenges and Opportunities (P08)

Judith Nelson, MD JD, Memorial Sloan Kettering Cancer Center, New York, NY. James Tulsky, MD FACP FAAHPM, Duke University, Durham, NC. Betty Ferrell, PhD MA FAAN FPCN, City of Hope National Medical Center, Duarte, CA. Colleen Mulkerin, MSW LCSW, Hartford Hospital, South Glastonbury, CT. Louis Voigt, MD, Memorial Sloan Kettering Cancer Center, New York, NY. Stacy Stabler, MD PhD, Memorial Sloan Kettering Cancer Center, New York, NY.

Objectives

- List 4 specific challenges for successful integration of palliative care with oncologic care.
- Consider/incorporate 3 key factors in striking an appropriate balance between generalist and specialist palliative care.

- Describe 3 approaches to enhance collaboration between palliative care and cancer researchers.

Successful integration of palliative care with oncologic care requires an understanding of specific challenges, opportunities, and strategies. Among challenges, the task of meeting palliative care needs while supporting patients, families, and clinicians who wish to continue cancer-directed treatment, including experimental therapies, is especially complex. Rapid developments in oncologic therapies with better outcomes for some malignancies may make it harder to establish realistic and appropriate goals of care. Other important issues include the appropriate distribution of responsibilities for palliative care within the healthcare team, so that not only are the contributions of clinicians across disciplines and professions valued, optimized, and coordinated, but also that patients with cancer receive the benefits of both generalists and specialists in palliative care. Effective collaboration between palliative care and cancer researchers is essential to enhance the evidentiary foundation for integrated care and to ensure attention to the palliative needs of patients participating in clinical trials. In addition, the development of innovative strategies is needed as we make progress in educating the clinical workforce, including oncologists, other generalists, and palliative care specialists to provide palliative care together with cancer care. Models of integration of palliative care in oncology must fit the needs of patients, families, and providers in community settings (inpatient and outpatient), where most cancer care in the US is delivered, as well as in academic referral centers. Finally, in our rapidly changing healthcare environment, palliative care must be paired with cancer care in ways that are appropriate across different systems for reimbursement, including distinctive systems that apply in some care hospitals. In the proposed workshop, we will bring together individuals with relevant expertise from across the country to provide an interprofessional perspective, help participants think about key topics, and engage them in envisioning the future for palliative care at the forefront of cancer care.

Pediatric Palliative Care and Hospice Program Development in 2016: Strategies for Success in an Ever-Expanding World (P09)

Lisa Humphrey, MD, Nationwide Children's Hospital, Columbus, OH. Sarah Friebert, MD FAAP FAAHPM, Akron Children's Hospital, Akron, OH. Elissa Miller, MD, Nemours/AI DuPont Hospital for Children, Philadelphia, PA. Lindsay Ragsdale, MD, Kentucky Children's Hospital, Nicholasville, KY. Shefali Parikh, MD, Pediatric Advanced Care Team, Philadelphia, PA.

Objectives

- Propose pediatric program design or expansion based on newly acquired skills of defining a desirable and functional scope that aligns with health system's missions and values and identifies areas of potential growth and collaboration within the health system.
- Discuss the creation of a formal business plan for development of a pediatric palliative care program to present to senior hospital leadership that effectively highlights the benefits and challenges of a billing revenue only strategy and thus a need for operating dollars and philanthropic support as a comprehensive business plan strategy.
- Develop a strategy for their community to implement PC with limited resources and increase buy-in from stakeholders.

As with adult palliative care, pediatric palliative care is experiencing rapid growth. Like adult palliative care, pediatric palliative care practitioners also need to design and sustain programs that respond to their own institutional needs and values, that show value added through metrics and quality improvement research, that acknowledge the national palliative care staffing shortage, that address the growing need for outpatient resources in all communities, and that have strategies embedded to prevent staff burnout. Distinct from adult palliative care is pediatrics' need for greater philanthropic and operational dollar support as pediatric palliative care has not had the patient volume to show the reduced cost savings strategy that drives many adult palliative care budget plans. This workshop will present strategies for preliminary pediatric program planning and budgeting that address these needs through the presentation of five distinct pediatric palliative care programs. Education will be heavily driven through case presentations that contrast resource-rich versus resource limited environments, newer programs versus more established programs, and inpatient versus outpatient arenas. After providing this platform, the workshop will utilize these experts to assist in small group discussions that focus on participants' unique program needs and questions.

Culturosity: Competence in Caring for Communities of Color (P10)

Joel Policzer, MD FACP FAAHPM, Vitas Innovative Hospice Care, Parkland, FL. Deborah Mizell, RN, VITAS Healthcare, Lauderhill, FL. Diane Deese, CACPFI EMT, VITAS Healthcare, Buford, GA. Richard Payne, MD, Duke Divinity School, Durham, NC. Lawrence Sanders, MD, Morehouse School of Medicine, Decatur, GA.

Objectives

- Understand the basis of cultural competence in caring for African-American communities.

- Discuss the effects of centuries of healthcare disparities and the implications for end-of-life decision-making in African-American communities.
- Understand cultural mainstays of importance that become barriers to care if they are not observed.

It is a well-established tenet of hospice and palliative care that care must be culturally sensitive and appropriate. Yet research shows that providers are often uncomfortable with patients and families not of their own culture, and this is a barrier to effective communication and palliative healthcare delivery. Cultural and worldview differences pose significant communication barriers, certainly when religious beliefs are brought into secular-oriented health care. Particular examples may be when there is a reluctance to "concede" or "claim" that a terminal diagnosis exists or when prayer and appeals for miracles are used as strategies for "managing" terminal illness. As African-American culture is often opaque to the majority population, three aspects of cultural competence will be discussed. Centuries of healthcare disparities have led to distrust of "the system" and of majority providers; there will be a discussion of the consequences of these disparities and methods to overcome them. Second, there are "cultural pearls" that are often unknown to majority providers; transgression of them develops an immediate barrier, while observance engenders a sense of respect for the patient and family. Finally, while the influence of religion is fading in the public square, the church remains a bedrock of African-American culture. Engaging pastors in the conversation early, knowing that patients and families rely on their counsel as much as, or more than, physician opinion, increases communication and leads to culturally appropriate care. Methods for operationalizing this information will be presented.

Rediscovering the Voice of Our Calling: The Power of Our Stories (P11)

Jonna Goulding, MD, Gifford Primary Care, Barre, VT. Suzana Everett Makowski, MD MMM FACP FAAHPM, UMASS Memorial Medical Center, UMASS Medical School, Grafton, MA. Daniel Spurgeon, MD, Metropolitan Jewish Health System, New York, NY.

Objectives

- Describe how the archetype of the wounded healer, present in many cultures, resonates with our experience as palliative and hospice care providers.
- Understand appreciative inquiry process and StoryCorps methodology as means of self-exploration through narrative.
- Integrate practices incorporating heroic healer myths, appreciative inquiry, and storytelling in order to revisit what brought each of us to this work, thus deepening resilience and preventing burnout.

In Chicago, home of StoryCorps, we call palliative care providers to examine the power and truth of their own stories. We hear stories from our patients and their families every day. But what about *our* stories?

We will explore our legacy, and birthright, of story by listening to stories of suffering, healing, and wounded healers from many different eras and cultures. Guided meditation, and deep inquiry exercises will be used to contemplate these stories, and to help understand and deepen our presence within our own stories. The space between the stories of our patients and our personal stories of "What called me to this work?" will be explored as sources of identity, confidence, and healing.

Palliative Wound Care (P12)

Oscar Alvarez, PhD CCT FAPWCA, Calvary Hospital, Bronx, NY. Bruce Chamberlain, MD FACP FAAHPM, Jordan Valley Hospital, Provo, UT. Aletha Tippett, MD HMDC, Brookdale Hospice, Cincinnati, OH.

Objectives

- Understand how to assess a wound and determine if palliative wound care is appropriate.
- Learn an approach to palliative wound care and how to determine strategy for various types of wounds, including venous, pressure, vascular, and malignant.
- Understand how to control the problems of pain and odor in palliative wound care.

The concept of palliation for chronic wounds is a relatively new concept within the past ten years. Palliation recognizes and accepts nonhealing endpoints as appropriate care and uses nonhealing strategies to comfort patients and improve quality of life. There is no formal education on palliative wound care at this time, other than scattered individual lectures at various wound care symposiums and the annual palliative wound conference held for the past four years. There are many hospice caregivers who desire more information on specific treatments available and on approaches to management of chronic wounds in terminally ill patient. Since 35% of end of life hospice patients will have a wound, it is paramount that hospice providers receive adequate training in palliative wound care.

There is a tremendous need for knowledge and training, especially in hospice, for palliative wound care. The traditional goal of wound care is to heal or prepare for surgical closure, but techniques and procedures used to "heal" a wound can be painful or uncomfortable and very costly. It is inappropriate to ignore wounds or declare them untreatable in patients at the end of life. Palliative wound care requires a different mindset than traditional wound care yet is based on the same fundamental scientific principles. This workshop presents an approach to palliation in wound care that involves being able to properly assess a wound and determine if palliation is appropriate, developing a comprehensive strategy for palliation of various types of wounds, and managing symptoms of chronic wounds, especially pain and odor.

The many benefits of an effective palliative wound program, including improved quality of life and achieving the goal of healing the whole person, will be addressed. The emphasis will be on palliative wound care helping to achieve hospice goals for the patient.

Achy Breaky Heart: Palliative and Hospice Care in Advanced cardiac Disease (P13)

Christine Westphal, NP MSN ACNS ACHPN, Beaumont Health Palliative Care Services, Dearborn, MI.

Objectives

- Relate signs and symptoms of heart failure, valve dysfunction and malignant arrhythmias to the underlying pathophysiology.
- Use a case base approach recommendations to manage disease, optimize symptom management and improve quality of life in collaboration with cardiac specialists.
- Discuss strategies for supporting decision-making related to the use and discontinuation of life-saving and/or life-prolonging therapies.

This session will examine the palliative and hospice care of adult patients with select advanced cardiac diseases, such as heart failure, valve dysfunction, and malignant arrhythmias. A case base approach will focus on assessment and recommendations related to optimizing symptom management, improving quality of life, and supporting decision making related to the use of life-saving and/or life-prolonging therapies.

1:15—5 pm

From Surviving to Thriving: A Self-Care Path to Resilience (P14)

Sandra Sanchez-Reilly, MD FAAHPM, UT Health Science Center, San Antonio, TX. Vyjeyanthi Periyakoil, MD, Stanford University School of Medicine, Palo Alto, CA. Jennifer Kapo, MD, Yale University, Bethany, CT. Jane deLima Thomas, MD FAAHPM, Dana Farber Cancer Institute, Boston, MA. Lynn O'Neill, MD FAAHPM, Emory University, Atlanta, GA.

Objectives

- Discuss the importance of having a self-care and a self-awareness plan when caring for seriously ill patients.
- Practice validated methods to increase personal and team self-care, enhance self-awareness, and thrive in being resilient.

It has been demonstrated that clinicians who care for seriously ill patients and their families are at high risk for diminished personal well-being, including high rates of burnout, moral distress, and compassion fatigue. Hospice and palliative care (HPC) clinicians become closely involved in the numerous physical, spiritual, and psychosocial challenges their patients endure, often forgetting to fulfill their own personal needs.

Basic levels of self-care such as adequate sleep, love, belonging, security, and family well-being are crucial to ensure survival. If those needs are met, the path to thriving may begin by improving self-awareness, a stance that permits the clinician to simultaneously attend to the needs of the patient and oneself, leading to both enhanced self-care and improved patient care and satisfaction.

How do we cease to strive for survival and begin to thrive when caring for the sickest of the sick? How do we foster resilience? Resilience is the quality that allows people to recover readily from stress or adversity. Resilience ensures a thriving path.

This session will first describe levels of self-care in depth, as it pertains to personal self-care, team self-care, and the crucial need to incorporate required activities to enhance thriving. Further, self-awareness techniques/methods and resilience stories will be shared. Participants will 1) reflect on types of self-care and will work on a concrete self-awareness plan, 2) discuss alternatives to thrive by incorporating self-care as a career priority, such as peer-support groups and educational initiatives, and 3) use validated methods to enhance HPM clinicians' self-awareness such as mindfulness meditation, the Johari Window Team Model, and reflective writing. Large and small group brainstorming will be encouraged to devise creative solutions and discuss alternatives to personal and team resilience. Networking opportunities will also be emphasized and encouraged.

"I've Got This Difficult Case…" Ethics Facilitation and Documentation in Pediatrics (P15)

Liza-Marie Johnson, MD MPH MBE, St Jude Children's Research Hospital, Memphis, TN. Deena Levine, MD, St Jude Children's Research Hospital, Memphis, TN. Justin Baker, MD FAAHPM, St Jude Children's Hospital, Memphis, TN. Chris Feudtner, MD PhD MPH, The Children's Hospital of Philadelphia, Cherry Hill, NJ. Robert C. Macauley, MD FAAHPM, University of Vermont Medical Center, Burlington, VT.

Objectives

- Explain what is special about clinical ethics consultation in pediatric populations.

- Apply principles of communication theory, mediation, and shared decision making to the process of resolving ethical conflicts in pediatrics.
- Practice essential skills competencies identified in the *Core Competencies of Health Care Ethics Consultation* (2nd edition, American Society of Bioethics and Humanities).

Clinical ethics consultations in pediatrics are often highly complex and frequently involve evaluations of parental decision-making with particular consideration of the risks and benefits of alternative medical pathways. Pediatric providers need to balance their fiduciary responsibility to the patient with respect for autonomy of the family unit. Many ethical dilemmas involve a breakdown in communication rather than a true conflict in core ethical principles. Uncertainty over goals of care, the purpose of a medical intervention, or concern that a child is at risk of harm can be distressing for pediatric providers. Children receiving complex medical technologies or intensive nursing care in the context of a guarded or uncertain prognosis risk triggering provider distress if they fail to improve or clearly benefit from this high level of medical care.

The synthesis of ethical principles with high-quality communication and shared decision-making skills may facilitate negotiation of a treatment plan agreeable to clinicians and families and reduce moral distress among clinical staff. This is an important skill for clinicians working with pediatric patients and may resolve conflicts without the need for a formal ethics consultation. As with any form of clinical consultation, documentation of the process and the advice rendered is essential. Formal consultations should be organized into a clinical ethics consult note. For informal consultations, palliative care teams should consider integration of ethical issues into their standard chart note.

How to Design, Build, and Pay for a Community-Based Palliative Care Program (P16)

James Mittelberger, MD MPH, Optum, Oakland, CA. Dana Lustbader, MD, ProHEALTH Care Associates, Great Neck, NY. Daniel Hoefer, MD, Sharp HealthCare, San Diego, CA. Kathleen Kerr, BA, Kerr Healthcare Analytics, Mill Valley, CA. Michael Rabow, MD FAAHPM, University of California at San Francisco, San Francisco, CA.

Objectives

- Describe the payment methodology for fee for service, Medicare advantage, accountable care organizations, Commercial health plan, Medicaid, and hospice to be able use the information in program design.
- Describe methods for identification and engagement of palliative care patients, explain the importance of effective targeting to program effectiveness and return on investment, and be able to discuss benefits of each alternative method.
- Describe the staffing and care design options for community based palliative care and understand how different options may be suited to different communities.

Community-based palliative care (CBPC) is the cutting edge of palliative care and offers enormous potential to improve care for those facing serious illness. Effective implementation of community-based palliative care requires understanding of rapidly changing new payment structures and systems in widely varied healthcare systems delivering care to different patient populations. This half-day session will cover the essential concepts needed to design a community-based palliative care program. It will discuss payment methodologies, patient identification options, staffing design considerations, outcome measurement, and other essential elements of successful program implementation. The teaching methodology will include presentation of key concepts illustrated by case examples based on the presenters' experience with extensive discussion of cases with the audience.

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

Christina Puchalski, MD MS FACP FAAHPM, George Washington University, Arlington, VA. George Handzo, MA, Handzo Consulting, Los Angeles, CA. Betty Ferrell, PhD MA FAAN FPCN, City of Hope, Duarte, CA.

Objectives

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

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

Many healthcare professionals believe that resolution of these types of cases requires special skills and time that they do not have. An expressed belief that a miracle or another religious belief will or might occur can arise from several causes, not all of them rooted in religion or spirituality. Thus, it is important for the provider to first determine what the belief means to this particular family through a proper assessment and relationship building. Through didactics, discussion, and use of case examples, this workshop will present practical and time-efficient processes for forming positive alliances with families who hold strong religious beliefs and are coming to decisions about end-of-life care that respect both the medical realities and the family's religious beliefs. Important elements of this process are respectful attentive listening, a thorough spiritual history, and specific practical communication strategies for aligning with the patient and identifying common goals of care. Differentiating situations truly based on religious issues and situations in which the issues are actually emotional but framed in religious language will be discussed.

Incorporating Geriatric Oncology Concepts into Palliative Medicine Across the Cancer Care Continuum (P18)

Ira R. Parker, DDS MA MPH, Geriatric Oncology Solutions, La Jolla, CA. Holly M. Holmes, MD MS, University of Texas Health Science Center at Houston, Houston, TX.

Objectives

- Understand and use geriatric medicine centered principles and cancer-focused geriatric assessment to enhance the delivery of comprehensive supportive cancer care for older adults.
- Understand the potential role of primary and consultative geriatrics relating to the continuum of care of an older adult who has received a cancer diagnosis.
- Develop the necessary skillset to recognize and treat geriatric conditions to facilitate providing palliative care earlier in the continuum of care for geriatric oncology patients.

As the number of older adults at risk for and/or having been diagnosed with cancer steadily increases, so does the necessity for models of greater collaboration between geriatrics, palliative medicine, and oncology. Cancer will surpass cardiovascular disease as the leading cause of mortality in older adult cohorts within several decades. The 2013 Institute of Medicine (IOM) report *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis* has highlighted the multi-factorial need for change in the delivery of cancer care—focusing specifically upon older adult population issues. "The expert committee concluded that the cancer care delivery system is in crisis due to: 1) a growing demand for cancer care; 2) increasing complexity of treatment; 3) a shrinking workforce; and 4) rising costs." Recognizing the need for enhanced collaborative efforts between the disciplines of palliative and geriatric medicine and oncology, and in response to this IOM report, the American Geriatrics Society/American Society of Clinical Oncology Geriatric Oncology Summit was convened in December 2013. Select representatives from each organization discussed the potential opportunities and existing barriers impacting the delivery of best-practices cancer care to older adults ranging from prevention to end-of-life care. Palliative medicine practitioners will increasingly be caring for older adults earlier in the cancer care continuum and will need to be prepared to assess and treat age-related conditions and geriatric syndromes in order to provide best supportive care. The goal of this preconference workshop is to provide relevant information and tools employed by geriatric oncology to palliative medicine practitioners caring for older adults with cancer. This preconference session will explore the interface between palliative medicine, geriatrics, and oncology and consider how the collaborative care among the three disciplines contributes to optimal supportive care. This workshop will focus upon the geriatric oncology based knowledge and clinical competencies necessary for palliative medicine providers to best serve their older adult patients.

The Language We Cry In: The Cultural Diversity of the African Diaspora (P19)

Julie Tanner, BSN RN-BC CHPN, Hospice and Palliative Nurses Association, Pittsburgh, PA. Edda L. Fields-Black, PhD, Carnegie Mellon University, Pittsburgh, PA.

Objectives

- Detail factors that influence the diverse cultural values, beliefs and traditions impacting end-of-life health care practices
- Adapt end of life culturally effective care delivery techniques through utilization of cultural interviewing methods and case discussions
- Collaborate on constructing culturally effective care plans for end of life care delivery in the Gullah Culture, the foundation of African Cultural Heritage

You can speak another language; you can live in another culture. But to cry over your dead, you always go back to your mother tongue; the language you cry in. It is understood that there are wide variances among cultures in how we process grief. These variances are often subtle and challenging to recognize and are fundamental to how a culture feels and behaves about end of life decisions and care. This session will detail factors that influence the diverse cultural values, beliefs, and traditions of end of life healthcare practices; adapt end-of-life culturally effective care delivery techniques through utilization of cultural interviewing methods and case study discussions; and collaborate on constructing culturally effective plans for end of life care delivery.

THURSDAY, MARCH 10
8–9:45 am

Plenary Session

The C-Suite Speaks: National Leaders on the Future of Palliative Care (102)

Betty Ferrell, PhD MA FAAN FPCN, City of Hope, Duarte, CA (moderator). Christine Cassel, MD, National Quality Forum, Washington, DC. Mark Ganz Cambia Health Solutions, Portland, OR. Paul Grundy, MD MPH FACOEM FACPM, IBM and Patient-Centered Primary Care Collaborative, Somers, NY.

Objectives

- Describe the relationship between total comprehensive care population management and palliative care.
- Discuss the dynamics of national healthcare and the place of palliative care going forward.
- Identify an action step to enhance the impact of palliative care in your practice arena.

Three national and global leaders in healthcare come together as a moderated panel to discuss palliative care in the context of the changing healthcare environment. Each panelist will provide their perspective on where palliative care “fits” in current landscape and discuss opportunities to impact the culture, quality, and structure of care. The audience will be able to engage the panel in open dialogue using Twitter.

10:30–11:30 am

Concurrent Sessions

Palliative Care for the Elderly Trauma Patient: Models for Early Screening and Intervention (TH300)

Sangeeta Lamba, MD, Rutgers New Jersey Medical School, Newark, NJ. Anne Mosenthal, MD FACS, Rutgers New Jersey Medical School, Newark, NJ. Jasmine Garces-King, DNP RN CCRN ACNP-BC, University Hospital, Newark, NJ. Debra Mazza, MEd LAC CGC, University Hospital, Newark, NJ.

Objectives

- Describe the unmet palliative care needs and patient-centered quality outcomes in the elderly trauma patient.
- Identify screening criteria or “triggers” for assessment of palliative care needs in the elderly trauma patient.
- Describe models of proactive palliative care assessment and interventions for the elderly trauma patient in the emergency department and Surgical ICU.

Trauma is a sudden, often catastrophic, event that has a significant impact on the patient. The injured patient’s family is also unprepared and often has to deal with the challenge of making complex decisions in the face of uncertain outcomes. The elderly have significantly worse outcomes after trauma and are much more likely to be hospitalized and less likely to return to independent function or return to an acceptable quality of life. The injured elderly also face the added burden of being frail and having multiple preexisting comorbidities. Engagement of palliative care in the elderly trauma patient is rare and often occurs too late in the disease process to make a real difference. We will discuss the emerging literature on geriatric trauma and palliative care. We will describe the “screening criteria or triggers” for early palliative care consultations in the elderly trauma patient that we have developed. These “triggers” include preexisting functional status, delirium, and Palliative Performance Scale as well as injury severity scores and injury patterns in the elderly. Models of proactive palliative care assessment and intervention in the emergency department and the surgical intensive care unit (ICU) will be described. We will also discuss how we have established an institutional culture of collaborative trauma palliative care in the emergency department and surgical ICU. The interdisciplinary panel will highlight the collaborative shared decision-making approach that includes early assessment and communication in order to support patients and families in the surgical ICU, particularly during transitions of care.

When Faith Hurts: Redemptive Suffering and Refusal of Symptomatic Treatment (TH301)

Robert Macauley, MD FAAHPM, University of Vermont Medical Center, Burlington, VT. Vyjeyanthi Periyakoil, MD, Stanford University School of Medicine, Palo Alto, CA.

Objectives

- Define and explain the significance of “redemptive suffering” in caring for the seriously ill patient and family.
- Describe theological bases for redemptive suffering from various traditions.
- Use a framework to better understand the operative construct of redemptive suffering.

- Identify the various types of redemptive suffering, using illustrative cases and strategize about how to manage these complex situations.

Patients' spiritual beliefs influence how they deal with serious illness. Palliative care clinicians may encounter resistance to optimal symptom management based on the concept of "redemptive suffering," or the belief that suffering can lessen the divine penalty for sin. This belief is based on an interpretation of specific verses in Christian scripture (eg, "Take up your cross daily and follow me," Luke 9:23) and has been attributed to both Roman Catholic and Protestant leaders, such as Pope John Paul II and Rick Warren (author of *The Purpose Driven Life*).

It can be extremely frustrating for palliative care practitioners to witness patient suffering when they have the tools to ameliorate it but are not permitted to use them. Being prevented from doing what they feel they (should) can cause a sense of helplessness and moral distress, as well as significant conflict between the team and the patient/family—and within the team itself.

Using real cases, this session will explore the challenges clinicians face and identify appropriate approaches to refusal of symptom management based on redemptive suffering. Distinctions will be drawn between refusals by the patient and by the family, as well as refusals stemming from a sense of obligation (a theological dilemma) and those stemming from a sense of enhanced connection with the divine (a spiritual dilemma). The role of a professional's belief in redemptive suffering in assessment and treatment will also be explored, based on empirical studies. References will be made to famous examples of redemptive suffering in literature (eg, Flannery O'Connor's Wise Blood) and cinema (eg, *The Mission*, directed by Roland Joffé).

The presenters—a pediatric palliative care clinician who is also an Episcopal priest, and an adult palliative care clinician—will combine professional experience, evidence-based clinical practice, and theological analysis in providing attendees with practical tools for approaching these challenging situations.

Design and Implement a Generalist Palliative Care Education Model: Hows, Whys, and What to Do Next (TH302)

Dominic Moore, MD, Rainbow Kids Palliative Care and Primary Children's Hospital, Salt Lake City, UT. Victoria Wilkins, MD MPH, University of Utah and Primary Children's Hospital, Salt Lake City, UT. Holly Spraker Perlman, MD MS, University of Utah and Primary Children's Hospital, Salt Lake City, UT. Jen Yu Wei, DO, University of Utah School of Medicine, Salt Lake City, UT.

Objectives

- Address needs of generalist palliative care learners.
- Apply adult learning best practices in Education Model Design.
- Understand the need for learner feedback and evaluation in generalist palliative care education.

In 2014, the University of Utah and Intermountain Healthcare, Inc., recognized a large gap in both generalist and specialist palliative care for a five-state catchment area. As a result, local palliative care specialists came together with local and national leaders to create a program for generalist palliative care (GPC) education. The first cohort completed training in February 2015, with three more cohorts scheduled before the 2016 AAHPM NCE. This presentation will examine curriculum design and implementation with focus on adult learning best practices, lessons learned, and problem solving using specific case studies.

The session will begin with an interactive exercise as participants create a list of learning objectives for a GPC curriculum. After brainstorming, the panel will discuss the process of refining a curriculum based on the needs of learners.

Adult learning best practices will be introduced using examples from the GPC curriculum. Lesson plans will be made available to learners in the preconference electronic distribution, as well as during the activity. The panel will discuss the effort to avoid slides in favor of more interactive teaching and give practical recommendations of when this is most and least effective.

Learners will review the pre- and post-GPC session questionnaires. Various forms of evaluation and feedback will be discussed, along with the ideal timing to solicit feedback. The group will discuss benefits and drawbacks of early and late feedback. The presentation will include actual GPC course learner feedback. Case studies from the panel's experience will be used to discuss common challenging scenarios, including a resistant learner, a disruptive learner, and an offended learner. The session will close with a brief question-and-answer period.

Surrogate Decision Making in Clinical Practice: Whose Interests? Which Judgments? (TH303)

Lois Snyder Sulmasy, JD, American College of Physicians, Philadelphia, PA. Daniel Sulmasy, MD PhD, University of Chicago, Chicago, IL. Carrie Horwitch, MD MPH FACP, Virginia Mason Medical Center, Seattle, WA. James Tulsky, MD FACP FAAHPM, Duke University Health System, Durham, NC.

Objectives

- Understand ethical issues raised by surrogate decision making in the clinical context.

- Determine what interests of patients, physicians, family members, and the community are at stake in surrogate decision making for clinical care.
- Understand how the process and outcomes of surrogate decision making can be improved.

Despite the attention it has received in recent years, surrogate decision making continues to be challenging for all involved. Currently accepted models for surrogate decision making often fail to ensure that patient's preferences and interests are protected, family caregivers are respected, and appropriate care is provided. As the American population ages, an increasing number of patients will require surrogate decision making, especially if the patient does not have a detailed advance directive (and sometimes even then). But more often, the patient's specific preferences are unknown. Would approaches beyond substituted judgment—such as the Substituted Interests/Best Judgment Model—serve patients and surrogates better? Using a role play format and case scenario, this session will reconsider surrogate decision making; the values, goals, and standards that inform it; and alternative approaches that may more ethically and effectively achieve its purposes in clinical care.

Together We Can Go Farther: Using Palliative Care Collaboratives to Drive Quality Improvement (TH304)

Ashley Bragg, BS, University of California San Francisco, San Francisco, CA. Kara Bischoff, MD, University of California San Francisco, San Francisco, CA. Steven Pantilat, MD MHM FAAHPM, University of California San Francisco, San Francisco, CA. Arif Kamal, MD, Duke Cancer Institute, Durham, NC. Katherine Ast, MSW LCSW, American Academy of Hospice and Palliative Medicine, Chicago, IL.

Objectives

- Consider the advantages of standardized quality data collection and reporting in palliative care.
- Understand how two multi-site networks have enabled coordinated data collection, benchmarking, and collaborative quality improvement.
- Describe how standardized data collection can support the Measuring What Matters initiative and The Joint Commission quality reporting.

In the past, the simple presence of a busy palliative care service has been sufficient to justify funding. However, increasingly, individual palliative care services are being challenged to demonstrate their quality of care. This change has ignited a broad conversation about how the quality of palliative care can best be measured, and multiple committees—including AAHPM's Measuring What Matters team and The Joint Commission—are promoting unified quality metrics for the field.

Despite the growing emphasis on quality improvement (QI) and benchmarking in palliative care, many busy palliative care services are without sufficient expertise, support, or time to optimize QI efforts independently. To assist individual teams in their QI efforts and provide benchmarking of outcomes, two networks of palliative care services have been established to guide teams through the collection of prospective, standardized data on key care processes (eg, advance care planning activities) and patient-level outcomes (eg, daily symptom scores). Data are stored in centralized databases that analyze data and generate reports with comparison to others. These growing networks allow palliative care services to benchmark with others and identify best practices, which both simplifies QI and promotes greater gains in QI than any single service could make alone.

In this session, we will describe two approaches to prospective data collection—the Palliative Care Quality Network (PCQN) and Quality Data Collection Tool (QDACT)—and demonstrate how these systems can support palliative care services in their QI efforts, enable QI benchmarking as promoted by the Measuring What Matters initiative, and facilitate advanced certification in palliative care through The Joint Commission. Attendees will learn QI methods and practice the initial steps in designing a QI project that they can implement in their local environment.

Doc, Can You Stop the Haldol? We Don't Use It in Our Skilled Nursing Facility! Navigating Regulatory Pressures in Nursing Homes When Treating Agitated Hospice Patients (TH305)

Martina Meier, MD, Providence TrinityCare Hospice, Cerritos, CA. Rebecca Yamarik, MD FAAHPM, Providence TrinityCare Hospice, Cerritos, CA. Eric Prommer, MD HMDC FAAHPM, University of California Los Angeles School of Medicine, Los Angeles, CA. Shirley Bruhl, RN, TrinityCare Hospice, Cerritos, CA.

Objectives

- Name 3 key points on how to successfully collaborate with long-term care staff in the treatment of behavioral problems in hospice patients.
- Know the current literature about nonpharmacologic and pharmacologic treatment of agitation of hospice patients.
- Know the side effects and blackbox warnings associated with antipsychotic medications and sedatives commonly used for behavioral problems.

This presentation will highlight the challenges unique to hospice patients admitted to skilled nursing facilities who are exhibiting mental status changes. Hospice patients commonly exhibit behavioral abnormalities, either as a part of their underlying disease process, particularly in dementia, or due to terminal delirium. There are clear and widely accepted guidelines in the hospice literature for the treatment of agitation. On the other hand, skilled nursing facilities (SNFs) are reporting increasing regulatory pressure to limit the use of psychoactive medications, specifically antipsychotics and benzodiazepines. These restrictions have increased in recent years due to the concern over their overuse as "chemical restraints" for nursing home residents with behavioral problems. In addition, concern over increased mortality with antipsychotic medication use and other side effects have led to crackdowns on use by the regulatory bodies that oversee nursing homes. This can lead to conflicts between the nursing homes and hospice agencies. Frequently, nursing home staff demand to have psychoactive medications removed from the hospice patient's medication profile. They will ask the hospice staff to pursue invasive tests to work up delirium or ask the hospice to use alternative medications with a less beneficial safety profile.

This talk will address the conflicting priorities between hospice and SNF staff in regard to the pharmacologic treatment of delirium/agitation. By way of case presentations and didactics, this session will provide the attendee with current data on pharmacologic treatment of delirium/agitation, with discussion of black box warnings on some antipsychotic medications, an update on Medicare/other governing bodies' regulations of antipsychotic medication use with an emphasis on SNF strategies to successfully collaborate with SNF to manage agitated SNF patients on hospice.

Feeding Intolerance and Edema in Children and Adults with Severe Neurological Impairment: Features in the Last Year of Life (TH306)

Julie Hauer, MD, Boston Children's Hospital, Boston, MA. Dianna Yip, DO, Rainbow Babies & Children's Hospital, Cleveland, OH.

Objectives

- Discuss risk for over-estimating fluid and nutrition requirements in children and adults with childhood onset severe impairment of the central nervous system (CNS).
- Define etiologies of feeding intolerance and edema secondary to severe impairment of the CNS.
- Utilize a step-wise approach to feeding intolerance and edema that may occur in the last months of life.

Medical nutrition and fluids provided by feeding tube benefit many individuals with impairment of the central nervous system (CNS). Such individuals are also at significant risk when excessive feeding is not recognized. This can occur when what has been identified as "required" is continued without understanding reasons for harm from this amount. Little has been written about the reasons why irreversible changes in the ability to tolerate tube feedings can occur in such individuals. Lack of information increases symptom burden, especially in the last months of life.

This session will discuss reasons why children and adults with childhood onset severe impairment of the CNS are at risk for feeding intolerance and/or edema without clear cause. These include decrease in metabolic expenditure as health declines and progressive alterations in the areas of the CNS that regulate intestinal motility, visceral sensation, the vomiting center, and vascular tone. Case examples will highlight these problems, including individuals with such features first noted 2 weeks to 6 months prior to death.

Information will include estimating fluid requirements in patients with diminished metabolic needs, which is significant given that metabolic expenditure accounts for more than half of fluid estimation. Guidelines in recognizing and anticipating clinical changes that benefit from an empirical decrease or discontinuation of medical nutrition and fluids will be provided so as to minimize harm from overfeeding and excessive fluids. Home care plans and how information can be framed for parents will be discussed, including the inability to predict when such changes are transient versus irreversible, with some surviving with intermittent use of such trials, as well as avoiding symptoms at end of life. Understanding this information is critical as we partner with parents to develop care plans that best meet identified goals. This information can then minimize harmful tests, interventions, and suffering in this vulnerable population.

An Interdisciplinary Outpatient Palliative Care Model for Cancer Patients: Successful and Reproducible (TH307)

Tara Albrecht, NP PhD RN, University of Pittsburgh, Pittsburgh, PA. Eduardo Bruera, MD FAAHPM, MD Anderson Cancer Center, Houston, TX. Egidio Del Fabbro, MD, Virginia Commonwealth University, Richmond, VA.

Objectives

- Identify key attributes that an integrated interdisciplinary care team model brings to the palliative care clinic, the delivery of care and patient outcomes.
- Identify key components of a successful outpatient palliative care model that integrates interdisciplinary palliative care with oncology in a cancer center.
- Identify benefits and opportunities to influence institutional leaders, initiate, maintain, and advance outpatient palliative care programs, while recognizing some of the challenges and

pitfalls of initiating, sustaining, and expanding an outpatient program within academic institutions and in the community cancer center.

Only 59% of NCI centers have outpatient palliative care clinics. Clinics are crucial for the integration of palliative care into oncology and improve outcomes, including caregiver satisfaction, symptoms, and survival. ASCO's recommendation for comprehensive cancer care by 2020 includes "dissemination of effective models of cancer care that incorporate palliative care." They recognize MD Anderson Cancer Center (MDACC) as an innovative model for integration of palliative care into oncology. We will describe the MDACC model and exponential growth of the outpatient program, including improved clinical outcomes supported by published research. We will discuss the necessary ingredients for a successful program, including the importance of changing an institutional culture; how an interdisciplinary team brings an additive role to palliative care; the use of routine screenings for symptom distress and chemical coping; the use of family conferences and split visits (parallel meetings with patient and accompanying family for counseling); and unique methods of follow-up such as phone care programs and same-day consults. And, in spite of some institution-specific characteristics unique to MDACC, the clinical model, including an interdisciplinary palliative care team and a simultaneous cancer care approach, is reproducible. To demonstrate this, we will describe the Virginia Commonwealth University palliative care program that implemented core features of the MDACC model into their supportive care clinic, producing an eight-fold increase in patient contacts and clinic availability. We will conclude with discussing the opportunities and benefits for adapting this model into cancer centers to advance delivery of care, as well as the challenges and pitfalls encountered. Ultimately, the information delivered will provide concrete experiences for both academic institutions as well as community cancer centers to apply effective strategies to implement a dynamic interdisciplinary model of palliative care.

Improving Palliative Care of the Older Lesbian, Gay, Bisexual, Transgender Population Across the Care Continuum (TH308)

AAHPM Geriatrics, LTC, and LGBT SIG Endorsed. Paul Tatum, MD MS MSPH CMD FAAHPM, University of Missouri, Columbia, MO. Bruce Scott, MD HMDC FACP, Wright State University, Boonshoft School of Medicine, Germantown, OH. Laura Fosler, MS RN FNP-BC ACHPN, Rush University Medical Center, Chicago, IL.

Objectives

- Identify the unique psychological, social, cultural, and community aspects of caring for aging LGBT patients in clinics, hospitals, hospices, and nursing homes.
- Integrate support of the care needs into a palliative plan of care, including meeting the unique advance care planning needs of the LGBT older patient.
- Lead organizational change to create a culture of respect for LGBT patients including training of all providers.

List at least five best practices that helped other organizations institute cultural change and that will incorporate the American Geriatrics Society Care of LGBT Older Adults Position Statement and the Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE) resources to lead organizational change.

More than half of gay, lesbian, and bisexual patients and more than 70% of transgender patients have experienced discrimination in healthcare settings. Older adult LGBT patients may delay or avoid seeking health care due to prior experiences. Physical dependency can require increasing need for informal caregivers; these are frequently same-sex partners who lack the legal and financial protections afforded to heterosexual couples. Many patients feel the need to hide their identities, especially when admitted to a long-term care facility—some of them essentially going back into the closet.

Medical providers often lack the understanding and resources needed to provide good care for these vulnerable populations. Meeting the unique care needs of the LGBT population requires organizational change. The American Geriatrics Society's position statement on the care of lesbian, gay, bisexual, and transgender older adults calls for organizations, institutions, and healthcare providers to work to create an environment free from discrimination.

This session will present a progressive case illustrating changing care settings from clinic to hospital to nursing home and eventually hospice, with particular attention to the unique challenges and barriers to good multidisciplinary care. We will recommend strategies and highlight available resources. An open forum will follow to describe best organizational practices to meet older LGBT patients' needs.

Improving Palliative Care for Patients with Heart Failure and Family Caregivers: Results from a National Working Group Examining Clinical and Research Priorities for Heart Failure and Palliative Care (TH309)

Laura Gelfman, MD MPH, Mount Sinai School of Medicine, New York, NY. Marie Anne Bakitas, DNSc CRNP AOCN ACHPN FAAN, University of Alabama at Birmingham, Birmingham, AL. Timothy Fendler, MD MS, St. Luke's Mid America Heart Institute, Kansas City, MO. Nathan Goldstein, MD FAAHPM, Mount Sinai Hospital, New York, NY.

Objectives

- Review results from the June 2015 Clinical & Research Priorities for Heart Failure and Palliative Care National Symposium of cardiology and palliative experts (funded by the John A. Hartford Foundation, American Federation for Aging Research, National Palliative Care Research Center, University of Alabama-Birmingham, and Icahn School of Medicine at Mount Sinai), which focused on the barriers to and opportunities for improving palliative care integration among patients with advanced cardiac disease.
- Discuss opportunities and strategies for collaboration of palliative care and heart failure within the domains of research, clinical care, and policy change.
- Identify two specific implementation projects to improve care for patients with advanced heart failure within each area of research, clinical programs, and policy.

Hospital readmission rates, mortality rates, and Medicare costs for patients with heart failure (HF) are high. Patients with HF are burdened by multiple symptoms that increase as the disease progresses. Because HF carries a substantial burden, it is critical to understand how palliative care can contribute to improving the quality of care for this population. Yet, the evidence base demonstrating the benefits of palliative care on outcomes and quality of care in patients with HF is still lacking. Change can only happen with an interdisciplinary, explicit strategic change approach. We conducted a series of telephonic nominal groups followed by a 2-day in-person symposium, which pulled together a group of interdisciplinary, nationally-recognized clinicians, investigators, and policy experts representing HF, geriatrics, and palliative care to address the following 3 questions: 1) What are the greatest challenges and barriers faced in HF regarding the integration of palliative care? 2) What are the state of the science and gaps in knowledge regarding patients with advanced HF and their family caregivers? 3) What are the most successful care models or strategies that are currently making a difference in HF care?

The purpose of this concurrent session is to 1) describe the methods we used to develop consensus of strategies for each of these domains and 2) detail symposium results and achievements. The overall goal is to build support for a national agenda to advance the field of palliative care for patients with HF and their family caregivers. Specifically, we will review proposed research, clinical demonstration projects, national guidelines, and policy to develop priorities for implementation and endorsement. We will also describe and solicit additional input to create sustainable working groups that can formulate research, policy, and practice priorities and potential opportunities for collaboration and funding in order to develop a sustainable model for future collaboration.

Paper Sessions

Impact of Consultation Triggers on Streamlining Palliative Care Interventions (TH310A)

Anjali Grandhige, MD, Emory University, Atlanta, GA. Zachary Binney, MPH, Emory University - Rollins School of Public Health, Atlanta, GA. Danielle Moulia, MPH, Emory Palliative Care Center, Atlanta, GA. Tammie Quest, MD, Emory University School of Medicine, Atlanta, GA.

Objectives

- Explain the growing role of informatics for proactive patient finding.
- Describe the effect of the "trigger" list on inpatient palliative care volume, time to consult and hospital length of stay (LOS).

Original Research Background. Early palliative care (PC) intervention has been shown to reduce hospital length of LOS and readmissions. Use of informatics to proactively identify patients appropriate for PC consultation is one method to optimize PC involvement.

Research Objective. The purpose of this study was to examine the impact of proactively identifying patients appropriate for palliative care consult upon hospital admission.

Methods. Using informatics, a daily "trigger" list of patients admitted to the hospital medicine service in the last 24 hours who potentially meet PC criteria was sent to the PC team beginning in August 2014. Data was collected on all patients who met the "trigger" criteria and were admitted between January 2014 and June 2015. Consult volumes and time to consult in the seven months before (January 2014 – July 2014) and the 10 months after (August 2014 – June 2015) implementation of the "trigger" list were compared using t-tests. Length of stay was stratified by time to palliative care consult (<24, 24-72, and >72 hours) and compared using ANOVA.

Results. Mean number (standard deviation [SD]) of patients who met "trigger" criteria and received a PC consult significantly ($p<0.05$) increased from 9.8 (1.4) consults per month before the list was implemented to 31.9 (4.6) consults per month after the list was implemented. Mean time to consult decreased from 7.4 (3.2) days to 6.3 (1.8) days.

Patients seen by the PC team within <24, 24-72, and >72 hours of admission had significantly ($p<0.05$) longer LOS the later they were seen by the PC team, 6.7 (0.3), 8.6 (0.5), and 18.1 (8.4) days, respectively.

Conclusions. Use of informatics significantly increased the volume of PC consults and reduced the time to consult. Patients with later consults (>72 hours) had a 50% greater LOS compared to patients seen earlier.

Implications for Research, Policy, and Practice. With proactive palliative care involvement, hospitalizations can be streamlined by better aligning treatments with the patient's goals and preferences.

Setting the Agenda: What do Academic Hospitalists Want to Learn from Their Palliative Care Colleagues? (TH310B)

Leah Rosenberg, MD, Massachusetts General Hospital, Boston, MA. Eva Chittenden, MD, Massachusetts General Hospital, Boston, MA. Jeffrey Greenwald, MD, Massachusetts General Hospital, Boston, MA. Juliet Jacobsen, MD, Massachusetts General Hospital, Boston, MA.

Objectives

- Describe a survey designed to explore perceived needs for palliative care education among academic hospitalist providers.
- Determine palliative care topic areas of particular interest to hospitalists.
- Compare hospitalist perceived needs for education against common reasons for consultation in formal requests.

Introduction. Hospitalists are on the front lines of providing care for the increasing numbers of patients with chronic serious illnesses. Given the high clinical volume and intensity of hospitalist practice, it is important to optimize educational interventions to create the most "high-yield" experiences. A survey investigation was intended to explore educational perceived needs in primary palliative care among academic hospitalists.

Methods. A voluntary survey was distributed via email to 60 academic hospitalist physicians who had greater than one year of experience. The providers were surveyed regarding their educational preferences for topics within palliative care. The offered topics were adapted from a previous investigation by Weissman, et al (1998) and Chittenden and Schaefer (2014). Topics were randomly listed but classified into three categories: symptom management, communication, and advance care planning. Qualitative written feedback was also collected.

Results. In this hospitalist cohort, there was a 25% response rate with 15 respondents. The most popular topic, with 46% of respondents indicating interest, was "use of opioid analgesics." It was followed by "management of terminal delirium." Written responses focused on wanting more information about "pain management 2.0" and "non-opioid analgesics." No respondents indicated interest in learning about conducting family meetings or breaking bad news. One respondent indicated interested in an ethical question related to palliative care.

Conclusions. Academic hospitalists express a higher level of interest in learning about practical, symptom management-related content than topics focused on communication or advance care planning. Further research is needed to explore how these perceived needs cohere with clinical questions stated in formal consultation requests.

Implications for Research, Policy, and Practice. Enhancement of hospitalist educational efforts based upon assessment of perceived needs will improve clinician engagement and facilitate the provision of primary palliative care.

Integrating Palliative Care into the ICU: Experiences, Attitudes and Barriers of ICU Clinicians (TH310C)

Felicia Hui, MD, Yale-New Haven Hospital, New Haven, CT. Jennifer Kapo, MD, Yale University, New Haven, CT. Kathleen Akgün, MD MS, VA Connecticut, Yale School of Medicine, New Haven, CT.

Objectives

- Describe the potential palliative care (PC) needs for patients in the ICU.
- Recognize the opportunities for and challenges of developing a system-wide ICU palliative care trigger tool.

Original Research Background. Multiple methods have been used to integrate palliative care into the care of patients with serious life-limiting conditions admitted to ICU. Trigger tools for palliative care consultation (PCC) may benefit in early identification of such patients.

Research Objectives. To assess the experiences, attitudes, barriers of ICU clinicians, and suggested criteria for developing an ICU PCC trigger tool.

Methods. A taskforce was assembled to create a needs assessment survey for a quality improvement project within a 2,130-bed health system that includes 12 adult ICUs. Paper and/or electronic surveys were distributed to full-time ICU clinicians (attending physicians, nurses, advanced practice providers; N=526) in eight ICUs across four demographically and culturally diverse hospitals. Survey domains were adopted from the ICU Palliative Care Quality Assessment Tool. A

5-point Likert scale was used. Responses ≥4 (agree, strongly agree) were considered positive.

Results. Survey response rate was 31% (MD/DO 31%, RN 60%, APP 9%). Experiences in providing palliative care was variable. Routine symptom management was reported by 89%, while goals of care conversations (55%) and emotional support to other clinicians were less routine (53%). The majority of respondents (95%) believed palliative care was an important part of their patients' care; 79% felt they could personally provide this care; and 84% felt they could ask for PCC. The most commonly perceived barriers to PCC were patient/family reluctance or uncertainty, disagreement within or between teams, and inadequate comfort level. Active stage IV malignancy, patient/family support, or request and decision to forgo life-sustaining treatment were the most commonly reported PCC triggers.

Conclusion. While a majority of ICU clinicians report PCC is important, experiences, attitudes, and barriers in providing such care vary widely.

Implications for Research, Policy, and Practice. This survey involving key stakeholders identified barriers to target for interventions, including development of a PCC trigger tool, tailored to needs of ICUs in this health system.

Palliative Care Integration for Patients Receiving Left-Ventricular Assist Device (LVAD) as Destination Therapy (SR) (TH310D)

Manik Aggarwal, MD MPH, Medstar Georgetown University Hospitals, Washington, DC. Kathryn Walker, PharmD BCPS CPE, Medstar Health, University of MD School of Pharm, Baltimore, MD. Renee Holder, PharmD BCPS CPE, MedStar Washington Hospital Center, Washington, DC. Joan Panke, NP MA ACHPN, MedStar Washington Hospital Center, Washington, DC. J Hunter Groninger, MD AAHPM, Medstar Washington Hospital Center, Washington, DC.

Objectives

- Review morbidity, mortality, and supportive care needs associated with LVAD therapy indicating palliative care consultation.
- Describe model for single-institution integrated palliative care (PC) and advanced heart therapy multidisciplinary approach to LVAD care.
- Explicate descriptive analysis of PC consults for LVAD-DT patients in pilot program.

Original Research Background. Left-Ventricular Assist Device as Destination Therapy (LVAD-DT) can be life-prolonging therapy available to select patient with advanced heart failure (HF). It is also associated with significant morbidity, mortality, and supportive care needs. The Joint Commission now mandates palliative care (PC) participation in accredited centers providing LVAD-DT. MedStar Washington Hospital Center began integrating palliative care services for LVAD-DT patients in January 2015. Considering the paucity of data in this area, this study was designed to describe the first six months of consultations.

Research Objectives. To describe palliative care consultative interventions, length of stay, and disposition for patients receiving LVAD-DT.

Methods. All LVAD-DT patients who received PC consultation between January and July, 15, 2015 were reviewed retrospectively using the electronic health record. Data collected included reason for PC consultation, pain and symptom assessment (day 0, day 2), PC interventions, and disposition. Descriptive statistics were used to analyze data.

Results. Thirty-one LVAD-DT patients received PC consultations and were included in this study. The primary reason for PC consultation was pain (25/31), and the median time to consultation was nine days. (Median total length of stay was 26 days.) Eighty-one percent (25/31) of patients had moderate-severe symptoms at time of consult, which decreased to 20% (5/25) on day two. Additional PC interventions included psychological (19%), spiritual (32%), and/or medication (87%) counseling as well as disease state education (26%), proxy determination (13%), and change in code status (3%). Most patients went home (58%) or to rehab (39%) on discharge; 3% died in the hospital.

Conclusion. LVAD-DT candidates experienced notable symptom burden and required multiple PC interventions, highlighting the value of PC integration.

Implications for Research, Policy, and Practice. Future research should further elucidate PC consultation's role and benefit in LVAD-DT patients.

Evaluating the Reliability and Validity of a New Pediatric Palliative Care Needs Assessment Tool (TH311A)

Kelly Michelson, MD MPH, Ann & Robert H. Lurie Children's Hospital, Chicago, IL. Kimberly Downing, RN BSN JD, Greater Illinois Pediatric Palliative Care Coalition, Chicago, IL. Margaret Rudnik, MBA, Greater Illinois Pediatric Palliative Care Coalition, Forest Park, IL. Jason Cloen, MSW, Lifetime Care, Rochester, NY. James Donnelly, PhD, Canisius College, Williamsville, NY.

Objectives

- Describe categories of need faced by parents and patients in pediatric palliative care.
- Describe unmet needs faced by parents and patients in pediatric palliative care.

- Describe potential uses for a needs assessment tool in the delivery of pediatric palliative care.

Original Research Background. Despite the challenges faced by children with life-limiting conditions and their families, there is no validated needs assessment tool for use in pediatric palliative care. To address this gap, we developed the Parent/Child Needs Tool (PC Needs), which assesses physical, psychological, social, and healthcare team needs.

Research Objectives. Test the reliability and validity of PC needs, and identify unmet needs in pediatric palliative care.

Methods. Four community-based organizations in Chicago, IL and Rochester, NY distributed surveys to parents of pediatric palliative care patients. The surveys included three sections: parent demographics; the PC Needs (22 items rating degree of need from 1—10 and scored by adding responses); and the World Health Organization Quality of Life (WHOQOL-BREF) tool (26 items measuring four domains: physical, psychological, social and environmental). We assessed reliability using Cronbach's alpha and validity by calculating correlations between the PC Needs score and WHOQOL-BREF domains.

Results. Surveys were collected from 82 parents, ages 26 to 64 (Mean= 42). Parents were: 73% female and 89% white, 5% African American and 6% Other. The mean PC Needs score was 81.3 (range= 25—139, SD=26.4). The lowest rated (most fulfilled) needs were palliative care team respect for child and parent and parent-child relationship. The highest rated needs were impact of the child's illness on the family; managing physical problems; and financial needs. Reliability (Cronbach's alpha) was 0.83. Correlations between the PC Needs score and the WHOQOL-BREF domains were in the predicted direction (i.e., greater need=lower quality of life): Physical r=-0.44; Psychological r=-0.55; Social r=-0.59; Environmental r=-0.45 (all p<.001).

Conclusion. The PC Needs Tool is a reliable and valid needs assessment measure for pediatric palliative care. Unmet needs reported by parents included impact on the family, physical problems, and finances.

Implications for Research, Policy, and Practice. Future work will assess the use of the PC Needs in clinical care.

Improving Training in Palliative Care for Pediatric Fellows — A Simulation-Based Multi-Institution Trial (TH311B)

Katharine Brock, MD, Dana-Farber Cancer Institute, Boston Children's, Boston, MA. Harvey Cohen, MD PhD, Stanford University, Stanford, CA. Barbara Sourkes, PhD, Lucile Packard Children's Hospital Stanford, Palo Alto, CA. Julie Good, MD, Packard Children's Hospital Stanford, Palo Alto, CA. Louis Halamek, MD, Stanford University, Stanford, CA.

Objectives

- Describe different methods of palliative care education, including simulation-based education and didactic education.
- Delineate differences between pediatric fellow self-assessment data and external reviewer data of fellow performance.
- Describe how a simulation-based curriculum can lead to changes in palliative care consultation at an institution.

Original Research Background. Although palliative care (PC) skills can be learned "on the job," pediatric trainees have few opportunities and often receive no formal PC education.

Research Objectives. (1) To assess whether simulation-based or didactic education is a more effective method for teaching PC communication. (2) To assess competence over time. (3) To determine if PC consultation rates would increase after simulation-based education.

Methods. (1) 35 pediatric fellows from cardiology, critical care, oncology and neonatology at two institutions enrolled 17 in the intervention group (IG) and 18 in the control group (CG). IG fellows participated in a 2-day intervention over three months consisting of three simulation scenarios with debriefing and a videotaped PC lecture. CG fellows received written PC education designed to be similar in content and time. Assessments were measured at baseline, post-intervention and at three months; mean differences for each outcome measure were assessed. (2) External reviewers rated IG encounters on nine communication competencies. Changes over time were assessed. (3) PC consultations from the IG institution's four departments were compared in the six months pre- and post-intervention, normalized to inpatient admissions and hospital days.

Results. Over three months, IG fellows significantly improved in self-efficacy (p=0.003) and perceived adequacy of medical education (p<0.001), but not knowledge (p=0.20) when compared to CG fellows. External reviewers noted improvement in three competencies (relationship building (p=0.04), opening discussion (p=0.01), gathering information (p=0.01)). There was a 65% increase in PC consultation rate, but no difference when normalized to inpatient admissions or hospital days (OR 1.5, 95% CI 0.9-2.5 for both). IG fellows more strongly agreed that they would use (p=0.04) and recommended (p=0.004).the education.

Conclusion. Our simulation-based curriculum is an effective method for teaching PC communication to pediatric fellows compared with a didactic education model.

Implications for Research, Policy or Practice. Such curriculum can be adapted for other pediatric trainees, and should be incorporated into fellowship training.

Quality of Life in Children with Advanced Cancer: A Report from the Pediquest Study (TH311C)

Abby Rosenberg, MD MS, Seattle Children's Hospital, Seattle, WA. Liliana Orellana, PhD MS, Deakin University, Burwood, VIC, Australia. Veronica Dussel, MD, Boston Children's Hospital, Boston, MA. Joanne Wolfe, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Understand the relationship between symptom distress and patient-reported quality of life among children with advanced cancer.
- Suggest hypotheses for future research and directions for clinical care.

Original Research Background. Modifiable factors of Health-Related Quality of Life (HRQOL) have not previously been studied among children with advanced cancer.

Research Objectives. To inform interventions and clinical care, we aimed to describe patient-reported HRQOL and its relationship to symptom-distress.

Methods. Prospective, longitudinal data from the Pediatric Quality of Life and Symptoms Technology (PediQUEST) study included primarily patient-reported HRQOL, using the Pediatric Quality of Life Inventory (PedsQL), and symptom-distress, using the Memorial Symptoms Assessment Scale (MSAS). We assessed associations between PedsQL scores and symptom-distress using linear mixed-effects models adjusting for sex, age, cancer-type, treatment-intensity, and time since disease progression.

Results. Of 104 enrolled children, 49% were female, 89% white, with a median age 12.6 years; 920 surveys were completed in the nine-month follow-up. Median total PedsQL score was 74 (IQR 63-87) and was "poor/fair" (e.g.<70) 38% of the time. "Poor/fair" categories were highest in physical (53%) and school (48%) compared to emotional (24%) and social (16%) sub-scores. Participants ≥13 years-old had 4.9-fold higher odds of reporting "poor/fair" physical HRQOL than younger children (95% CI 1.4-16.3). In adjusted analyses, 13 of 24 symptoms were independently associated with reductions in overall or domain-specific HRQOL scores. Symptoms were frequently reported concurrently, corresponding to larger HRQOL score reductions. Neither cancer-type, time since last progression, treatment-intensity, sex, nor age was associated with HRQOL scores in multivariable models. Among the 25 children completing surveys during the last 12 weeks of life, 11 distressing symptoms were associated with reductions in HRQOL.

Conclusion. We found strong associations between symptom-distress and HRQOL.

Implications for Research, Policy, and Practice. Future research should determine whether alleviating distressing symptoms improves HRQOL in children with advanced cancer.

The Role of Pediatric Palliative Care (PPC) in Children Who Undergo Stem Cell Transplantation (SCT) and Do Not Survive (TH311D)

Christina Ullrich, MD MPH FAAHPM, Dana Farber Cancer Institute, Boston, MA. Wendy London, PhD, Boston Children's Hospital/Dana-Farber Cancer Institute, Boston, MA. Dongjing Guo, MPH, Boston Children's Hospital, Boston, MA. Leslie Lehmann, MD, Dana-Farber Cancer Institute, Boston, MA. Joanne Wolfe, fMD, MPH, FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Madhumithra Sridharan Boston Children's Hospital, Boston, MA. Richard Koch Dana Farber Cancer Institute, Boston, MA.

Objectives

- Describe children who undergo stem cell transplantation (SCT) and do not survive, comparing those who receive pediatric palliative care (PPC) with those who do not.
- Delineate characteristics of PPC consultation for children who undergo SCT and do not survive.
- Describe associations between PPC consultation and end-of-life (EOL) care patterns for children who undergo SCT and do not survive.

Original Research Background. An intensive therapy delivered with curative intent, SCT offers the possibility of a cure for life-threatening conditions, though with high risk of serious complications and death. The role of PPC for children who undergo SCT is unknown.

Research Objectives. To evaluate whether PPC consultation is associated with differences in EOL care patterns for children who undergo SCT and do not survive.

Methods. Medical records of children who underwent SCT at Boston Children's Hospital/Dana-Farber Cancer Institute for any indication from September 2004-December 2012 and did not survive were reviewed. Child demographic and clinical characteristics and PPC consultation and EOL care patterns were abstracted.

Children who received PPC (PPC group) were compared with those who did not (non-PPC group).

Results. Children who received PPC consultation (n=37) did so, on average, 3.8 (SD=7.6) months before death. They did not differ from the non-PPC group (n=110) with respect to demographic or clinical characteristics, except they were more likely to have undergone unrelated allogeneic SCT (PPC=73%, non-PPC=41%, p=0.008) and have died from treatment-related toxicity (PPC=76%, non-PPC=54%, p=0.03). They were as likely to die in the ICU (PPC=49%, non-PPC=62%, p=0.06) and have hospice (PPC=22%, non-PPC=18%, p=0.6). However, discussions that the child was unlikely to survive occurred more commonly in the PPC group (PPC=97%, non-PPC=83%, p=0.04) as did resuscitation status discussions (PPC=88%, non-PPC=58%, p=0.002). The PPC group had earlier resuscitation status discussions (PPC=24.3 [SD=40.3], non-PPC=16.0 [SD=43.8] days prior death, p<0.001), was more likely to have resuscitation status documented (PPC=97%, non-PPC=68%, p=0.002), and received CPR less commonly (PPC=3%, non-PPC=20%, p=0.03).

Conclusion. Children who undergo SCT and do not survive experience intensive care at EOL, irrespective of PPC. However, PPC is associated with greater opportunity for EOL communication and advance preparation.

Implications for Research, Policy, or Practice. In the intense, cure-oriented SCT setting, PPC may facilitate advance care planning in this high-risk population.

1:30–2:30 pm

Concurrent Sessions

The Practice of Palliative Medicine in Developing Countries—Part One (TH320)

Arunangshu Ghoshal, MD, Tata Memorial Centre, Mumbai, India. Wendy Cristhyna Gomez Garcia, MD, Dr. Robert Reid Cabral Children's Hospital, Santo Domingo, Dominican Republic. Abhishek Kumar, MBBS DPH CCPPM, Pallium India and Cankids…Kidscan, Thiruvananthpuram, India.

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.

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

J. Hunter Groninger, MD FAAHPM, Medstar Washington Hospital Center, Washington, DC. George Ruiz, MD, MedStar Heart Institute, Bethesda, MD. Joan Panke, MA NP ACHPN, Medstar Washington Hospital Center, Washington, DC. Anne Kelemen, MSW, MedStar Washington Hospital Center, Washington, DC.

Objectives

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

With the evolution and growing availability of mechanical circulatory support (MCS) technology for patients with advanced heart failure come new frontiers for palliative care (PC) teams. Although data demonstrates that MCS devices, including left ventricular assist devices (LVADs), can improve survival and quality-of-life for patients with advanced heart failure, patients remain at risk for catastrophic events, like stroke or hemorrhage, persistent functional decline, or progression of other life-threatening medical conditions. Among patients receiving LVAD devices as destination therapy (DT), 30% will die within 2 years of implantation. Thus, PC is increasingly invited by advanced heart failure teams to provide patient and family support, sometimes even prior to implantation. As of October 2014, the Joint Commission on Accreditation of Healthcare Organizations requires PC representation on the core interdisciplinary team for LVAD-DT advanced certification.

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

Interdisciplinary Research in Palliative Care Units: Together We Thrive (TH322)

David Hui, MD MS MSC, MD Anderson Cancer Center, Houston, TX. Thuc Nguyen, RN, MD Anderson Cancer Center, Houston, TX. Chanelle Clerc, BSN RN, MD Anderson Cancer Center, Houston, TX. Maxine De La Cruz, MD, MD Anderson Cancer Center, Houston, TX.

Objectives

- Review the structure, processes, and outcomes of acute palliative care units.
- Highlight the role of interdisciplinary teamwork in two prospective studies in palliative care units.
- Discuss the many challenges and innovative solutions to conduct research in palliative care units.

Acute palliative care units (APCUs), located in acute care hospitals, provide intensive symptom management and psychosocial care for acutely ill patients and families in distress. They are staffed by an interdisciplinary team, including nurses, chaplains, pharmacists, physicians, social workers, and other allied health professionals. In addition to excellence in patient care, APCUs are ideally suited for interdisciplinary research aimed at improving the quality of life and quality of care at the end-of-life. In this presentation, we will discuss how interdisciplinary APCU teams overcome many challenges to conduct research related to prognostication and delirium, using the example of two prospective studies. The Investigating the Process of Dying study is a prospective longitudinal observational study that examined the frequency, onset, and diagnostic performance for impending death of 62 bedside physical signs. It involved clinical nurses and attending physicians providing longitudinal monitoring and documenting their bedside observations from admission until discharge or death. This teamwork allowed us to identify 15 physical signs associated with impending death. The second study is a randomized controlled trial on agitated delirium. Because the use of lorazepam at the end-of-life is controversial, this study compared haloperidol combined with either lorazepam or placebo for an agitation episode in the second line setting. The primary endpoint was level of sedation. Secondary endpoints include neuroleptic doses, delirium-related distress, communication capacity, and survival. Because agitation may occur at any moment, the medical team, pharmacy team, and clinical nurses played a critical role in many aspects of this study. In addition to interdisciplinary research, we will also address many methodologic challenges related to conducting research in the palliative care setting, such as obtaining consent, maximizing recruitment, and minimizing attrition. The last 15 minutes of this session will involve active discussion among participants and panelists, sharing their experience and/or comments related to research in palliative care.

Euthanasia, Assisted Dying, and Assisted Suicide in Palliative Care Settings: Reports from the Netherlands, Switzerland, and Washington State (TH323)

Sheri Gerson, ACHP-SW LICSW, Lancaster University, Lancaster, England. Debbie Lewis, MSc, Birmingham City University, Leicestershire, England. Claudia Gamondi, MD MSc, IOSI, Bellinzona, Ticino.

Objectives

- Identify use of different terminology, legislation, and the impact of legislation surrounding assisted dying and assisted suicide in the United States and Europe.
- Evaluate how culture impacts the approach to assisted dying and assisted suicide in diverse palliative care settings.
- Present strategies for practitioners to deal with assisted dying requests in jurisdictions where assisted dying and assisted suicide is permitted.

Changes in legislation on assisted dying, euthanasia, and physician-assisted suicide are increasingly being debated around the world. Terminology and differences in legislation are considerable and may contribute to how palliative care professionals deal with requests, communicate with patients about their wishes and interactions with patients and families during the assisted-suicide process through to bereavement. The use of varied terminology, including assisted dying, physician-assisted suicide, and aid in dying may depend on cultural, ethical, or political perspective and local legislation. The impact of euthanasia in the Netherlands, physician-assisted suicide in Switzerland, and the Death With Dignity Act in the United States will be highlighted to discuss how legislative differences add to the debate's complexity and may alter how professionals deal with requests and in which support is needed. The ethical and practical dilemmas that affect palliative care professionals will be presented, deriving from the results of field research conducted in the three different countries by the presenters of the workshop.

This workshop has a multidisciplinary dimension developed from the experiences of a nurse, social worker, and physician who have all worked as palliative care professionals and are each completing or have completed qualitative research on the impact of assisted dying legislation on palliative care in the United States and Europe. Their presentation will address different ways professionals deal with the requests and how they cope both personally and professionally. They will integrate their research findings to present strategies for hospice and palliative care professionals to utilize as they cope with current or changing legislation and the emotional and professional challenges in various locations.

Palliative Care and Heart Failure: An Evolving Partnership to Optimize Care, Staff Education, and Seamless Transitions at the End of Life (TH324)

Mary Keebler, MD, Vanderbilt University Medical Center, Nashville, TN. Lenys Biga, MSN BSN, Vanderbilt University Medical Center, Nashville, TN. Mohana Karlekar, MD, Vanderbilt University Medical Center, Nashville, TN. Julie Redding, MA MSSA, Vanderbilt University Medical Center, Nashville, TN.

Objectives

- List the challenges and successes of a rapidly growing advanced heart failure program from the perspective of the heart failure team, palliative care team, and administration.
- Describe the benefits from the perspective of hospital administration in better managing complex ventricular assist device (VAD) patients at the end of life as it relates to cost and quality metrics including national heart failure standards and overall value-based medicine.
- Describe how to operationalize a weekly multidisciplinary patient care conference between heart failure and palliative care that identifies at risk patients and develops a coordinated medical plan where all disciplines have an equal voice.

Our institution's advanced heart failure program has seen tremendous growth both in volume and complexity over the last several years. In calendar year 2014, we performed 91 ventricular assist device (VAD) placements. This represents a nearly 50-fold growth over the last 5 years, with the greatest amount of growth occurring between 2011 and 2013).

Not surprisingly, with such rapid growth, we have witnessed our fair share of both successes and challenges as it relates to our end-of-life (EOL) patients. In this session, we will describe these successes and challenges from the perspective of the heart failure team, hospital administration, and palliative care team. We will also describe the growing partnership between palliative care and the advanced heart failure team that has led to new educational initiatives for the heart failure team. The precipitant for the changes we implemented were a series of deaths over a short span within our institution that resulted in significant moral distress on the part of the heart failure team. These deaths created a tipping point for change. Specifically, a new weekly care collaborative care conference was developed for the most complex hospitalized patients to help develop medically realistic care plans consistent with a patient's wishes. This conference is predicated on the notion that all disciplines have an equal voice in coordinating a viable care plan for these complex patients. During the actual conference, educational pearls on important EOL communication skills, including palliative care resources, will be shared in real time as it relates to a specific patient. Other related educational initiatives developed will include EOL education for ICU nurses that focus on communication skills and symptom management, palliative care resource education for the heart failure case managers, and advance care planning and communication skills to the VAD nurse practitioners.

A New Generation of Comfort Care Order Sets: From Drips to Boluses and Beyond (TH325)

Melissa Bender, MD, University of Washington, Seattle, WA. Caroline Hurd, MD, University of Washington, Seattle, WA. Nicole Solvang, RN, University of Washington, Seattle, WA. Kathy Colagrossi, BSN RN, Harborview Medical Center, Seattle, WA. Diane Matsuwaka, PharmD, University of Washington, Seattle, WA.

Objectives

- Explain the historical development and principles of current commonly used medication order sets for withdrawal of life-sustaining treatments.

- List common concerns and complications that occur using these order sets related to rapid titration of infusions.
- Describe an updated, evidence-based comfort care order set for withdrawal of life sustaining therapies including provider decision tools, treatment algorithms, electronic ordering design and educational dissemination.

Pain, dyspnea, and other symptoms are common in life-limiting illness, particularly in the last weeks of life. Uncontrolled symptoms at the end of life cause distress and compromise quality of life for patients and families. Clinicians also experience distress while caring for these patients. Similar to previously published standardized approaches, our old comfort care order sets were based on historical protocols for sedation and analgesia, which allowed for frequent increases in intravenous opioid continuous infusions to manage symptoms. Clinically, we have seen rapidly increasing opioid doses cause toxicity, discomfort, and moral distress. We have also seen wide variability in practice in the application of these order sets among providers and nurses. A 2013 Cochrane Review recommended that institutions audit their end-of-life pathways, citing a lack of new studies and safety concerns with current pathways. For these reasons, we sought to revise our comfort care order set with a goal to provide better symptom management for patients receiving comfort-focused care at the end of life and to provide more guidance for clinicians involved in treating these symptoms. We will describe the historical development and current literature of comfort care order sets to illustrate common challenges and concerns with their use. We will focus on use of opioids and benzodiazepines for symptom management, ventilator withdrawal, and education for providers and nurses. We will then present key revisions we have made to our comfort care order set based on the updated evidence, clinical practice, and feedback from colleagues. These key revisions include educational material within the order set, such as algorithms and an opioid decision tree. Participants will apply these tools to patient scenarios, provide feedback, and participate in a large group discussion. We will also share preliminary results of provider and nursing surveys on our old and revised comfort care order sets.

"But I Can't Let Him Starve!" A Comprehensive Palliative Approach to the Assessment and Management of Anorexia (TH326)

Mary Buss, MD, Beth Israel Deaconess Medical Center, Boston, MA. Victoria Gurfolino, MSN, Beth Israel Deaconess Medical Center, Boston, MA. Lauren Fay, RD, Beth Israel Deaconess Medical Center, Boston, MA. Kathleen Rimer, EDD MDIV, Beth Israel Deaconess Medical Center, Boston, MA.

Objectives

- Describe a comprehensive, clinically relevant approach to assessing anorexia.
- Identify strategies for improving oral intake that lead to improved energy and quality of life.
- Apply an evidenced-based approach to the pharmacologic treatment of anorexia and weight loss in advanced illness.

Anorexia is a prevalent symptom among seriously ill patients and a common reason for referral to palliative care clinics. Loss of appetite is often accompanied by cachexia, weight loss, nausea, fatigue, and other symptoms, leading to substantial decline in patient quality of life. In addition to the cluster of physical symptoms, anorexia can have a profound impact on a patient's psychological well-being and diminish meaningful social interactions, which often revolve around food. Anorexia can also create friction between a patient and the family caregivers, who often demonstrate love and support through cooking and providing meals for the patient.

Using the cases of patients seen in a palliative care clinic, our interdisciplinary panel of a nurse practitioner, dietitian, physician, and chaplain will offer a comprehensive, clinically focused approach to assessing anorexia that also informs our approach to management. In discussing treatments, relevant literature will be reviewed and critiqued. When evidence basis is lacking, we will articulate our approach to assessing features of anorexia or concomitant symptoms, which help direct treatment. A registered dietitian will detail nonpharmacologic strategies for recommended meal patterns, as well as foods, beverages, and supplements recommended to consume, to help mitigate anorexia and weight loss. In addition to nutritional counseling, we will provide an algorithm for initiating and monitoring pharmacologic approaches to anorexia.

While anorexia can respond to treatment, at times, it is a manifestation of end-stage illness and may become refractory to treatment. In such circumstances, the paradigm of treatment shifts from attempts to "fix" the symptoms to helping patient and family prepare for the final stage of life. Our palliative care chaplain will lead a discussion on addressing issues of morality and meaning that arise when anorexia and weight loss are prominent features of advanced illness.

Primary Palliative Care in the Neonatal Intensive Care Setting: What Is Possible? What Is Necessary? (TH327)

Nancy English, PhD RN, University of Colorado, Denver, CO. Betty Ferrell, PhD MA FAAN FPCN, City of Hope, Duarte, CA. Krishelle Marc-Aurele, MD, University of California, San Diego, and Rady Children's Hospital, San Diego, CA.

Objectives

- Reflect on current neonatal intensive care practice for the seriously ill and or dying neonate.
- Explore the role of the primary palliative care clinician.
- Discuss palliative educational goals for intensive care clinicians.

Introduction: This session will be an interactive discussion with presenters (parent, palliative care nurse scientist/educator/author/neonatologist/palliative care pediatric nurse consultant). Our assumption is that primary palliative care is integral to the life-supporting care of neonates and their families on admission to the neonatal intensive care unit (NICU).

Background: In keeping with the recommendations of the 2014 Institute of Medicine's *Dying in America* report, primary palliative care must be included in the basic curriculum for every clinician who cares for patients with advanced or serious illness. Clinicians practicing in the NICU fall squarely in this category as demonstrated by the life-supporting measures required by sick newborns while addressing the vulnerable traumatized emotional state of parents, especially mothers. Few parents are able to grasp the enormity of the situations they are now facing.

Two-thirds of infant deaths (birth-1 year) occur in the neonatal period (birth-28 days). Other neonates remain with a significant degree of prognostic uncertainty, hovering between life and death for weeks or months. If an infant dies, parents are often unprepared and, in turn, the intensive care team is unprepared to respond to the intense suffering of parents.

Facilitated discussion: (Questions for discussion will be addressed as time allows.)

- What is the role of a primary palliative care clinician practicing in an intensive care setting?
- Are there core primary palliative care educational outcomes that are specific to any intensive care settings?
- Is the implementation of a primary palliative curriculum a possibility in the current intensive care environment?

Summary: Session facilitators will summarize the discussion points and share with attendees via e-mail if requested.

The ACO/Palliative Care Project: An Innovative Model for Upstream Palliative Care in a SNF (TH328)

Mona Patel, DO, Metropolitan Jewish Health System, New York, NY. Michael Zablow, MD, Metropolitan Jewish Health System, New York, NY. Wanda Gonzalez, MSW, Metropolitan Jewish Health System, New York, NY.

Objectives

- Describe an innovative model for early identification of palliative care consults in a long-term care setting using a standardized screening tool.
- Discuss clinical outcomes data and the successes, challenges, and pitfalls with program design and implementation using clinical cases to promote audience participation and interaction.
- Demonstrate how this program can be extrapolated to other SNF facilities to create similar positive outcomes.

The nursing home setting is ripe with opportunities for palliative care intervention given that the majority of residents typically have advanced illnesses and multiple comorbidities. While some advances in the identification of SNF patients that are appropriate for a palliative care evaluation have been made, many opportunities to do better still remain.

This interactive session will describe our organization's early palliative care intervention and screening program in a SNF via a partnership with a pioneer ACO. The purpose of this partnership is to identify patients who are appropriate for a palliative care consult early on.

Sub-acute and long-term care ACO patients are screened by a social worker using the palliative care screening tool and placed into one of two tiers. Tier 1 comprises those patients who screen positive and warrant a palliative care consultation. Tier 2 patients are those who either screen negative for a consult or those who have already had a palliative care consultation and no longer have a need for additional visits at the time. Tier 2 patients continue to undergo monthly social work screens using the tool. The tool evaluates the following: decline in functional status, decline in cognitive status, lack of advance care planning, weight loss, symptoms causing moderate to severe distress, and hospitalizations.

Outcomes data, including improved symptom management, increased advance care planning execution, decreased hospitalizations, and timely hospice referrals, will be shared during the session. Using case-based instruction, the audience will participate in active discussion regarding practical application of the screening tool and the project.

With appropriate staff education and training, we foresee future use of this tool as being incorporated in the monthly geriatric assessment by nursing home medical providers as well as in the weekly interdisciplinary floor rounds in the SNF as part of primary palliative care.

Sustaining the Workforce Through Team Engagement: A Regional Training and Mentoring Program for Interdisciplinary Palliative Medicine Providers (TH329)

Stacie Levine, MD FAAHPM, University of Chicago, Chicago, IL. Sean O'Mahony, MD MS, Rush University Medical Center, Chicago, IL. Aziz Ansari, DO, Loyola University Medical Center, Maywood, IL. George Fitchett, PhD, Rush University Medical Center, Chicago, IL. Holly Nelson-Becker, PhD LCSW, Loyola University Chicago, Chicago, IL.

Objectives

- Describe components of a regional palliative care training program for interdisciplinary providers.
- Explain the composition and impact of a longitudinal mentoring program on development of the interdisciplinary palliative medicine team.
- Describe practice improvement projects, the engagement of hospital leaders, and the impact of both on creating institutional change.

Like many parts of the country, the greater Chicago area has experienced rapidly changing healthcare environments with increased demand for hospice and palliative medicine services (HPM). Limited resources and personnel to meet this need have led to great concern over interdisciplinary team (IDT) sustainability and provider burnout. In response, local HPM leaders, with support from the Coleman Foundation, developed and implemented the Coleman Palliative Medicine Training Program. This 2-year program utilizes multimodal educational strategies, including biannual workshops, evening group sessions, e-learning, and experiential training. From 2013 to 2015, the program trained 29 physicians and nurses from over 20 adult and pediatric healthcare systems seeking to start or improve HPM programs. Another cohort of 28 clinicians, which included social workers and chaplains, was added in 2015. Individual and group mentoring is provided by 39 regional IDT experts from academic and community-based HPM programs. Thirteen trainees from the first cohort also remained in the program as "junior mentors." A leadership conference directed at HPM program directors and hospital leadership was convened in May 2015 aimed at aligning institutional goals and clinical initiatives to address the Institute of Medicine priorities. During this session we will describe unique features of this program including 1) IDT longitudinal mentoring support to ensure adequate clinical skill development and team resiliency; 2) individual and group practice improvement projects completed by program participants that address educational gaps, quality improvement efforts, or clinical program developments at their respective health institutions; 3) strategies used to engage hospital administrators and foster regional collaboration. Finally, we will explore the strengths, weakness, opportunities, and challenges of applicability of this program to other HPM professionals through an interdisciplinary small group discussion.

Paper Sessions

Cancer CarePartners: Can Family Caregivers Help Cancer Patients to Manage Their Symptoms? (TH330A)

Maria Silveira, MD MPH FAAHPM, University of Michigan, Ann Arbor, MI.

Objectives

- Introduce the audience to the Cancer Care Partners system.
- Demonstrate the efficacy of Cancer CarePartners in alleviating the symptoms of cancer treatment.

Original Research Background. "Cancer CarePartners" is a system designed to engage informal caregivers to support patients' efforts to maintain quality of life as they receive chemotherapy. The system provides weekly, automated telephonic symptom assessment to patients and symptom alerts, plus tailored management advice to their caregivers. We conducted a randomized control trial to test the efficacy of this program.

Research Objectives. 1) To test whether patients receiving the intervention for 10 weeks report lower summed symptom severity in comparison to controls. 2) To test whether caregivers participating in the intervention experienced more distress or burden in comparison to controls.

Methods. Consenting patients with solid tumors undergoing chemotherapy reporting any symptom at a 3 (out of 10) or higher who also had a consenting caregiver were randomly assigned to 10 weeks of either Cancer CarePartners or an attention control. Arms were balanced for lung cancer status and caregiver type. Subjects were surveyed at 0, 10, and 14 weeks; charts were reviewed at 14 weeks. We tracked patient and caregiver use of the system.

Results. Among the 151 (41%) patients who consented, 91% entered the study and 82% completed the trial. At 10 weeks, intervention patients experienced lower summed symptom severity (mean 19.5) than controls (mean 23.2) (Coef.= -1.56, P=0.030 for GEE model relating symptom severity to Arm, severity at baseline, week number, caregiver type, and cancer site). Intervention caregivers, in turn, reported less depression (CESD Coef -1.08, P=0.094, 95% CI -2.35 to 0.19) and similar burden as controls.

Conclusion. Cancer CarePartners can enhance caregiver support for patients and improve their symptom management, while adding no burden to the caregiver.

Implications for Research, Policy, or Practice. This is the first study to demonstrate that informal caregivers can be supported with inexpensive informational technology to make a significant difference in the suffering of patients undergoing treatment for cancer.

The Caregivers Experience with an Illness Blog: A Pilot Study (TH330B)

Dana Hansen, PhD RN, Kent State University, Kent, OH. Denice Sheehan, PHD RN, Kent State University, Twinsburg, OH. Pam Stephenson, PhD RN AOCNS, Kent State University, Kent, OH.

Objectives

- Identify and describe an illness blog.
- Identify the experiences of the family caregiver who is participating in this type of interactive platform with their loved one.
- Identify how an illness blog provides a venue for communication, interaction and support.

Original Research Background. Life-limiting illness affects both the ill person and family caregivers in significant ways. Illness blogs provide an innovative way for families and friends to connect as the ill person shares their experiences. This study is one of the first to explore the experiences of family caregivers interacting with their loved one on an illness blog.

Research Objectives. The main objective of this study was to understand the experience of family caregivers as they interact with their loved on an illness blog.

Methods. Phenomenological methods were used. Semi-structured interviews were conducted with nine family caregivers who responded to study invitations posted on illness blogs.

Results. The overarching theme, "We are All in This Together," emerged from the data and was supported by three subthemes: "Enhancing Communication," "Finding and Accepting Support," and "Navigating New Roles." *Enhancing Communication* was the experience of reading the illness blog, which enhanced the caregiver's understanding of their loved one's perceptions of the illness. *Finding and Accepting Support* was described as seeking support from others experiencing similar situations, which provided comfort knowing that they are not alone. In addition, the illness blog offered clarification for N*avigating New Roles* for the family caregiver.

Conclusion. The illness blogs became a tool for communication and connection to the ill person, leading to face-to-face conversations and support for and from others, offering comfort and hope for positive outcomes. The family caregiver's participation in the illness blog clarified their understanding of the illness experience and provided time for responding and interacting with their loved one.

Implications for Research and Practice. The findings of this study demonstrate an innovative approach to understanding how family caregivers and their loved ones with life-limiting illnesses communicate and enhance their relationship. Additional research is needed to understand how these interactions change over time as the illness progresses.

The Effect of Training on the Self-Efficacy of Informal Caregivers of Colorectal Cancer Patients (TH330C)

Rachel Havyer, MD, Mayo Clinic, Rochester, MN. Michelle Van Ryn, PhD, Mayo Clinic, Rochester, MN. Patrick Wilson, MPH, Mayo Clinic, Rochester, MN. Joan Griffin, PhD, Mayo Clinic, Rochester, MN.

Objectives

- Identify the impact of self-efficacy on the experience and outcomes of informal cancer caregivers.
- Analyze the impact of caregiver training on the self-efficacy of informal caregivers of cancer patients found in a cross-sectional study.

Original Research Background. Patients undergoing cancer treatment often need support from an informal caregiver to help manage symptoms. Self-efficacy (SE) in caregiving refers to confidence in caring for the patient's needs. Low SE has been associated with increased caregiver burden and mental health symptoms, which can affect the quality of informal care provided.

Research Objectives. The objective of this study was to examine the relationship between caregiver training received from care providers and SE in caregivers of patients with colorectal cancer (CRC).

Methods. Caregivers of CRC patients were invited to complete a self-administered questionnaire. Caregivers were asked about specific patient problems (pain, bowel, fatigue, medications, and other). Perceptions of training adequacy and SE were assessed on a problem-specific basis. The patient's stage of disease was obtained from registry data. Associations between training and SE were examined for each problem using multivariate logistic regression and adjusted for age, relationship to patient, race, care burden, level of education, stage of disease, perception of patient's health, and general confidence as a caregiver.

Results. 417 caregivers completed the survey (70% response rate), of whom 374 (90%) were female and 284 (68%) were the patient's spouse/partner. The number of caregivers reporting inadequate training for CRC-related problems were pain 77 (38%), bowel 80 (38%), fatigue 121 (48%), medication 65 (26%), and other 101 (40%). The odds of having low SE were significantly higher among those with perceptions of inadequate training across the following CRC-related problems: pain, 10.10 (3.36, 30.39); bowel, 5.04 (1.98, 12.82); fatigue, 8.45 (3.22, 22.15); managing medications, 9.00 (3.30, 24.51); and other, 3.87 (1.68, 8.93).

Conclusion. This study showed a significant association between caregiver training and SE in a cross-sectional study.

Implications for Research, Policy, and Practice. Given that the perception of inadequate training among caregivers was common, further exploration of the longitudinal impact of training on caregiver SE should be done to identify interventions to help improve the experience of caregivers.

Adolescents' Strategies for Managing Life with a Parent in Hospice (TH330D)

Denice Sheehan, PhD RN, Ursuline College, Twinsburg, OH. M. Mayo, ACHPN, Ursuline College, Pepper Pike, OH. Grace Christ, DSW PhD, Columbia University, New York, NY. Ghada Shahrour, MSN, Kent State University, Kent, OH. Claire Draucker, PhD RN FAAN, Indiana University, Indianapolis, IN.

Objectives

- Identify the adolescent's "well world" and "ill world."
- Describe five processes used by adolescents to help them during the final months of the ill parent's life and after the death.

Original Research Background. The final stage of a parent's illness is exceptionally stressful for adolescents as they struggle to gain independence from their families while their parent is near the end of life. However, little research has been conducted on the complex and dynamic psychological processes used by adolescents to respond to a parent's impending death.

Research Objectives. To generate an explanatory framework of the coping strategies that adolescents use to manage the stressors they experience in the final months of their ill parent's life and shortly after their death.

Methods. Grounded theory methods were used. Semi-structured interviews were conducted with 14 ill parents, 17 well parents/guardians, and 30 of their adolescent children before the parent's death and, additionally, with six of these families after the death. The interviews were audio-recorded, transcribed verbatim, and analyzed using a grounded theory approach.

Results. Adolescents describe two worlds: the well world of normal adolescence and the ill world of having a parent near the end of life. The framework includes a core category labeled "managing two worlds." The five iterative processes in which adolescents manage their worlds are: Keeping the ill world and the well world separate, having the ill world intrude into the well world, moving between the ill world and the well world, being immersed in the ill world, and returning to the well world having been changed by the ill world. Unique strategies associated with each process will be presented.

Conclusion. The ways in which adolescents manage their lives when a parent is seriously ill involves complex and nuanced processes that vary among adolescents and change over time.

Implications for Research, Policy, and Practice. Understanding adolescents' perspective is foundational to developing effective interventions grounded in the adolescent's strategies while the parent is in the final months of life, a time when meaningful interventions can ameliorate potential adverse effects associated with a parental death.

Development and Validation of a Family Meeting OSCE Assessment Tool (FMOSCEAT) (TH331A)

Yuya Hagiwara, MD, Avera Medical Group Palliative Medicine, San Antonio, TX. Jennifer Healy, DO, University of Texas Science Center at San Antonio, San Antonio, TX. Sammar Ghannam, Medical Student, University of Texas at San Antonio, San Antonio, TX. Shuko Lee, MS, South Texas Veterans Health Care System, San Antonio, TX. Sandra Sanchez-Reilly, MD FAAHPM, University of Texas Science Center at San Antonio, San Antonio, TX.

Objectives

- Describe a novel tool to assess the skill to perform family meetings.
- Recognize the validity of the Family Meeting OSCE Assessment Tool (FMOSCEAT).

Original Research Background. A cornerstone procedure in Palliative Medicine is to perform family meetings, also referred to as family conferences. Learning how to lead family meetings is an important skill for physicians, nurses, and others who care for patients with serious illnesses and their families. Although efforts have been made to teach family meeting skills, there is limited evidence exploring methods to assess the skill to perform family meetings.

Research Objectives. To develop and validate an observational tool to assess trainees' ability to perform and lead family meetings.

Methods. Building on evidence from the literature search, guidelines and competencies, the Family Meeting Objective Structured Clinical Examination Assessment Tool (FMOSCEAT) was developed by our expert panel to evaluate best practice behaviors when leading a family meeting. As part of our palliative care curriculum, fourth-year medical students completed a Family Meeting OSCE, where each student assumed the physician role leading a complex family meeting with two standardized family members. The OSCE scenario replicated a "true life," clinically relevant situation where it would be appropriate for the physician to hold a family meeting. Two interdisciplinary evaluators were paired to observe and rate randomly chosen students' performances in the OSCE using the FMOSCEAT. Inter-rater reliability was measured using percent agreement. Internal consistency was measured using Cronbach's alpha.

Results. 133 trainees and 26 interdisciplinary evaluators participated. The FMOSCEAT was refined until the tool had acceptable inter-rater reliability. Overall rater agreement was 84%, and Cronbach's alpha of 0.85.

Conclusion. Evidence and expert-based content, high interrater reliability, and good internal consistency provided initial evidence of validity for this novel assessment tool.

Implications for Research, Policy, or Practice. We propose to further test the tool with trainees at various levels and of other disciplines.

Teaching Surgery and Emergency Medicine Residents the Communication Skills Around Death and Dying in the Trauma Setting (TH331B)

Sangeeta Lamba, MD, Rutgers New Jersey Medical School, Newark, NJ. Leslie Tyrie, FACS MD, Rutgers New Jersey Medical School, Newark, NJ. Sarah Bryczkowski, MD, Rutgers, New Jersey Medical School, Bridgewater, NJ. Roxanne Nagurka, BA, Rutgers New Jersey Medical School, Newark, NJ. Anne Mosenthal, MD FACS, Rutgers New Jersey Medical School, Newark, NJ.

Objectives

- Describe the unique aspects to the delivery of difficult news in the trauma setting.
- Demonstrate components of a hybrid simulation curriculum that incorporate teaching of effective communication skills in the trauma setting.
- Describe key steps for assessing communication skills using an Observed Skills Clinical Exam and conducting structured debriefing/feedback for trauma residents.

Original Research Background. Trauma resuscitations often end in patient death and/or significant disability. Resident training in both emergency medicine and surgery is focused on acquiring *technical* resuscitation skills, with little emphasis on *communication* skills around death and dying.

Research Objectives. Our goal was to design and assess outcomes of a novel curriculum using simulation and role-play to train residents how to deliver difficult news to family after a patient's traumatic injury.

Methods. Curriculum was delivered in three parts: 1) e-learning with case-based video didactics, 2) simulated trauma resuscitation resulting in poor prognosis or death, followed by immediate role-play and debriefing of communication to family, and 3) assessment of performance [(self and Standardized Family (SF))] using a teaching Objective Structured Clinical Examination (t-OSCE). Pre/post-curriculum questionnaires assessed residents' knowledge, skills, attitudes, and satisfaction.

Results. 39 surgery (PGY1-2) and emergency medicine (PGY1-4) residents at a level I trauma center participated in the curriculum. Pre/post ratings had a statistically significant increase in knowledge (79% and 89% respectively, strongly agree/agree, $p<0.04$). Comfort and confidence with delivery of difficult news also increased (no statistical significance). The SF-rated overall resident performance as competent (78%, 18/23). Residents reported satisfaction (90%) with the curriculum and found it valuable (84% video didactic, 89% simulation, and 92% t-OSCE). Debriefing identified that trauma resuscitations generate strong emotions in residents (anxiety, frustration, stress, and fear of performance). Residents perceived that family response to delivery of news of death in the trauma bay was frequently associated with anger, violence, and denial. Some residents report 'emotional detachment' as means for coping.

Conclusion. Simulated trauma resuscitation curriculum that incorporates role-play of delivering difficult news increased resident knowledge regarding communication. Assessment and feedback of communication skills is feasible with a t-OSCE. Debriefing is valued by residents. Educators should consider debriefing residents to help them cope with the strong emotional responses after real and simulated trauma deaths.

COMFORT Communication for Palliative Care Teams: Outcomes of a Statewide Training Course (TH331C)

Elaine Wittenberg, PhD, University of North Texas, Duarte, CA. Betty Ferrell, FAAN FPCN, City of Hope National Med Center, Duarte, CA. Joy Goldsmith, PhD, University of Memphis, Memphis, TN. Sandra Ragan, PhD, University of Oklahoma, Norman, OK.

Objectives

- Identify a statewide project to coordinate interprofessional communication training to improve inpatient care.
- Describe at least two models of excellence and barriers to team-based care in the hospital setting.
- Describe at least two teaching resources to enhance team communication competence in the hospital setting.

Original Research Background. Communication training for healthcare providers has traditionally focused on single disciplines. Yet, palliative care is delivered by an interprofessional team of healthcare professionals.

Research Objectives. The purpose of this presentation is to describe a statewide effort to improve team-based communication provided by interprofessional healthcare teams in hospital settings.

Methods. The project was based on the COMFORT Communication Curriculum, a national palliative care communication training curriculum based on communication theory and research in palliative care. With funding from the Archstone Foundation in California, the curriculum was created for a two-day training course for implementing evidence-based communication skills into practice. Using the National Consensus Project's Clinical Practice Guidelines for Palliative Care and the Core Competencies for Interprofessional Practice sponsored by the American Association of Colleges of Nursing and the Association of American Colleges of Medicine, the curriculum was built by a team of interprofessional faculty.

Results. The curriculum includes teaching materials, training videos, and supplemental resources to integrate communication skills building into existing clinical settings. Statewide interprofessional communication training took place in January, 2015 with 30 palliative care teams (2 providers per team). Physicians, nurses, social workers, and chaplains rated the course as excellent with a mean score of 4.81 (on a scale of 1=poor to 5=excellent), found the course stimulating (4.91), and said it met expectations (4.76).

Conclusion. This presentation will focus on the six- and nine-month post-course goal evaluations with emphasis on models of excellence and barriers cited.

Implications for Research, Policy, and Practice. This statewide training (www.pccinstitute.com) provides healthcare professionals with education on team-based care and communication, developing the skills needed to integrate palliative care into hospital systems and improve access and services to patients and families.

A Multisite Survey of Critical Care Nurses' Perspectives of Their Clinical Involvement in Palliative Care Communication (TH331D)

Deborah Boyle, MSN RN, University of California Irvine, Irvine, CA. Kathleen Puntillo, RN PD FAAN FCCM, University of California San Francisco, San Francisco, CA. Kathleen Turner, RN, University of California San Francisco Medical Center, San Francisco, CA. Susan Barbour, RN MS, University of California San Francisco School of Nursing, San Francisco, CA. Wendy Anderson, MD MS, University of California, San Francisco, San Francisco, CA.

Objectives

- Comprehend ICU nurses' perspectives of their role in palliative care communication.
- Identify two barriers to ICU nurses' involvement in PC communication.

Original Research Background. The intensive care unit (ICU) is increasingly becoming a setting of care for chronically ill patients with life-limiting illness. Nurses, spending the most time with patients and families, highly value their roles as liaison and advocate. Successful and sustained integration of palliative care (PC) into the ICU requires the active engagement of bedside nurses.

Research Objectives. To describe perspectives of ICU bedside nurses on their involvement in PC communication.

Methods. We designed a 46-item survey, based on prior work, to assess nurses' perspectives on palliative care communication, namely, the importance and frequency of their involvement, their confidence specific to these discussions, and barriers to their participation. The survey was distributed via email to 1791 bedside ICU nurses who worked in the five academic medical centers of the University of California.

Results. 598 nurses completed the survey (33% response rate). Most participants (88%) reported that their engagement in discussions of prognosis, goals of care, and PC was very important to the quality of patient care. However, a minority noted that they often discussed PC consultations with physicians (31%) or families (33%). Nearly half of the nurses (45%) confirmed that they rarely or never participated in family meetings. Confidence was also lowest for these behaviors. The three most frequent barriers to nurses' involvement in PC communication were: need for more training (66%), physicians not asking nurses' perspectives (60%), and concern over the emotional toll of PC communications (43%).

Conclusion. ICU nurses perceive their involvement in discussions of prognosis, goals of care, and PC as a key element of high quality patient care. Based on the identified barriers, efforts to promote education, team building, and self-care can reduce obstacles that deter optimal PC communication.

Implications for Research, Policy or Practice. Interventions are needed to ensure that all ICU nurses have the education, opportunities, and support to actively participate in palliative care communication.

3—4 pm

Educational Forum

Making Your Measurement Matter: Implementing the AAHPM & HPNA Measuring What Matters Project (TH341)

David J. Casarett, MD MA FAAHPM, 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, Johns Hopkins Sidney Kimmel Cancer Center, Baltimore, MD. Keela Herr, PhD RN AGSF FAAN, University of Iowa College of Nursing, Iowa City, IA. Joseph D. Rotella, MD MBA FAAHPM, American Academy of Hospice and Palliative Medicine, Chicago, IL. 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. Marianne Matzo, PhD APRN-CNP FPCN FAAN, Hospice and Palliative Nurses Association, Pittsburgh, PA.

Objectives

- Introduce the AAHPM & HPNA "Measuring What Matters" portfolio of hospice and palliative care measures.
- Present three examples of different settings (ie, home-care, LTC, and hospital settings) implementing the Measuring What Matters measures, with emphasis on both benefits and challenges of implementation.
  - Describe three examples of programs and groups that are using MWM to improve quality.
  - List challenges of implementing MWM measures and potential solutions.
- 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.
  - Discuss plans for developing resources for implementing Measuring What Matters.
  - Describe the preliminary work of the MWM E-Specifications Working Group and its future plans.

Leaders of AAHPM and HPNA's "Measuring What Matters" project will address how hospice and palliative care providers can integrate Measuring What Matters into their quality improvement programs and use Measuring What Matters 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 2013-2014, 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 Measuring What Matters measures ideally would be adopted by hospice and palliative care programs, health systems, and payors to enable comparison of quality data across settings. This workshop will introduce the Measuring What Matters project; identify three examples of implementing the Measuring What Matters measures in different settings, 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.

4:30—5:30 pm

Concurrent Sessions

Palliative Care: Is It at the National Policy Table or On the Menu? (TH350)

Marian Grant, DNP CRNP ACHPN, University of Maryland, Baltimore, MD. Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- List key factors affecting national health policy.
- List key policy and legislative priorities for palliative care on both the national and state level.
- List the role individuals and coalitions play in this arena.

In the current "do-nothing" Congress, little legislation is moving forward. Stand-alone bills rarely make it to the floor and any with price tags need to be fully paid for. From a palliative care standpoint, there is lingering hesitancy from the death panel days that could even impede regulatory changes, such as Medicare adding an advance-planning billing code. Despite this, health policy is a crucial arena for improving access to quality palliative care. Because interest in care models that improve quality and control costs is very strong, both legislative and executive branch policy makers have a stake in strengthening palliative care. Some legislative champions are particularly interested in advance care planning and this could be leveraged into efforts that also include palliative care.

The presenters will use their recent experience as Capitol Hill legislative and federal health agency fellows to educate participants on how the current legislative process really works, especially in regard to palliative care. The presentation will then review current palliative care bills and legislative and executive branch priorities, including the champions, sponsors, and coalitions supporting them. In addition, since much of the real policy action is outside of Washington, the presentation will review important state efforts to provide examples other states may want to consider. Participants will also gain information on how to participate in policy on a local, state, and national level, including tips on how to best position palliative care as a key solution within healthcare reform. The role and value of coalitions in this area also will be reviewed.

Enhancing Palliative Care Communication Through Interprofessional Education (TH351)

Elaine Wittenberg, PhD, City of Hope, Duarte, CA. George Handzo, MD, Handzo Consulting, Los Angeles, CA. Pam Malloy, MN RN OCN FPCN, American Association of Colleges of Nursing, Buellton, CA. Thomas Smith, FACP FASCO FAAHPM MD, Johns Hopkins Medical Institutions, Baltimore, MD. Myra Glajchen, DSW, Metropolitan Jewish Health System, New York, NY.

Objectives

- Define interprofessional communication competencies and describe a statewide hospital-based team training course in palliative care communication.
- Describe interprofessional education projects in medicine.
- Describe interprofessional education projects in nursing.

Since the inception of hospice and palliative care, it has been recognized that interprofessional teams are an essential element for providing holistic, comprehensive care and ensuring that communication and decision-making align with patient's and family's personal beliefs and values. The National Consensus Project for Quality Palliative Care (NCP) highlights the foundational role of interprofessional communication in the eight domains of the clinical practice guidelines (www.nationalconsensusproject.org). While model communication programs have been developed to address the training needs of palliative care providers, the greatest emphasis has been on a specific discipline rather than team-based communication. Meanwhile, policy, research, and practice guidelines emphasize team-based care as necessary to ensure quality, comprehensive, patient-centered care. In 2011, the *Core Competencies for Interprofessional Practice*, sponsored by the American Association of Colleges of Nursing and the Association of American Colleges of Medicine was created to provide a framework for teaching and evaluating team-based communication practices. In this session, interprofessional faculty members will describe their own work to promote interprofessional palliative care education and team communication skills. Examples and resources will be provided, including continuing education courses, training videos, interprofessional webinars, and curriculum design. After faculty have presented, participants will be invited to share their own plans for enhancing education and leadership in palliative care communication.

Physician Assisted Dying Position Statement: The AAHPM Ethics Committee Reports on Its Work (TH352)

Jeffrey Berger, MD FACP, Winthrop Hospital, Mineola, NY. Lida Nabati, MD, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Understand the process undertaken by the Academy Ethics Committee in developing the updated position statement.
- Understand major similarities and differences between the established and updated position statements.
- Be familiar with the Academy members' responses to the updated position statement.

The AAHPM Ethics Committee recently endeavored to update the Academy's position statement on physician assisted death, last updated in 2007. This contentious issue, set in a rapidly evolving contemporaneous legal landscape, presented the committee and the Academy with the great challenge of forging a consensus among widely disparate views on the subject. Members of the Ethics Committee will 1) describe the committee's process of updating the position statement, 2) compare and contrast content of the established and updated statements, 3) provide a review of the memberships' comments/responses elicited during the Academy's call for comments, and 4) discuss the key position elements in the updated statement.

You Can't Have Your Cake and Eat It Too, Or Can You? Supporting Advanced Palliative Oncologic Therapies Within a Hospice Program (TH353)

Ruth Thomson, DO FACOI HMDC FAAHPM, Hospice of Dayton, Dayton, OH. Mary Murphy, RN ACHPN AOCN, Hospice of Dayton, Dayton, OH. Rebecca Collins, BSN RN OCN CHPN, Hospice of Dayton, Dayton, OH. Cleanne Cass, DO FAAHPM, Hospice of Dayton, Dayton, OH.

Objectives

- Describe the need and challenges of supporting advanced palliative oncologic therapies for hospice patients.

- Identify the resources needed to implement a program to support advanced palliative oncologic therapies under the hospice “umbrella.”
- Illustrate how to develop and implement a decision tree for supporting advanced palliative oncologic therapies for your hospice program.

All too often cancer patients meet eligibility criteria for hospice but are denied access because they wish to continue to receive advanced palliative oncologic treatment such as chemotherapy or radiation. Many hospice programs have historically been challenged to support these advanced oncology modalities due to resource and financial constraints. Attitudes of community oncologists and the misperception by patients and their families of giving up “hope” by entering a hospice program have also contributed to the problem. There is growing evidence of the benefits of cancer patients receiving hospice and palliative care while still receiving what would have traditionally been described as “curative care,” so much so that CMS continues to work toward a model of concurrent care. Hospice of Dayton has been successfully providing concurrent care for our oncology patients for several years and we continue to strive to improve and expand our program to broaden access and provide superior care and services. Through a process of continuous improvement, we developed our Focus Care program for oncology, which is supported by an interdisciplinary team and embraced by our community oncology partners. Within this structure, we successfully developed and implemented oncologic therapies algorithms, supported by a prior authorization process and endorsed by our hospice physicians and community oncologists. The Focus Care program is built around a framework of educational, policy, nursing, and physician support to ensure we can provide the highest quality of care to our cancer patients. We are proud of the success of our Oncology Focus Care program and hope that other hospice programs can benefit from our experiences to increase access and support the care of patients in their communities with advanced cancer.

It’s Time to Write the Order: A Practical Approach to Palliative Sedation (TH354)

Kelly Wu, MD, Mayo Clinic, Rochester, MN. Virginia Thompson, PharmD, Mayo Clinic, Rochester, MN. Katie Fitzgerald jones, MSN RN, Hebrew Senior Life, Marshfield, MA. Jacob Strand, MD, Mayo Clinic, Rochester, MN.

Objectives

- Build a take-home guide of common medications for palliative sedation and how they can be applied to local practice cultures and specific patient situations.
- Manage a patient needing palliative sedation in which midazolam either is ineffective or causes unwanted side effects.
- Recognize and proactively address nursing concerns regarding the administration of palliative sedation in an interdisciplinary capacity.

You’ve tried everything else. You’ve debated the ethical issues behind palliative sedation. You’ve talked with the patient and/or the patient’s family. You have brought together an interdisciplinary team to help everyone feel prepared and ready to start palliative sedation for the patient’s intractable symptom. Now it is actually time to order the medications and begin the procedure. Where, and, ultimately, what do you start?

Palliative sedation is a true procedure for palliative care and hospice clinicians. While most symptoms are able to be alleviated through expert palliative care and hospice teams, intractable symptoms do occur and present a significant challenge to the team caring for these patients. The knowledge to perform and monitor palliative sedation allows clinicians the opportunity to relieve suffering and minimize the emotional burden of palliative sedation on interdisciplinary teams.

Once the decision to begin palliative sedation is made, how to successfully perform this procedure is often influenced by availability of medications, the hospital or hospice culture where palliative sedation is performed, and by clinician experience and gestalt. This session will provide participants with a practical guide to medication selection and initial dosing, as well as best practices for titrating, monitoring, and documenting the effects of these medications. Using a case-based, interactive format, the presenters will also explore specific situations that may call for atypical medication regimens and will discuss emerging medications to keep in your palliative sedation armamentarium.

This session also will explore common nursing concerns around the administration of palliative sedation and how to ensure that all members of the interdisciplinary team are supported while providing this high level patient care.

Compassionate Extubation in the Home: It Takes a Team (TH355)

Ellen Melnick Brown, MD, Pathways Home Health and Hospice, San Francisco, CA. Carmel Thorn, RN CHPN, Pathways Home Health and Hospice, San Francisco, CA. David Cowell Pathways Home Health and Hospice, San Francisco, CA.

Objectives

- Describe steps to take before starting the procedure to ensure comfort for the patient and family.
- Identify likely symptoms during and after the extubation and their management.

- Describe ways to support family and staff during and after the extubation.

Compassionate extubation or the removal of mechanical ventilation in the home requires the involvement of the entire hospice team to ensure both patient and family comfort. With the assistance of the hospice physician, nurse, social worker and chaplain, patients and families should not have to leave their home to come off ventilatory support.

We will present four cases of home discontinuation of support: two elderly female patients and two children. We did not have IV access in any of the cases but were able to anticipate and manage their symptoms using subcutaneous medications administered via a pump or medications administered via a gastric tube in one of the pediatric patients.

The process involved the whole team (ie, hospice physician, nurse case manager, social worker, and spiritual counselor) making visits to the home prior to and during the extubation. Also, the pharmacy department was essential in providing assistance in symptom management. These were emotionally difficult experiences for staff, as well as for families. We will describe ways to provide effective bereavement support for families as well as support for staff. Our hospice team was able to provide what these patients and families needed in a compassionate way and in an appropriate setting.

Review of the literature reveals little information on home extubation. We hope to provide information on positive experiences for patients, their families, and staff.

When to Say When: Helping the Team and Family Recognize when Death is Inevitable After Pediatric Bone Marrow Transplant (TH356)

Deena Levine, MD, St. Jude Children's Research Hospital, Memphis, TN. Liza-Marie Johnson, MBE MD MPH, St. Jude Children's Research Hospital, Memphis, TN. Christina Ullrich, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Justin Baker, MD FAAHPM, St. Jude Children's Hospital, Memphis, TN.

Objectives

- Gain an understanding of complex prognostication following complications of pediatric bone marrow transplant (BMT).
- Gain skills for communicating the reality of poor likelihood of survival with a cure-oriented team and family following pediatric BMT.
- Gain a better understanding of the ethical issues surrounding pediatric BMT patients receiving what may be considered inappropriate care at the end of life.

Pediatric bone marrow transplantation is a unique setting in which patients and families tend to accept a high risk of extreme toxicities in exchange for a small chance at a cure. Even when the chance of cure seems remote and the morbidity is high, the tendency is to continue aggressive medical interventions with curative intent. In some cases, the nature of the complications and the patient's overall condition render the chance for cure an unrealistic goal. In these cases, continued artificial life-sustaining therapy may be considered medically futile and may prolong suffering in a dying child.

It can be extremely challenging for medical teams to identify the patients who may have reached a point of inevitable impending death and for whom continued cure-directed therapy is no longer indicated. It can be even more challenging for multiple disciplines to all agree that this point has been reached and achieve consensus among providers and consultants. Helping a family accept that their child's cure-directed care will not achieve its desired result and assisting them in shifting goals to comfort and acceptance can be a far greater challenge.

It is essential for palliative care providers who encounter this population to be familiar with the complications of pediatric bone marrow transplantation, as well as the evidence and clinical consensus required for prognostication. Expert communication skills can aid in aligning the medical team and family in order to establish realistic goals for the patient, minimize suffering, and avoid requests for nonbeneficial interventions. In addressing the complexities of pediatric bone marrow transplant patients with irreversible life-limiting complications nearing the end of life, critical aspects of prognostication, futility, and communication will be elucidated with broad applicability to the field as a whole.

Palliative Radiotherapy for Hospice and Palliative Medicine Clinicians: Opening the Black Box of Palliative Radiotherapy to Encourage Collaboration with Radiation Oncologists in the Era of Early Palliative Care (TH357)

Joshua Jones, MD MA, University of Pennsylvania Health System, Philadelphia, PA.

Objectives

- Develop a vocabulary for discussing palliative radiotherapy with patients, families, and other clinicians.
- Describe fundamental principles that guide the practice of palliative radiotherapy.
- Identify competing factors that influence the tailoring of palliative radiotherapy.

In the era of early palliative care interventions for patients with advanced cancer, many hospice and palliative medicine clinicians are being asked to help patients, families, and clinicians think about risks and benefits of palliative radiotherapy for patients with advanced cancer. At the same time, the fundamental landscape of palliative radiotherapy is actively and rapidly changing. Resources for staying up to date on advances in radiation oncology and their application to the world of hospice and palliative medicine are limited. Groups such as AAHPM are appropriately advocating for single fraction radiotherapy for uncomplicated bone metastases, but, simultaneously, there is increasing use of advanced techniques in radiation oncology (eg, stereotactic radiotherapy, intensity modulated radiotherapy) for palliation of symptoms of advanced cancer. This presentation will provide an overview of the use of palliative radiotherapy for patients with advanced cancer, highlighting a prognosis-based approach to palliative radiotherapy that allows hospice/palliative medicine clinicians to collaborate effectively with radiation oncologists and provide care that incorporates patient and family values into the radiation treatment regimen. The presentation will highlight the latest research and writing on palliative radiotherapy and opportunities for collaboration, including coverage of the following:

- Review of fundamental principles of palliative radiotherapy
- Indications for palliative radiotherapy including bone metastases, brain metastases, symptomatic visceral primary tumors and metastases, bleeding, obstructive symptoms, etc.
- Principles of tailoring palliative radiotherapy to meet individual patient and family needs, encouraging appropriate use of single fraction radiotherapy and judicious use of more advanced radiotherapy techniques and other dose-fractionation schemes when appropriate
- Opportunities for appropriate use of radiotherapy for patients enrolled in hospice.

The presentation will be designed for any palliative care clinician (physician, nurse, social worker, chaplain, etc) who interacts with patients and families receiving radiotherapy, enhancing understanding of patient experience and empowering active collaboration with radiation oncology teams.

A Culturally Responsive Approach to Advance Care Planning: A New Communication Framework Tool to Reduce Racial Disparities in End-of-Life Care (TH358)

Kathleen Mitchell, MD, Jamaica Hospital Medical Center, Astoria, NY. Alan Roth, DO FAAFP, Jamaica Hospital Medical Center, Jamaica, NY. Gina Basello, DO, Jamaica Hospital Medical Center, Jamaica, NY. Jeffrey Ring, PhD, Health Management Associates, Costa Mesa, CA.

Objectives

- Describe the current status of racial disparities in this country in regards to understanding of advanced directives, use of advanced directives, and desire for aggressive care vs hospice care at end of life.
- Identify how culture and culturally responsive care impacts advance care planning and more effectively use models of cross-cultural communication to enhance the effectiveness of advance care planning.
- Recognize barriers to completing advance directives in clinical situations and create solutions for these barriers.

Our country's population is growing older, becoming more diverse, and surviving longer with chronic conditions. Healthcare professionals must develop skills to provide culturally sensitive care while practicing in an already overburdened healthcare system. Advance care planning is the process of establishing patient and family-centered goals of care in the event of life-threatening illness, and these sensitive conversations are integral to providing quality end-of-life care. Newer models have demonstrated that through efficient and early advance care planning we can achieve the IHI Triple Aim of improved healthcare quality, improved patient satisfaction, and reduced end-of-life cost within a patient-centered model of care. However, data demonstrate large disparities still exist within minority and underserved communities in the understanding of advance directives, use of advance directives, and desire for aggressive care vs hospice care at end of life. Culture plays an important role in how individuals see themselves, see others, interpret illness, respond to illness, receive and communicate bad news, and make decisions regarding end-of-life care. These racial disparities must be addressed by practitioners well-versed in conducting these crucial conversations in a culturally sensitive manner, navigating practitioner-patient relationships, in developing skills for delivering bad news, and in establishing culturally appropriate and patient-centered goals of care in the context of ethnic variability. Most importantly, we must become aware of our own views and values regarding health, illness, and death through continual self-reflection. This session will consist of facilitated group discussion, self-reflection, and didactic presentation components. Didactics will focus on health disparities data, the patient-centered and financial benefits of advance care planning, and introduce the new communication tool, "A REFLECTION." Guided self-reflection and facilitated group discussion will lead to awareness about personal and systemic barriers and demonstrate how to navigate cultural issues and overcome barriers in advance care planning.

Tips for Being an Excellent (and Helpful) Reviewer for Professional Journals (TH359)

David Casarett, MD MA FAAHPM, University of Pennsylvania, Philadelphia, PA. Keela Herr, PhD RN FAAN, University of Iowa, Iowa City, IA. Joan Penrod, PhD, Icahn School of Medicine at Mount Sinai, New York, NY. Sree Battu, MD, Cleveland Clinic Foundation, Cleveland, OH. Felicia Hui, MD, Yale-New Haven Medical Center, New Haven, CT.

Objectives

- Use key reviewing skills to provide constructive feedback to authors.
- Include key elements in your reviews that provide effective and constructive feedback to editors.
- Avoid common pitfalls and errors in conducting effective peer reviews.

Background. In order to advance the field of hospice and palliative care through journal publications, it is essential to have a community of peer reviewers who can evaluate a manuscript's quality, novelty, and importance to the field. Peer reviewers form the backbone of the process by which innovation, new ideas, and research results are used to guide clinical practice and future research. The peer review process is particularly important in a relatively new field such as palliative care. However, researchers and clinicians receive little or no formal training in how to provide high-quality peer reviews for journal manuscripts.

Session. In this session, an interprofessional faculty will describe the review process from the perspective of new reviewers, an experienced reviewer, an editor of the *Journal of Pain and Symptom Management* (the AAHPM journal), and an author. Together, we will describe approaches to gain experience in reviewing, some of the challenges that new reviewers face, and strategies for overcoming those challenges. We also will describe the review process from the dual perspective of an editor and an author in order to define the features of a review that are most (and least) helpful.

Conclusion. Participants will gain concrete, usable reviewing skills and an interprofessional perspective on how to do a high-quality, helpful review of a journal manuscript.

Paper Sessions

In-Hospital Mortality Among California's Jail and Prison Inmates: The Need for Improved Data on the Causes of Death (TH360A)

Jason Flatt, University of California San Francisco, San Francisco, CA. Cyrus Ahalt, MPP, University of California San Francisco, San Francisco, CA. Renee Hsia, MD, MSc, University of California San Francisco, San Francisco, CA. Brie Williams, MD, University of California San Francisco, San Francisco, CA.

Objectives

- Compare health characteristics and causes of death between incarcerated and non-incarcerated persons in California hospitals.
- Discuss policy implications for healthcare delivery, data collection and reporting on hospitalizations and mortality among California's prisoners.

Original Research Background. California incarcerates nearly 10% of U.S. prisoners. While prisoners experience poor health and early mortality, little is known about the chronic conditions or causes of death of prisoners who die in our community hospitals.

Research Objectives. To compare the characteristics and causes of death among incarcerated and non-incarcerated hospitalized adults in California.

Methods. Cross-sectional comparisons of sociodemographics and health conditions between patients admitted from prison or jail and non-incarcerated patients who died in the hospital using 2009-2013 data from the California Office of Statewide Health Planning and Development. Sub-analyses compared causes of death using data from 2009-2011.

Results. From 2009-2013, 745 prisoners (1% of prisoner admissions) and 370,086 non-prisoners (2.3% of non-prisoner admissions) died in California hospitals. Deceased prisoners had higher rates of cancer, liver disease, and mental health problems than deceased non-prisoners (all $p<0.001$). Age at death was 55 years (prisoners) vs. 73 years (non-prisoners), $p<0.001$; and 23% of prisoners vs. 36% of non-prisoners had do-not-resuscitate (DNR) orders. Causes of death analyses were inconclusive because data were available for only 38% of prisoners vs. 92% of non-prisoners. Comparisons of the available data suggest that infectious diseases (including viral hepatitis) and external injuries (including overdose, suicide, and homicide) were more common among prisoners.

Conclusion. Although prisoners who died while hospitalized were nearly 20 years younger and less likely to have a DNR order, they had higher rates of several chronic health conditions than non-prisoners. Data describing the causes of death of hospitalized prisoners were inadequate.

Implications for Research, Policy, and Practice. Palliative care efforts should be targeted to prisoners with advanced chronic disease, regardless of age, including addressing advanced care planning for those who are hospitalized. In addition, efforts to collect and evaluate in-hospital causes of death in prisoners are needed to inform the development of policies and practices that can improve the quality of palliative care for this population.

Detained and Distressed: Persistent Distressing Symptoms in a Population of Older Jail Inmates (TH360B)

Marielle Bolano, BS, University of California Davis, Davis, CA. Cyrus Ahalt, MPP, University of California, San Francisco, San Francisco, CA. Christine Ritchie, MD MSPH FAAHPM, University of California San Francisco, San Francisco, CA. Irena Stijacic Cenzer, MA, VA Medical Center & University of California San Francisco, San Francisco, CA. Brie Williams, MD, University of California, San Francisco, San Francisco, CA.

Objectives

- Describe the prevalence of symptomatic distress in a population of older jail inmates, including physical, psychological, existential, and social suffering.
- Identify sociodemographic and health factors associated with physically distressing symptoms in this population.
- Understand the high prevalence of overlap among physical distress and other forms of distress (psychological, social, and existential) in older jail inmates and its implications for jail-based treatment paradigms.

Original Research Background. Among older adults, distressing symptoms are associated with decreased function, acute care use, and mortality. However, little is known about distressing symptomatology in the rapidly growing population of older jail inmates.

Research Objectives. This study describes the prevalence of and factors associated with distressing symptoms in older jail inmates, and examines the overlap between different forms of symptom distress.

Methods. This descriptive cross-sectional study of 125 jail inmates age 55 or older in the San Francisco County jail examined the following forms of symptom distress: physical (Memorial Symptom Assessment Scale, defined as severe, frequent, and distressing), psychological (anxiety [GAD-2] or depression [PHQ-2]), existential (Patient Dignity Inventory), and social (Three Item Loneliness Scale). Participant sociodemographics, health conditions, functional ability, and behavioral health risk factors were collected using self-report and chart review. We identified factors associated with physical distress using Chi-squared tests, and determined overlap between forms of distress using set theory analysis.

Results. Participants had a mean age of 60 (range 55-87 yrs.) and were predominantly black (63%) and of low-income (86% <$15,000/yr). Overall, 100 (80%) participants reported one or more distressing symptoms, including physical (44%), psychological (56%), existential (71%), and social (45%). Factors associated with physical distress included low income, multimorbidity, serious mental illness (SMI), and functional impairment. Many participants experienced multiple forms of distress; of the 100 participants with any distressing symptom, 51% reported 3 or more forms of distress. Nearly all participants with physical distress also reported existential distress (93%).

Conclusion. Among older inmates, physical distress was associated with poor health (multimorbidity, functional impairment, SMI) and low income. Overlap between forms of distress was common, particularly physical and existential distress.

Implications for Research, Policy, and Practice. Findings suggest older inmates would likely benefit from a geriatric and palliative care approach that integrates the management of all forms of symptom distress into an overall treatment paradigm.

The Introduction of Palliative Care Consults in Nursing Homes: The Effect on End-of-Life Hospitalizations (TH360C)

Susan Miller, PhD MBA, Brown University, Providence, RI. Roshani Dahal, MPH, Brown University, Providence, RI. Janet Bull, MD FAAHPM HMDC, Four Seasons, Flat Rock, NC. Edward Martin, MD MPH FACP HMDC, Home and Hospice Care of Rhode Island, Providence, RI. Laura Hanson, MD MPH FAAHPM, University of North Carolina, Chapel Hill, NC.

Objectives

- Describe how, in markets where palliative care (PC) consults are available, nursing homes introducing palliative care consults are different than nursing homes that do not.
- Describe how nursing home introduction of palliative care consults is associated with end-of-life hospitalization rates.

Original Research Background. While specialty PC consults in hospitals or outpatient settings are associated with lower costs, their impact in nursing homes (NH) is unknown.

Research Objectives. To understand whether the introduction of NH PC consults and increases in their use are associated with reductions in end-of-life hospitalizations.

Methods. We collected annual consult data (consult residents and visits per NH) for 2000-2010 from seven hospice-affiliated NH PC providers in 24 counties; all 286 NHs in these counties were included. An NH-level file for years 2000-2010 included aggregated resident assessment and claims data and NH- and county-level data. The annual proportion of NH residents receiving consults was calculated, and introduction was considered "yes" the year this proportion reached 1%. Volume was represented annually by the number of residents with consults per 100 NH residents. Panel multivariate regression analyses with NH fixed-effects examined whether changes in rates of hospital deaths and hospitalizations in the last 30 days of life differed for NHs that introduced consults or increased their volume.

Results. 170 (59%) of the 286 study NHs introduced specialty PC consults by 2010. NHs introducing consults, compared to others, were more often in rural areas and more competitive NH markets; also, resident acuity and staffing was higher. Multivariate analyses showed NHs introducing consults (compared to others) had a 1% greater reduction in their hospital death rates ($P<0.10$) and a 1.7% greater reduction in rates of hospitalizations in the last 30 days of life ($p<0.05$). No statistically significant associations were observed between changes in volume and study outcomes.

Conclusion. The availability of specialty PC consults in NHs is associated with reductions in end-of-life hospitalizations.

Implications for Research, Policy, and Practice. Medicare policy supporting the provision of PC consults in NHs may lead to lower end-of-life hospital expenditures and higher quality of life for dying residents.

The Utility of the Surprise Question in Identifying Patients Most at Risk of Death (TH360D)

Judith Vick, BA, Johns Hopkins University, Baltimore, MD. Nathan Pertsch, BA, Dana-Farber Cancer Institute, Boston, MA. Mathilde Hutchings, MPH, Ariadne Labs, Boston, MA. Bridget Neville, MPH, Ariadne Labs, Boston, MA. Rachelle Bernacki, MD MS FAAHPM, Dana Farber Cancer Institute, Boston, MA.

Objectives

- Identify the Surprise Question (SQ), its accuracy, and methods for employing it as a population management strategy for providing quality palliative care for all patients.
- Describe two reasons why the Surprise Question may be a more useful tool in research and administration than other prognostic indices that currently exist.

Original Research Background. Identifying patients at high risk of death is crucial to providing quality palliative care for all patients. Evidence suggests that the "Surprise Question" (SQ)—"Would you be surprised if this patient died within the next year?"—is useful in identifying those most at risk of death, but prior studies are limited by relatively small numbers.

Research Objectives. To calculate adjusted proportions of survival for patients about whom the SQ was asked. To determine predictors of death.

Methods. From August 2012 to October 2014, oncology clinicians at Dana-Farber Cancer Institute enrolled in an RCT on the impact of an intervention to improve conversations about values and goals—the Serious Illness Care Program. The SQ was posed to clinicians about their patients. A weighted propensity score approach was used to calculate adjusted proportions of survival at six months and one year, clustering by SQ clinician. To determine death predictors, we fit a multivariable Cox model, and looked for the largest increase in the Cox-regression goodness-of-fit c-statistic.

Results. 81 oncology clinicians enrolled in the study, and we had complete data on 4617 patients: 3821 (83%) for whom the clinician answered "Yes" to the SQ and 796 (17%) for "No." Propensity-adjusted one-year survival for "Yes" was 93% (95%CI 91-96%) vs. 53% (95%CI 46-60%) for "No" ($p<0.0001$). Sensitivity of the "No" response was 59% (95%CI 49-68%), and specificity was 90% (95%CI 86-93%). Positive predictive value was 49% (95%CI 45-54%), and negative predictive value was 93% (95%CI 90-95%). The SQ was more predictive of patient death than cancer type, age, cancer stage, or time since diagnosis.

Conclusion. The SQ identified cancer-center patients at high risk of death within one year better than cancer type, stage, patient age, or time since diagnosis.

Implications for Research, Policy, and Practice. The SQ is a useful tool to systematically identify patients at high risk of death.

Mild, Moderate and Severe Cut-Points for the Respiratory Distress Observation Scale: A Receiver Operating Characteristic Curve Analysis (TH361A)

Margaret Campbell, RN PHD FPCN, Wayne State University, Detroit, MI. Thomas Templin, PhD, Wayne State University, Detroit, MI. Katherine Kero, BSN, Wayne State University, Detroit, MI.

Objectives

- Describe the method for determining intensity cut-points for a symptom scale.

- Describe the results of an ROC curve analysis of intensity cut-points for the RDOS.

Original Research Background. The RDOS© is a solution to assessment of dyspnea when a self-report cannot be elicited, as typifies patients near death. The RDOS has scale reliability, inter-rater reliability, and convergent, construct, and discriminant validity. Previous cut-point determination with cognitively intact proxies for the intended RDOS population revealed 3 as an indicator of any distress (p<.01). Subsequent testing with dying patients was needed to distinguish mild-moderate from severe distress.

Research Objectives. To distinguish intensity cut-points of the RDOS.

Methods. Receiver Operating Characteristic (ROC) curve analysis was conducted with patients ranked by expert palliative care nurse practitioners (NP) into levels of respiratory distress—none, mild, moderate or severe. A research assistant measured the RDOS blinded to NP rating. Patients were near death and had one or more of heart failure, COPD, lung cancer or pneumonia.

Results. Participants were 84 adult inpatients; mean age 72.6 (SD = 15.2), 78% African American, 54% male, with mean Palliative Performance Scale 12 (SD = 4.6). Nurse-practitioner ranking was distributed: none = 25 (30%), mild = 22 (26%), moderate = 26 (31%) and severe = 11 (13%). RDOS scores ranged 0−13, mean = 4.84 (SD = 3.1). A strong, significant correlation between NP ranking and RDOS was found (rho =.91, p <.01). ROC curve analysis determined clinically meaningful cut-points (Table).

Ranking	RDOS	AUC	Sensitivity	Specificity	p
Any distress	≥3	.996	.93	1.0	<.01
Mild or Moderate	4-6	.948	. 97-.68	.80-.94	<.01
Severe	≥7	.958	.82	.90	<.01

Conclusion. In accordance with our aim, we identified RDOS cut-points distinguishing none vs. any distress and mild-moderate vs. severe. Furthermore, we validated our previous identification of RDOS 3 signifying any distress.

Implications for Research, Policy, and Practice. The additional psychometrics to identify intensity cut-points enhances the clinical utility of the RDOS. Clinician users of the RDOS may benefit from applying these cut-points into dyspnea treatment regimens.

Using the Distress Thermometer to Highlight Palliative Care Needs of Patients with Acute Myeloid Leukemia (AML) (TH361B)

Thomas LeBlanc, MD MA, Duke University School of Medicine, Durham, NC. Areej El-Jawahri, MD, Massachusetts General Hospital, Boston, MA. James Tulsky, MD FAAHPM FACP, Dana-Farber Cancer Institute, Boston, MA. Amy Abernethy, MD PhD FAAHPM, Flatiron Health, New York, NY.

Objectives

- Describe the magnitude and sources of distress faced by patients with acute leukemia.
- Recognize opportunities to integrate palliative care into the care of patients with acute leukemia to improve the cancer care experience and reduce patient distress.

Original Research Background. Distress screening is a recommended component of comprehensive cancer care, but the severity and sources of distress among patients with acute myeloid leukemia (AML) are unknown.

Research Objectives. To describe the etiology and severity of distress in patients with AML.

Methods. We enrolled hospitalized patients with AML who were initiating induction chemotherapy, and assessed their distress levels weekly during their month-long hospitalization using the NCCN distress thermometer (DT). The DT is a validated (0-10), 11-point ordinal scale with an accompanying 39-item problem list. We analyzed data using descriptive statistics and Kruskal-Wallis tests.

Results. Twenty-six patients provided complete data. Mean age of participants was 58.7 (SD 12.2). Most had high-risk disease characteristics, including 13 (50%) being > 60 years old, 13 (50%) with high-risk cytogenetics, and 9 (31%) with relapsed disease. Distress levels were high during the first week of induction (median 5.5; IQR 2-8). The most frequent concerns were from the "emotional problems" section of the DT problem list, including: worry (77%), nervousness (62%), fears (54%), and sadness (54%). Physical problems like fatigue (69%) and sleep difficulties (58%) were also prominent. Median distress scores remained above the threshold for referral to support services (score ≥4) in weeks two and three (median 4 (1-8) and 5.5 (2-7), respectively), but improved to 2 (1-6) in week four. Nervousness and worry were significantly improved at week four (p<0.01), but sadness persisted in 32% and fatigue in 60% of patients at the fourth assessment. Problems with eating and with diarrhea were also prominent in week four, at 48% and 36% respectively.

Conclusion. Distress is prominent among inpatients with AML who are receiving induction chemotherapy, with frequent psychological concerns upfront and persistent symptom distress in later weeks of therapy. These findings underscore the burden of unmet palliative care needs among hospitalized patients with AML.

Implications for Research, Policy, and Practice. Interventions are needed to address psychological and physical distress in leukemia patients.

Pain or Fatigue: Which Correlates More With Suffering? (TH361C)

Armida Parala-Metz, MD, Cleveland Clinic, Cleveland, OH. Chirag Patel, MD, Cleveland Clinic, Cleveland, OH. Ruth Lagman, MD MPH FACP FAAHPM, Cleveland Clinic, Cleveland, OH. Mellar Davis, MD FCCP FAAHPM, Horvitz Center for Palliative Medicine, Cleveland, OH.

Objectives

- Discuss the correlation of pain and fatigue to suffering in cancer patients.
- Compare the correlation of pain and fatigue to suffering, and identify other potential sources of suffering in cancer patients.

Original Research Background. Improvement of quality of life by prevention and mitigation of suffering in patients with life-limiting illnesses are the goals of palliative care. The association of pain and suffering seems intuitive, but evidence substantiating this association is still lacking. In surveys of cancer patients, fatigue, not pain, is the most prevalent and debilitating symptom.

Research Objectives. 1) Compare pain and fatigue severity and temporal pattern with suffering and 2) identify other factors contributing to suffering.

Methods. 150 cancer patients were surveyed. Fifteen variables were measured on a 0-10 point scale: suffering, pain, level of acceptable pain, effect of pain on quality of life, fatigue, level of acceptable fatigue, effect of fatigue on quality of life, and specific types of suffering (due to symptoms, spiritual distress, loss of enjoyment in life, concern for loved ones, unfinished business, fear of the future). Pearson correlation was used to assess the effect of pain and fatigue on quality of life and to assess the effect of continuous variables on suffering. Linear regression analysis and bootstrapping was used to model variables that are most related to suffering.

Results. Suffering was greater among patients who were depressed (mean 5.4 vs 4.3, $P=0.019$) and who feared pain (mean 5.5 vs 4.2, $P=0.008$). Highest pain (parameter estimate 0.38) has a greater impact on suffering than highest fatigue (parameter estimate 0.21). By linear regression modeling and bootstrapping, 36.2% of suffering was accounted for by pain "now," age, and fatigue in the past 24 hours.

Conclusion. The most important predictors of suffering in cancer patients are pain "now," younger age, and fatigue in the past 24 hours.

Implications for Research, Policy, and Practice. Designing interventions to reduce fatigue in addition to pain management may help in alleviating overall patient suffering.

Computerized Patient Reported Symptom Assessment in Radiotherapy: A Randomized, Controlled Pilot Trial (TH361D)

Erik Fromme, MD MSCR FAAHPM, Oregon Health & Science University, Portland, OR. Emma Holliday, MD, University of Texas MD Anderson Cancer Center, Houston, TX. Michelle Hribar, PhD, Oregon Health & Science University, Portland, OR. Karen Lyons, PhD, Oregon Health & Science University, Portland, OR. Lillian Nail, PhD RN, Oregon Health & Science University, Portland, OR.

Objectives

- Learn how to design a user-friendly touch screen device that acquires patient reported symptom and quality of life measures and produces a report that can be used in radiotherapy clinician office visits.
- Learn how the application is performed in a pilot randomized trial and how such application's performance can be assessed.

Original Research Background. Computer-based, patient-reported symptom survey tools have been described for patients undergoing chemotherapy.

Research Objectives. We hypothesized that patients undergoing radiotherapy might also benefit, so we developed a computer application to acquire symptom ratings from patients and generate summaries of patient-reported symptoms for use at point-of-care office visits. Next, we conducted a randomized-controlled pilot trial to test its feasibility.

Methods. Subjects were randomized prior to beginning radiotherapy. Both control and intervention group subjects completed the computerized symptom assessment, but only for the intervention group were printed symptom summaries made available before each weekly office visit. Metrics compared included the Global Distress Index (GDI), concordance of patient-reported symptoms and symptoms discussed by the physician, and numbers of new and/or adjusted symptom management medications prescribed.

Results. 112 patients completed the study, with 54 in the control and 58 in the intervention arms. 109 (97.3%) patients were treated with curative intent. There were no differences in GDI over time between the control and intervention groups. In the intervention group, more symptoms reported by subjects using the computerized questionnaire were actually discussed in radiotherapy office visits: 46/202 vs. 19/230. A sensitivity analysis to account for within-subjects correlation yielded 23.2% vs. 10.3% ($p=.03$). Medications were started or adjusted at only 15.4% (43/280) of control visits compared to 20.4% (65/319) of intervention visits (p=.07).

Conclusion. This computer application is easy to use and makes extensive patient-reported outcome data available at the point of care. Although no differences were seen in symptom trajectory, patients for whom printed symptom summaries were made available had improved communication during office visits and a trend towards more active symptom management during radiotherapy.

Implications for Research, Policy, and Practice. These findings suggest that this technology has real potential to improve patient outcomes if incorporated as part of a multi-modal intervention, but this needs to be validated in a multi-site randomized trial.

FRIDAY, MARCH 11 7—8 am

Early-Riser Concurrent Sessions

Affecting Change: Putting Theory to Practice (FR400)

Ira Byock, MD FAAHPM, Providence Health and Services, Redondo Beach, CA.

Objectives

- Identify at least 4 common barriers to change in healthcare systems.
- Identify at least 4 categorical forces that influence human behavior.
- Plan for organization and system change through mission-oriented, values-based approaches that apply multiple tactics and coordinate efforts of key stakeholders to achieve strategic goals.

We all recognize the need for constructive change in our organizations, health systems, and society. Indeed, change is inevitable. The capacity to adapt is a feature of healthy individuals and groups. Still, the prospect of redesigning complex systems, correcting long-held assumptions, and changing established behaviors can seem daunting. Understanding the nature of change and the key elements of strategic planning can enable substantial progress to occur against seemingly long odds.

Principles, theories, and time-tested approaches to change have proven effective in business and social movements. We will review fundamental social and organizational architecture and basic elements of individual and group behavior (such as rules, motivation, incentives, rewards, and penalties). Common contemporary barriers to change include limited financial and personnel resources, time pressures, productivity expectations, and competing priorities, including an ever-present tyranny of the urgent.

Salient theories of change offer guidance from psychology (Prochaska's Stages of Change), business (Kotter's Eight-Stage Process), sociology (Roger's Diffusion of Innovation), negotiation (Fisher's Getting to Yes), and social activism (natural birthing, among others). These lessons illuminate component strategies for relaxing resistance to change, converting new champions, and shifting problematic patterns of practice and redesigning health service delivery to create measurable improvements in patient-centered outcomes.

The session will be highly interactive. Participants will be invited to brainstorm how these principles may apply to current organization goals or initiatives. We will identify key constituencies and examine how multiple, mutually-reinforcing levers of change can be integrated within a cohesive strategic plan to advance new programs and initiatives within organizations, systems, and communities.

Don't Be a Boiling Frog: Take Action to Prevent Burnout (FR401)

Janet Bull, MD HMDC FAAHPM, Four Seasons, Flat Rock, NC. Martha Twaddle, MD FACP FAAHPM, JourneyCare, Barrington, IL. Sandra Bertman, PhD FT LCSW, Good Shepherd Community Care Institute, Newton, MA.

Objectives

- Demonstrate the incidence and most common features associated with burnout.
- Learn reflective practices techniques to reduce and prevent burnout.
- Develop a plan to foster self-care and increase resiliency.

Burnout is highly prevalent in the field of hospice and palliative medicine. High rates of depersonalization and emotional exhaustion can have devastating effects on a clinician's quality of life and affect relationships in harmful ways. Depression, anxiety, substance abuse, and suicide ideation are associated with high burnout rates. Burnout may lead clinicians to either change career paths or leave medicine all together. Patient outcomes suffer when burnout rates are high, with an increase observed in medical errors and failure-to-rescue rates and lower patient satisfaction scores. As demand for hospice and palliative care continues to grow and outweigh supply, clinicians will be under increased pressure to see more patients and work in areas where staffing in short supply.

In this presentation, we will discuss who is at greatest risk for burnout and the impact it's having on our field. Results from the 2013 AAHPM survey will be shared, which includes data from more than 1000 members and will be analyzed by age, gender, hospice versus palliative care, years in the field, and care settings. Interventions focused on enhancing reflective practice will be explored, which include gratitude, meditation, journaling, and use of art, poetry, and literature. Debriefing difficult cases, use of team support and collaboration, recognition of transference, and boundary violation will be discussed as well. While each individual will be encouraged to develop a practice that works for them, our hope is that clinicians will leave the session with tools and techniques they can incorporate into daily practice to reduce the risks of burnout. The boiling frog analogy is fitting; a frog placed in boiling water recognizes the temperature and hops out quickly, whereas a frog put in tepid water and brought to a boil dies as he loses the ability to recognize the danger.

Final Destination: Air Travel in the Setting of a Terminal Illness (FR402)

Adam Marks, MD, University of Michigan, Ann Arbor, MI. Janice Firn, MSW, University of Michigan, Ann Arbor, MI. Kaoru Harada, BS, University of Michigan, Ann Arbor, MI.

Objectives

- Understand the physiologic changes associated with air travel and the impact these changes have on advanced illness.
- Recognize the practical and medical barriers to air travel for patients with advanced illness.
- Review potential procedural issues around air travel with a terminal disease.

The world in which we practice medicine is increasingly global, and many patients receiving palliative or hospice care may want to travel by air during the end-stages of their disease. This request to travel may carry with it profound hopes for a meaningful end of life. As specialists in advanced and terminal disease, palliative care providers should have a working knowledge of how to manage the medical and practical complexities of air travel at the end of life.

We will begin this concurrent session with two case reports of patients with advanced, terminal disease who express the wish to travel to their home country. We will then provide an overview of the physiologic changes associated with air travel, and the impact these changes can have on a variety of common advanced disease states. We will review current “fit to fly” regulations, as well as how to anticipate and manage symptoms that might occur during an international flight and how to counsel a family and patient for the possibility of death in flight. Finally, we will discuss international medical insurance coverage, and how to determine what (if any) hospice resources may be available in the international setting.

Managing Constipation Without Laxatives: What Is new? Is It possible? Should We? (FR403)

Mellar Davis, MD FCCP FAAHPM, Horvitz Center for Palliative Medicine at Taussig Cancer Institute, Cleveland, OH.

Objectives

- Assess constipation using the categories of medical and perceived constipation and have a fundamental understanding of assessment tools.
- Assess the strength of evidence for the use of non-laxative approaches to constipation to determine whether they should be used in palliative care.
- Understand the rationale for non-laxative drug combinations.

Laxatives have been standard treatment for constipation and prophylaxis for those on opioids. However, laxatives have not been subject to randomized controlled trials compared with placebo, and there have been few comparisons between laxatives. Half of patients respond poorly to laxatives and side effects are common. The cause of constipation in advanced illness is usually multifactorial and laxatives are not targeted specifically to the cause of constipation. Constipation assessment is based on medical (classically defined as $<$ 3 spontaneous bowel movements per week) and perceived constipation. Multiple tools have been developed to assess constipation responses in clinical trials though primary outcomes are most often based on medical constipation. Over several years, multiple medications have been developed to treat chronic idiopathic constipation, constipation associated with functional bowel syndromes, and opioid induced constipation (OIC). These medications include 1) prucalopride, a selective receptor agonist; 2) lubiprostone, a chloride channel agonist; and 3) linaclotride, a quanylate cyclase-C agonist. Comparisons have been made among these agents and placebo in randomized trials. Among the peripheral restricted mu-receptor antagonists used to treat or minimize OIC are methylnaltrexone, alvimopan, naloxegol, and the combination analgesic, sustained-release oxycodone/sustained-release naloxone. The number needed to treat to benefit those on opioids on peripheral mu-receptor inhibitors ranges between 3 and 5, consistently. Lubiprostone also has been licensed for OIC. Recent evidence suggests that gut microbiota control gut motility, which is altered by chemotherapy and antibiotics. Probiotics containing *Lactobacillus* and *Bifidobacterium* species improve constipation in patients with functional constipation by increasing migrating myoelectric complexes and as a result reduces transit time. This workshop will review the evidence and clinical use of lubiprostone, prucalopride, linaclotride, probiotics, and restricted mu-receptor antagonists in the management of constipation.

SOS: Soothe Our Souls—A Support Program for Nurses to Develop Resiliency (FR404)

Vickie Leff, MSW LCSW ACHP-SW, Duke University Hospital, Durham, NC. Tracey Lanier, RN, Duke University Hospital, Durham, NC. Tanya Arbogast, PA-C, Duke University Medical Center, Durham, NC.

Objectives

- Identify emotional support needs and barriers of inpatient nursing staff.
- Outline an effective plan to implement monthly resilience/support group for bedside nursing staff; including administrative support.
- Use professional Quality of Life survey to measure success level of intended group.

Nurses have a high level of burnout in both palliative care and hospice. Finding programs that can specifically meet their unique support needs is critical for maintaining their quality of care, career satisfaction, retention, and overall wellbeing. Nursing care usually involves long stretches of time during which it is difficult to conduct any daily self-care or team support. Seeing the high turnover rates and hearing of the difficulties our staff were having on our pulmonary step down unit in our acute care hospital, we have worked for over 2 years on designing a program that could both meet the emotional needs of our staff and instill long term resilience techniques. The SOS (Soothe Our Souls) monthly meetings were specifically designed for bedside nurses working with critically ill, often dying, patients. In addition to designing a usable and portable group structure, we worked with administration to gain their support and financial assistance in providing these groups to our staff. We think this unique group model can easily be adapted to many settings to provide the type of support, meaning making, and resilience skill building that nurses in particular need and deserve. We will reveal the initial findings from our pre- and post-quality of life measurements from participants to inform future interventions and designs.

Palliative Care Research Funding Across the NIH and ACS: Who, What, When, Where, Why, and How? (FR405)

Jeri L. Miller, PhD, National Institute of Nursing Research, Bethesda, MD. Basil A. Eldadah, MD PhD, National Institute on Aging, Bethesda, MD. Lynne Padgett, PhD, American Cancer Society, Atlanta, GA.

Objectives

- List current funding opportunities for research in palliative care at various NIH Institutes and the ACS.
- Identify research priorities in hospice and palliative care across NIH Institutes and the ACS.
- Identify NIH Institute and ACS contacts and resources to assist in NIH and ACS grant applications.

What funding opportunities are available in palliative care research? Who gets funded? What went wrong? My proposal wasn't discussed! Wouldn't having a dedicated study section solve most of my research problems? Can I really submit a grant an unlimited number of times? Am I allowed to talk to Program Directors/Project Officers? What is an Early Stage Investigator/New Investigator? If you've asked these questions in the process of submitting a proposal, you are not alone.

This symposium targets the needs of both junior and senior investigators interested in obtaining research funding from the National Institute of Nursing Research, National Cancer Institute, National Institute on Aging, and the American Cancer Society. In a roundtable format, representatives from these funding agencies will provide brief presentations that highlight their funding priorities in end-of-life and palliative care science, important funding policies, specific funding announcements and collaborative opportunities, and recent policy changes affecting grant submission. Presentations will also provide new or junior investigators with tips on grantsmanship, whom to contact for questions, and common pitfalls of the submission and review process. The forum will provide opportunities for question and answer discussion from the audience and information sharing on useful resources for applicants.

8:15–10 am

Plenary Session

Toward Better Public Spaces: Transforming Our Cities Through Art and Design (103)

Candy Chang Taiwanese-American artist, New Orleans, LA.

Objectives

- Inspire self-examination and personal development.
- Generate ideas for community engagement and collaboration.
- Discuss creative approaches to their own work.

Combining urban planning, street art, and graphic design, Candy Chang transforms simple objects such as stickers, stencils, and chalkboards into powerful tools that spark conversations in public spaces around the world. In her talks, she poses new strategies for civic life and inspires you to think differently about how you approach your own work. Through personal stories from her childhood to the present, she will illustrate how seemingly disparate experiences in countries from Kazakhstan to South Africa to Finland have come together to incite new perspectives and form a coherent philosophy. Carefully crafted for each audience and cultivated from her own evolving questions, Chang's provocative and intimate talks explore the power of personal introspection in public space and what we can learn from our collective wisdom.

10:45–11:45 am

Concurrent Sessions

PC-FACS 2015: A Year in Review (FR410)

Donna S. Zhukovsky, MD FACP FAAHPM, MD Anderson, Houston, TX. Mellar Davis, MD FCCP FAAHPM, Horvitz Center for Palliative Medicine at Taussig Cancer Institute, Cleveland, OH.

Objectives

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

PC-FACS (Fast Article Critical Summaries for Clinicians in Palliative Care), one of the highest rated member benefits of the American Academy of Hospice and Palliative Medicine, offers busy clinicians an efficient way to stay on top of pertinent literature in a field that is rapidly expanding. Now in its 11th year, PC-FACS, delivered in a convenient format to the email box of Academy members, provides topical electronic summaries of just published research from more than 100 journals that are not specifically dedicated to HPM and might not otherwise come to attention. Editorial board members, peer experts selected from the Academy membership, author succinct, thought-provoking commentaries that have practical implications for practice and for the field as a whole. In addition to monthly issues that offer commentaries spanning the gamut from basic science; bioethics, humanities, and spirituality; geriatrics and care transitions; hospice, hospice and palliative medicine interface, and regulatory issues; pediatrics; and psychosocial issues to symptom assessment and management, PC-FACS now offers special issues that provide more in-depth coverage of one or more of these topic areas. In this session, Editor-in-Chief Donna S. 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. Session participants will have an opportunity to contribute their own perspectives of the literature for an enriched discussion of the clinical implications of this research.

Upstream Adventures: Initial Results from a Clinical Trial of Early Palliative Care, Delivered in the Community by Trained Lay Persons (FR411)

Eric Anderson, MD, Allina Hospice & Palliative Care, Minneapolis, MN. Sandra Schellinger, MSN NP-C, Allina Health, Minneapolis, MN.

Objectives

- Describe the role of trained lay persons in delivering palliative care.
- Identify the key outcomes that result from early introduction of palliative care.

Beginning in 2012, a large Minnesota healthcare system designed a late life supportive care model to address the question: Will whole-person support for patients with serious illness and their families result in better quality-of-life and care experience, and will it improve utilization and access to palliative care and hospice?

The intervention (LifeCourse) is an in-home approach, structured on the domains and recommended practices of palliative care. LifeCourse is delivered primarily by trained lay persons (care guides) supported by a clinical team. It is directed to persons with heart disease, cancer, and dementia who are living with serious illness and may be in the last 3 years of life. About 1200 individuals, including participants, family members, and comparison patients and families, are enrolled to date. All are surveyed quarterly.

We will describe the hiring, training, and workflows that allow care guides to address National Quality Forum-identified best practices. We will describe their role in recognizing issues upstream, communicating goals of care, and empowering patients and families to find solutions to their needs.

Early results of the intervention were analyzed using a mixed methods study, comparing LifeCourse to usual care. For LifeCourse patients and families, several aspects of quality of life and care experience fared better than for comparison patients and families. Hospital days in the last 6 months of life were lower for LifeCourse patients, and emergency department visits were significantly reduced. LifeCourse patients were more likely to be referred to inpatient palliative care and hospice, and they spent about twice as many days under hospice care. Total cost of care data was available from a subset of patients. These individuals were statistically matched to similar-spending controls and followed over time. Overall spending was lower for the LifeCourse patients. This intervention shows promise in extending the reach of palliative care.

Update on Spinal Cord Compression: The Key Role of the Hospice or Palliative Care Clinician (FR412)

Janet Abrahm, MD FAAHPM, Dana-Farber Cancer Institute & Brigham Women's, Boston, MA. Tracy Balboni, MD MPH, Dana-Farber Cancer Institute, Boston, MA. Andrea Cheville, MD MSCE, Mayo Clinic, Kasson, MN. Marco Ferrone, MD, Brigham & Women's Hospital, Boston, MA.

Objectives

- Assess a cancer patient who presents with back pain and with possible malignant spinal cord compression (SCC) and identify the essentials of symptomatic treatment of the patient during evaluation and SCC therapy.
- Discuss how, by informing colleagues about the SCC patient's goals, values, hopes, and fears, hospice and palliative care clinicians can facilitate communication among the clinical stakeholders (eg, radiation oncologists, medical oncologists, physiatrists, and surgeons) to develop a patient-centered plan as rapidly as possible. Review the benefits and burdens of the therapeutic options for these patients and be able to facilitate translation of these the options to the patient and family. Apply principles of prognostication in patients with SCC to ensure that prognosis informs the decision-making and that it is used to guide future care, eg, to facilitate enrollment in hospice for appropriate patients.
- Identify the role of rehabilitation specialists in managing patients with physical impairments and their activity and participation limitations from SCC.

Hospice and palliative care clinicians are often asked to consult on cancer patients with back pain. Because these patients may have normal neurologic exams, the referring team may not have evaluated the patient for spinal cord compression (SCC) even though research indicates that back pain alone in these patients should trigger an MRI. Hospice and palliative care clinicians, therefore, have a crucial role to play in protecting patients from what can be a catastrophic and life-changing injury. Even patients with prognoses limited to months can benefit if the epidural tumor is found and treated before weakness or bowel or bladder incontinence develop. Only 40%-50% of paraparetic patients will walk again after treatment; and only 10% of paralyzed patients ever regain their ability to walk. A high index of suspicion and strong advocacy for obtaining a full spine MRI are keys to detecting epidural disease before it progresses to SCC. Once SCC is found, hospice and palliative care clinicians assist the multidisciplinary team in deciding on therapeutic recommendations by sharing the patients' goals and values together with their hopes and fears. Furthermore, they can assist in educating patients and their families about the burdens and benefits of spinal surgery, single or multiple fraction radiation therapy, stereotactic body radiation therapy (SBRT), or pharmacologic and rehabilitative therapy alone. Rehabilitation therapists can ameliorate disability from spinal cord compression, whether or not patients receive specific SCC treatment. They help patients and their families cope with residual limitations, and achieve their goals. This presentation will enable hospice and palliative care clinicians to make an early diagnosis of SCC, provide expert symptomatic treatment, understand the benefits and burdens of the various therapeutic options, identify patients eligible for hospice care by virtue of the alteration in prognosis created by the SCC, and understand the role of various rehabilitative therapies.

A New Framework for Resilience Skills to Prevent Burnout and Ensure Sustainability (FR413)

Anthony Back, MD, University of Washington, Seattle, WA. Vicki Jackson, MD MPH FAAHPM, Massachusetts General Hospital and Harvard Medical School, Boston, MA. Karen Steinhauser, PhD, VA and Duke Medical Centers, Durham, NC. Arif Kamal, MD, Duke Cancer Institute, Durham, NC.

Objectives

- Identify key elements of a new framework for resiliency skills for palliative care clinicians.
- Use a method for tracking emotional arousal and self-regulating emotional arousal.
- Learn a mindfulness habit that enables a micro-break during the day.

Burnout is now a critical issue for PC clinicians. Palliative care clinicians care for persons experiencing physical, emotional, and existential suffering. In the face of this suffering, it is not surprising that PC clinicians experience reactions of their own. Unfortunately, for too many palliative care clinicians, a profession that began with an aspiration to serve patients and families results in unresolved stress and burnout. To address this urgent need, we have designed a new burnout prevention and sustainability intervention, named "Refresh," that draws on conceptual models addressing both individual level and system level issues, so that even as this intervention focuses on individual skills, these skills are designed to assist clinicians in managing system level stressors. A 3-site pilot study has been funded by the National Palliative Care Research Center and the Gold Foundation; preliminary data will be presented. In this session, we will preview the conceptual framework of Refresh and teach 2 resilience skills in brief experiential exercises, so that attendees will practice these skills. We will also present dissemination plans to make this intervention widely available. This session is applicable to palliative care clinicians from all disciplines.

Dignity Therapy: Narratives at the End of Life (FR414)

Michelle Weckmann, MD FAAHPM, University of Iowa Hospitals & Clinics, Iowa City, IA. Emily White, BS, University of Iowa, Iowa City, IA. Lori Montross Thomas, PhD, University of California San Diego, San Diego, CA.

Objectives

- Describe the utility of Dignity Therapy and recognize which patients and families would benefit from a dignity therapy referral.
- Understand the framework for using Dignity Therapy at end of life and how the framework provides a means to explore themes and analyze narratives in medicine.
- Observe how Dignity Therapy can be used to create rich patient narratives in a variety of settings by a variety of providers.

Ninety percent of US physicians believe that the concept of human dignity has "practical relevance for clinical medicine." It has been shown that loss of dignity has profound implications at the end of life and is the most common reason patients seek out physician-assisted death. Understanding dignity through the patient's narrative would provide areas of attention for the mitigation of suffering at the end of life and help to prevent dignity loss. Dignity Therapy is a brief psychosocial therapeutic intervention designed to generate a patient narrative. It has been shown to improve quality of life, suffering, and depression in patients nearing the end of life.

This presentation will explore the narrative themes that form the framework of Dignity Therapy (ie, generativity, continuity of self, role preservation, maintenance of pride, hopefulness, aftermath concerns, and care tenor) in their relation to the narratives collected during various therapy sessions. This discussion of dignity therapy narrative analysis will explore the pedagogy, the translation of education to clinical practice, and provide an assessment of narrative therapy. Following the presentation, participants will be able to describe the utility of Dignity Therapy, discuss narrative-based therapy in medicine, understand the framework for using this therapy at end of life, and realize the potential for students and volunteers to execute narrative therapy.

Exploring Spiritual Needs of Children Facing Life-Threatening Illness (FR415)

Elisha Waldman, MD, Morgan Stanley Children's Hospital, New York, NY. George Handzo, MA, Handzo Consulting, Los Angeles, CA.

Objectives

- Summarize the current state of our understanding of spiritual needs of children facing life-threatening illness.
- Learn basic skills for being a spiritual generalist and how to begin exploring spiritual needs of children facing life-threatening illness.

Many of those who work with children facing life-threatening illness report that these children have complex spiritual needs. Yet, little is known about the nature of these needs and what approaches might be most suitable, especially for the generalist without any training in pastoral care. There is increasingly robust literature on the spiritual needs of adults facing life-threatening illness. But the literature from pediatrics remains limited; the subject is particularly challenging because of developmental issues, diverse cultural backgrounds, and a hesitance on the part of many parents and clinicians to explore this sensitive territory. After reviewing the adult literature, we will review theories of children's spiritual development as well as review in detail what peer-reviewed literature on spiritual needs of children facing life-threatening illness does exist. Having identified what we do and don't know, and where we may benefit from more research, we will go on to review some practical tips and approaches to exploring spiritual needs of these children. Skills reviewed will include approaches to being a spiritual generalist, partnering with other practitioners (such as chaplaincy and child life), and adapting tools such as FICA in an age- and developmentally-appropriate way to screen for spiritual distress and to evaluate needs. We will also introduce several examples of situations where generalists might encounter challenges surrounding evaluation of spiritual needs of children facing life-threatening illness, along with discussion and suggestions as to how such situations might be safely navigated. Participants should emerge with a basic understanding of spiritual needs of children facing life-threatening illness, a grasp of what it means to be a spiritual generalist, and some basic tools for evaluation.

Speed Dating with Pharmacists: The Pharmacy Ladies Ride Again! (FR416)

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

Objectives

- Discuss 3 pearls related to pharmacology of palliative medications.
- Discuss 3 pearls related to appropriateness of maintenance medications in EOL care.
- Discuss 3 pearls related to using palliative medications in a safe and effective manner.

After “meeting” in 2012, a bond has formed and new tips are on the way for Round Four. 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 1-hour session will flirt with tips and tricks on using medications appropriately for patients facing advanced diseases. Whether debriding a medication profile, aggressively treating symptoms, or strategizing a dosage formulation, it can be hard to commit to medication decisions. Two pharmacists will speed-date their way through medication tips designed to highlight important and little known medication facts that are important in palliative medicine. Topics to be covered include determining appropriate maintenance medications, side effects such as hypogonadism with opioids, alternate administration of oral medications, using topical products, tips for maximizing dosing of patches, buccal vs transmucosal administration, medications that you can crush vs dissolve, and more! Finding a tip you are compatible with just may change your life.

Finding the Right Fit: How to Use the Evidence to Make a Great Hire (FR417)

Juliet Jacobsen, MD, Massachusetts General Hospital and Harvard University, Boston, MA. Lori Earnshaw, MD, University of Louisville, Louisville, KY. Jane deLima Thomas, MD FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Identify challenges specific to hiring in palliative care.
- Reflect on how programs can prepare themselves to make a good hire by clearly defining their mission and strengths.
- Explore strategies for screening and interviewing candidates such as the use of behavioral interviewing techniques and personality tests.

Hiring the right person, whether social worker, nurse practitioner, physician assistant, or physician, is a high-stakes task in palliative care. This interactive session begins by exploring challenges specific to hiring in palliative care, such as the need to screen for candidates who can process complicated emotional stressors, manage counter-transference, and work well in teams. We will then focus on strategies for making a good hire. First, we will teach how programs can reflect on their mission, vision, strengths, and needs to create a shared mental model of the right candidate and use this model to screen and recruit applicants. Second, we will discuss and practice how to use behavioral interviewing techniques to learn more about how the candidate’s job performance can be gauged during the interview. Finally, we will discuss the use of personality tests as an additional source of information in the hiring process.

“Bas Sona”: Healing Versus Sedating Using a Celtic Framework for Total Pain (FR418)

Kevin Dieter, MD FAAHPM, Summa Health System, Canton, OH. Cheryl Waitkevich, MN FNP-BC, Providence St Peter Hospital, Olympia, WA. K.J. Williams, MD, Visiting Physician Associates, Madison, WI. Rachel Berry, BSN RN, Stein Hospice Service, Inc, Sandusky, OH.

Objectives

- Discuss the importance of addressing emotional and spiritual needs as an essential components of pain and symptom management.

- Describe the relationship between meaning, forgiveness, relatedness, and hope to healing, wellness, and health.

One of the problems inherent in our current medical model is the tendency to address and manage suffering as if it were a symptom with a purely physiologic basis that can be "fixed." According to Michael Kearney, MD, Western medicine has no model to help people live through their suffering. As a result, clinicians often find themselves treating suffering solely through pharmacologic means, which can mask the real opportunities for healing for both the patient and the clinician.

In this session, we will identify the four dimensions of spiritual pain, which contribute to Dame Cicely Saunders' concept of "total pain," and we will explore the relationship between spiritual pain, healing, and clinician wellness. The attendees will learn about practical tools that can augment pharmacologic management of suffering, explore useful approaches to suffering from ancient wisdom traditions, and experience the impact of a team approach to care that embodies the belief that "WE are the medicine."

Paper Sessions

Risk Factor Assessment of Hospice Patients Who are Readmitted Within Seven Days of Acute Care Hospital Discharge (FR419A)

Anthony Wilson, MD, North Shore Long Island Jewish, New Hyde Park, NY. Diana Martins-Welch, MD, North Shore Long Island Jewish, New Hyde Park, NY. Earle Bridget, MD, North Shore University Hospital, Manhasset, NY. Andrzej Kozikowski, PhD, North Shore Long Island Jewish, New Hyde Park, NY. Lori Ann Attivissimo, MD FACP FAAHPM HMDC, North Shore Long Island Jewish, New Hyde Park, NY.

Objectives

- Become aware of the differences between readmission rates for different populations.
- Generate ideas for reasons differences exist between readmission rates for different populations.

Original Research Background. Although 20% of adults 65 and older are rehospitalized within 30 days of discharge, there is a dearth of research investigating readmission of patients discharged to hospice and the predictors of these readmissions.

Research Objectives. To identify risk factors for hospital readmission within seven days of discharge to home hospice.

Methods. This was a retrospective case-control study with cases being patients discharged to home hospice that were readmitted to the hospital within seven days. Controls were patients discharged to home hospice and not readmitted to the hospital within seven days. The Chi-square test or Fisher's Exact test were used to compare categorical predictors between cases and controls. The two-sample t-test or the Mann-Whitney test were used to compare continuous predictors between cases and controls.

Results. There were 163 subjects, 46 cases (28.22%) and 117 controls (71.78%). The most frequent hospital diagnosis was cancer (56.4%). There was a significant association between seven-day readmission (i.e., case) and age ($P < 0.0041$), race ($P < 0.0008$), language ($P < 0.0007$), and insurance ($P < 0.0001$). Specifically, cases were significantly younger than controls (69.5 vs. 77.0). Cases were more likely to be Hispanic (15.2 vs. 5.1), Asian (15.2 vs. 5.1) and other (13.0 vs. 2.6) when compared to controls. Cases were more likely to speak Spanish (13.3 vs. 3.5) or other (20.0 vs. 5.3) and less likely to speak English (66.7 vs. 91.2). Cases were less likely to have Medicare (8.7 vs. 82.9) and more likely to have Medicaid (32.6 vs. 4.3), private insurance (13.0 vs. 10.3), or another form of insurance, including dual-eligibility (45.7 vs. 2.6).

Conclusion. Our data highlights four risk factors, namely age, race, language and insurance status, as factors predicting readmission within seven days of acute care hospital discharge.

Implications for Research, Policy, and Practice. Further study of these predictors may identify opportunities for interventions to obviate these readmissions.

The Burden of Healthcare Costs in the Last Five Years of Life (FR419B)

Amy Kelley, MD MS MSHS, Mount Sinai School of Medicine, New York, NY.

Objectives

- Learn about the total social costs (i.e., personal/familial costs and external/governmental costs) experienced in the last five years of life across a range of illnesses.
- Learn about the financial risk faced by Medicare beneficiaries in the last five years of life.

Original Research Background. Common diseases, particularly dementia, entail large social costs, previously well-described for the U.S. population. Less is known about end-of-life costs of specific diseases and the associated financial risk for individual households.

Research Objectives. We aimed to examine social costs (i.e., personal/familial costs and external or governmental costs) and financial risks faced by Medicare beneficiaries five years before death.

Methods. Using the nationally representative, longitudinal Health and Retirement Study, we sampled Medicare fee-for-service beneficiaries, aged 70 years or older, who died between 2005 and 2010 (N = 1702). Subjects were stratified into four cohorts: individuals with high probability of dementia, or with either heart disease, cancer, or other causes of death. Measurements included total social costs and its components (Medicare, Medicaid, private insurance, out-of-pocket, and informal care), measured over the last five years of life and out-of-pocket spending as a proportion of household wealth.

Results. Average total cost per decedent for dementia ($287,038) was significantly greater than for those who died of heart disease ($175,136), cancer ($173,383), or other causes ($197,286), p<0.001. While Medicare expenditures were similar across groups, average out-of-pocket spending for dementia patients ($61,522) was 81% higher than for non-dementia patients ($34,068); a similar pattern held for informal care. Out-of-pocket spending for the dementia group (median $36,919) represented 32% of wealth measured five years before death, compared to 11% for non-dementia decedents (p<0.001). This proportion was greater for Blacks (84%), those with less than high school education (48%), and unmarried/widowed women (58%).

Conclusion. Healthcare expenditures among those with dementia were substantially larger than for other diseases, with much of those expenses uninsured, thus placing a large financial burden on families. These burdens are particularly pronounced among demographic groups least prepared for financial risk.

Proactive, Community-Based Palliative Care Reduces End-of-Life (EOL) Hospital Utilization and Costs (FR419C)

J Brian Cassel, PhD, Virginia Commonwealth University, Richmond, VA. Daniel Hoefer, MD, Sharp HealthCare, San Diego, CA. Suzanne Johnson, MPH RN, Sharp HealthCare, La Mesa, CA. Kathleen Kerr, BA, Kerr Healthcare Analytics, Mill Valley, CA. Donna McClish, PhD, Virginia Commonwealth University, Richmond, VA.

Objectives

- Understand methods used in observational research on community-based palliative care and the collaboration between community health system and academic researchers.
- Quantify impact of community-based palliative care on utilization and costs.
- Assess financial sustainability and replicability of this model.

Original Research Background. Palliative care (PC) delivered proactively in ambulatory and community settings to patients with progressive, life-limiting diseases is becoming more common. In this paper, we evaluate the impact of one such program: the Transitions program at Sharp HealthCare.

Research Objectives. Evaluate utilization and costs for Transitions patients matched to comparison patients.

Methods. We analyzed clinical, billing and administrative data from 2007-2014. Patients had one of four diseases (cancer, COPD, CHF or dementia), Medicare Advantage, two or more years of utilization data, and were known to be deceased. Transitions patients (37 cancer, 65 COPD, 174 CHF, 92 dementia) were matched to comparison patients (111 cancer, 189 COPD, 499 CHF, 276 dementia) using the logit of the propensity score. Multivariate statistics were used to evaluate the impact of Transitions enrollment on utilization and costs. Outcomes were assessed from point of enrollment in Transitions forward, using the same number of days prior to death for the matched comparison patients.

Results. For each disease, hospital and total expenditures per month were lower for Transitions patients (p<=.002). For each disease, the percentage of patients hospitalized and the number of hospital days were lower for Transitions (p<=.0001). For each disease, the percentage being admitted in the final 30 days of life (p<.0001), using the ICU in the final 30 days of life (p<.0005), and dying in the hospital (p<.0001) were lower for Transitions. The mean 30-day re-admission rate was lower for Transitions patients with COPD, CHF and Dementia (p<=.01), but not with cancer (p=.08). The mean differential in expenditures attributable to Transitions ranged from $10,653 per patient for cancer to $23,685 for COPD. The costs of the program averaged $4,585 per patient.

Conclusion. The Transitions program had significant impact on utilization and fiscal outcomes across four disease groups.

Implications for Research, Policy, and Practice. These findings can inform efforts to design and evaluate similar programs elsewhere.

The Impact of a Perinatal Palliative Care on Length of Stay, ICU Days and Invasive Procedures (FR419D)

Heidi Kamrath, DO, University of Minnesota, Minneapolis, MN. Jennifer Needle, MD MPH, University of

Minnesota, Minneapolis, MN. Erin Osterholm, MD, University of Minnesota, Minneapolis, MN. Rachael Stover-Haney, MSW LICSW, University of Minnesota Masonic Children's Hospital, Minneapolis, MN.

Objectives

- Describe the history, epidemiology, and role of perinatal palliative care.
- Examine the impact of perinatal palliative care on neonatal outcomes at the University of Minnesota.
- Explore the potential benefits of perinatal palliative care for the infant, the parent, and the healthcare system.

Original Research Background. The Perinatal Palliative Care Program (PPCP) at the University of Minnesota is a multidisciplinary program involving maternal-fetal medicine, neonatology, genetics and social work. This team coordinates palliative care services for families whose infants have prenatally diagnosed life-limiting conditions.

Research Objectives. The aim of this study was to investigate the impact of perinatal palliative care planning on care provided for infants born with a life-limiting condition. We hypothesized that perinatal palliative care planning would decrease length of stay (LOS), number of neonatal intensive care unit (NICU) days, and number of invasive procedures.

Methods. This was a retrospective chart review of infants with life-limiting conditions treated from 1/01/11-9/30/14. Infants were identified through PPCP records and NICU death records. Descriptive statistics were used to describe the patient populations, continuous data was analyzed using the Mann-Whitney *U* test, and categorical data were analyzed with Fischer's exact test.

Results. Twenty-seven infants were identified, 18 in the PPCP cohort and 9 in the No PPCP cohort. Infants with an active palliative care plan at birth had a statistically significant decrease in number of NICU days ($p=0.001$), invasive procedures performed ($p=0.0008$), CPR ($p=0.002$) and resuscitation medication administration ($p=0.008$).

Conclusion. Perinatal palliative care is a relatively recent concept in the field of palliative care medicine. This study provides novel data that a perinatal palliative care program can alter interaction with the healthcare system after birth for newborns with life-limiting conditions.

Implications for Research, Policy, and Practice. Given the alteration in interaction with the medical system after birth, perinatal palliative care planning may lead to a decreased stress burden on families, caregivers and the infant. Additionally, perinatal palliative care planning may decrease cost of care for these infants. Future research involving families and caregivers would be informative.

Nurses Have the Magic Touch: Determining the Effect of Embedding a Palliative Care Nurse Within the MICU (FR420A)

Christina Mireles, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX. Jennifer Healy, DO, University of Texas Health Science Center at San Antonio, San Antonio, TX. Shuko Lee, MS, South Texas Veterans Health Care System, San Antonio, TX. Sandra Sanchez-Reilly, MD FAAHPM, University of Texas Health Science Center at San Antonio, San Antonio, TX. Bethany Kapp, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX.

Objectives

- Identify whether or not the integration of a palliative care nurse within the medicine ICU affects overall length of stay.
- Identify whether or not the integration of a palliative care nurse within the medicine ICU affects hospitalization cost.

Original Research Background. Critically ill patients admitted to the medical intensive care unit (MICU) setting are at high risk for significant morbidity and mortality. As such, goals-of-care discussions and end-of-life decisions are often warranted during their hospitalization course. Prior studies have evaluated the palliative care consult's (PCC) role within the MICU setting; however, full MICU integration of PC nurses and its effects on length of stay (LOS) and overall admission costs (OAC) has not been assessed.

Research Objectives. To assess whether the integration of a PC nurse practitioner within the MICU affects LOS and hospital costs.

Methods. 40-month period (2012-2015) de-identified data was analyzed, including all patients admitted to a tertiary hospital MICU. Of the 86,131 hospital admissions, there were 1449 MICU patients with 3829 visits. We matched PCC-patients with standard care (SC)-patients using three or more DRG variables. N= 1347 matched. 40% female. 931/1347 patients had a PCC. Variables such as LOS and OAC were compared for PCC and non-PPC groups before the start of the embedded palliative NP and after.

Results. In regard to LOS, there was a significant decrease in days in the PCC arm (from 16.9 to 12.2;

p value=0.0006). There was non-significant decrease in LOS in the non-PCC arm (from 24.3 to 22.5; p=NS), and in the OAC: PCC arm (from $129,014 to $109,807; p=0.1539). Interestingly, there was a non-significant increase in OAC for non-PCC arm (from $173,452 to $204,599; p=0.0664).

Conclusion. This study revealed significant LOS decrease upon embedding palliative NP within the MICU service. However, there was not a significant difference in OAC.

Implications for Research, Policy, and Practice. This study indicates that integration of a palliative NP within the MICU may be beneficial to promoting increased communication and thus decreasing LOS. Further investigation is warranted to determine how MICU integration of a palliative NP may affect patient care.

Integrating Multidisciplinary Palliative Care into the ICU (IMPACT-ICU) Project: A Multi-Center Nurse Education Quality Improvement Initiative (FR420B)

Susan Barbour, RN, University of California San Francisco Medical Center, San Francisco, CA. Kathleen Puntillo, RN PhD FAAN FCCM, University of California San Francisco, San Francisco, CA. Jenica Cimino, BA, University of California San Francisco, San Francisco, CA. Wendy Anderson, MD MS, University of California San Francisco, San Francisco, CA.

Objectives

- Describe the impact of communication training workshop on bedside ICU nurses' ability to integrate enhanced palliative care communication into their practice.
- Explain the importance of ongoing palliative nurse mentoring in the ICU setting.

Original Research Background. Integration of palliative care into intensive care units (ICUs) requires engagement of bedside nurses. ICU bedside nurses report inadequate education and support in palliative care.

Research Objectives. To integrate palliative care into the ICU by training and supporting bedside nurses.

Methods. The project was conducted at all five University of California academic medical centers. Its two main components were: 1) An eight-hour workshop using learner-centered methods, role-play, and reflection. Nurses learned to facilitate communication about prognosis, goals of care, and palliative care among families and physicians as well as practice self-care. Pre- and post-workshop surveys assessed participants' confidence and skill in 15 palliative care communication tasks. 2) Structured biweekly rounds, during which advanced practice nurses and nurse educators coached bedside nurses in identifying and addressing palliative care needs.

Results. 428 ICU bedside nurses completed the communication workshop. Post-workshop, the percentage of participants who reported a high level of confidence and skill was significantly greater than pre-workshop for all 15 evaluated communication tasks, p<0.001. These included: identifying a family's need for information about a patient's illness and treatments (36% vs. 70%), responding to family distress (31% vs. 61%), participating in family meetings (31% vs. 69%), describing palliative care consultation (20% vs. 65%), and self-care (24% vs. 66%). In coaching rounds, bedside nurses identified and created plans to address palliative needs for 74% of their patients; needs included uncontrolled symptoms (51%), family distress (43%), and inadequate prognosis and goals of care communication (31%).

Conclusion. Nurses who completed the communication workshop reported increased skill and confidence in engaging with families and physicians in palliative care communication. Coaching rounds provided in-the-moment support to identify and address palliative care needs.

Implications for Research, Policy, and Practice. Training and supporting critical-care nurses is a powerful way for institutions and palliative care programs to identify and address the palliative care needs of critically ill patients.

Proactive Palliative Care in Intensive Care Units: A Retrospective Study (FR420C)

David Lee University of California, Irvine, Irvine, CA. Jonathan Wu, MPH MS, University of California, Irvine, CA. Sarah Dobson, MS, University of California, Irvine Medical Center, Orange, CA. Mudit Dabral, MD, University of California, Irvine Medical Center, Orange, CA.

Objectives

- Examine the effectiveness of a proactive screening tool and huddle in the ICUs.
- Examine the cost benefit of early compared to late palliative care consultations for patients in the ICU.

Original Research Background. Studies have shown that palliative care (PC) can improve communication between healthcare professionals and patients and family, improve quality of care, and decrease unwanted aggressive treatment. Yet most patients who die in the intensive care unit (ICU) do not receive PC consultations.

Research Objectives. This study assessed the effectiveness of a proactive screening process for PC consultations in the ICU and evaluated which patients would benefit from a PC consultation.

Methods. This single-center retrospective study of 888 patients examined the impact of a PC screening tool and huddle on dying patients in the ICUs. Data was collected before (phase 1) and after (phases 2 and 3) the intervention. Phase 2 involved the implementation of a nationally recommended screening tool, and phase 3 included both the screening tool and an interdisciplinary huddle.

Results. The intervention reduced the time to PC consultation after ICU admission from 9.6 to 4.8 days ($p<0.01$) and after meeting screening criteria from 8 to 2.2 days ($p<0.01$). The average number of PC consultations per month increased from 10.6 to 17.7 ($p<0.01$) from phases 1 to 3. However, the proportion of patients who received a PC consultation among total hospital deaths per month decreased from 67% to 51% ($p<0.01$). The sensitivities and specificities of the screening tool plus huddle were 65.7% and 62.5%, respectively. Among patients who received a PC consultation, those who received an early consultation had costs significantly less than those with late consultation.

Conclusion. This intervention assisted critical care physicians in discriminating which patients may benefit from a PC consultation, reduced the time to PC consultation following ICU admission, improved access to PC for patients, and showed that early compared to late PC consultations reduce costs.

Implications for Research, Policy, and Practice. A proactive screening tool improves access to palliative care consultations and helps critical care physicians better identify which patients are appropriate for consultation.

If You Build Them, They Will Fill Them: Change in ICU Beds and Admission of Persons with Advanced Medical Illness that Resulted in Severe Functional Impairment (FR420D)

Joan Teno, MD MS, Brown University, Providence, RI. J Randall Curtis, MD MPH, University of Washington, Seattle, WA. Pedro Gozalo, PhD, Brown University, Providence, RI. Nita Khandelwal, MD MS, Harborview Medical Center, Seattle, WA. Ruth Engelberg, PhD, University of Washington, Seattle, WA.

Objectives

- Understand the role of ICU in the care of people with severe functional impairment.
- Become familiar with policy implications with the expanding ICU bed supply in the U.S.

Original Research Background. Decisions regarding ICU admission reflect patient factors and available resources. With a 15% increase in ICU bed supply, a concern is the appropriate use of those beds.

Research Objectives. Examine whether changes in ICU bed supply is associated with ICU utilization among persons with advance medical illnesses and severe functional impairment.

Methods. Retrospective cohort of persons with CHF, advance cognitive impairment, pneumonia and/or septicemia with four pre-existing ADL impairments hospitalized in 2000, 2005, 2007, or 2010. All persons were in the 20% sample of Medicare Part B residing in a nursing home 120 days prior to hospital admission. A hospital fixed-effect model examined changes in ICU bed supply with the prevalence of ICU admission among hospitalized patients after adjusting for patient characteristics, cognition, functional status and other medical conditions.

Results. In the years examined, 162,359 persons with advanced medical illness and severe functional impairment were hospitalized with one-year mortality of 67.4%. The prevalence of ICU admission increased from 22.0% (2000) to 41.1% (2010). The proportion of persons with a DNR order admitted to the ICU increased from 28.6% (2000) to 32.3% (2010). Over this time frame, ICU beds increased from a mean of 22.6 to 33.5 beds per hospital. An increase of one ICU bed in a hospital over time was associated with 1% increased probability in a person being admitted to the ICU (AOR 1.01 95%CI 1.008-1.012).

Conclusion. Although causality can't be inferred, we found increasing ICU bed supply was associated with greater likelihood of persons with advance medical illness and severe functional impairment being admitted to the ICU.

Implications for Research, Policy, and Practice. Persons with advanced medical illness resulting in severe functional impairment are "the canary in the coal mine," providing a unique window into our healthcare systems' decision making.

1:30–2:30 pm
Concurrent Sessions

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

Bibek Acharya, MD, National Academy of Medical Sciences, Kathmandu, Nepal. Venita Eng, MD, Indonesian Cancer Foundation, DKI Jakarta, Indonesia. Ahmad Mustafa Mehran, MD, Wazir Mohammad Akbar Khan Hospital, Kabul, Afghanistan. Layth Mula-Hussain, MB ChB, CCI, MSc, JB, EF, Zhianawa Cancer Center, Sulaymaniyah, Kurdistan, Iraq.

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.

Stoned: A Doctor's Case for Medical Marijuana Reading and Discussion(FR431)

David Casarett, MD MA FAAHPM, University of Pennsylvania, Philadelphia, PA.

Objectives

- Understand the mechanisms of action of common cannabinoids.
- Explain marijuana's potential benefits to patients.
- Counsel patients about the most common/severe risks of marijuana.

Does medical marijuana "work?" Does it have any therapeutic value, or is just an excuse to get high? And does it have any risks? In this session, David Casarett describes his own journey to answer these questions in the process of researching and writing Stoned: A Doctor's Case for Medical Marijuana. Using a mix of evidence, anecdote, and patient stories, he describes what we know about marijuana's risks and benefits, and how it works.

Paying for Palliative Care: Innovative Models (FR432)

Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI. Janet Bull, MD HMDC FAAHPM, Four Seasons, Flat Rock, NC. Martha Twaddle, MD FACP FAAHPM, JourneyCare, Barrington, IL. Dana Lustbader, MD, ProHEALTH Care Associates, Great Neck, NY. James Mittelberger, MD MPH, Optum, Oakland, CA.

Objectives

- Describe important trends in healthcare payment change, and emerging opportunities for palliative care providers.
- Summarize key features of four innovative palliative care programs that are successfully navigating new payment models.
- Identify opportunities in your own healthcare delivery system to improve care for seriously ill patients and their families.

The US healthcare system is in the midst of historic change. Driven by significant pressures to increase healthcare quality and access while controlling cost growth, providers and payers (both public and private) are responding by substantially realigning both delivery systems and payment structures. In fact, the Centers for Medicare & Medicaid Services (CMS) has recently announced that by 2018, fully half of Medicare payments will be made through alternative payment models such as Accountable Care Organizations, bundled payments, episodes of care, and others.

While the future payment landscape is far from clear, there is no doubt that patients with serious, advanced illness are and will remain a key focus of innovation, given their significant care and resource needs. As a result, palliative care programs across the country are rapidly engaging alternative payment models in new and promising ways.

This session will feature four programs that are successfully navigating new payment models. These innovations are diverse in type, geography, and setting, and include 1) a home-based palliative care program anchored to a large physician organization; 2) a CMS Innovations-based initiative to integrate palliative care delivery across settings and communities and propose a new palliative care payment structure to CMS; 3) a national payer innovating to tailor care for beneficiaries with serious illness; and 4) a community-based palliative medicine provider that spans the continuum of serious illness. Each program's leader will describe its objectives, structure, staffing, workflow, and metrics, as well as sharing program development "pearls" and lessons learned. Participants will then be invited to share opportunities and challenges to palliative care payment change within their own healthcare environments. Our presenters will serve as a panel to respond and stimulate discussion around the key elements of successful innovation and strategies to overcome barriers.

Clinic-Based Palliative Care: Lessons Learned (FR433)

Anna Skold, MD MPH, The Southeast Permanente Medical Group Palliative Care, Decatur, GA. Allison Riendeau, PharmD BCACP, Kaiser Permanente, Atlanta, GA. Jane Dausner, MSW, Kaiser Permanente, Atlanta, GA. Cathy Anderson, MDiv BCC, The Southeast Permanente Medical Group, Kennesaw, GA. Ashley Stowers, RN CHPN, Kaiser Permanente, Atlanta, GA.

Objectives

- List two ways of incorporating palliative care into other outpatient multidisciplinary healthcare groups.
- Describe "pre-palliative care" processes, which may help up-stream patients receive benefits from palliative care clinics.
- Explain pre-palliative care clinic processes, which increase effectiveness of the palliative care encounter.

The Kaiser Permanente (KP) Healthcare system often has been a leader in the movement of palliative care. In this 1-hour session, we would like to present the Georgia KP model for outpatient palliative care clinics, highlighting the interdisciplinary team approach of physician, nurse, chaplain, social worker, and PharmD. We will use a case-based approach to accentuate new areas for improvement in outpatient palliative care. The cases will highlight 1) the incorporation of palliative care team members into interdisciplinary care such as the heart failure clinic, tumor board, and patient education sessions; 2) pre-clinic phone calls by PharmD to complete med recquisitions, check for interactions, discuss how medicines should be taken, perform symptom assessment, and discover amounts of opioid requirements; 3) explanation and review of a program entitled Advanced Illness Care Coordination (AICC), which is six free sessions with a palliative-trained LCSW focusing on adjustment disorder related to a new diagnosis, coping strategies, and resources; and 4) discussion regarding use of direct access to the clinic and scheduled phone call follow-ups for questions, symptom checks, and direct referrals to home hospice, when needed. The purpose of this talk is to feature best practices and discuss new opportunities in how palliative care can be more broadly used and incorporated into a systemic approach to quality care.

Prognostication, Relatedness, and the Hospice Formulary: Where Are We, and Where Are We Going? Part 1 (FR434)

Robert Crook, MD FACP, Mount Carmel Health System, Columbus, OH. Joan Harrold, MD MPH FACP HMDC FAAHPM, Hospice & Community Care, Lancaster, PA. Judi Lund Person, MPH, National Hospice & Palliative Care Organization, Alexandria, VA. Rebecca Sears, MSN RN, Mount Carmel Health System, Columbus, OH.

Objectives

- Understand the current hospice regulatory environment.
- Identify common indicators of decline, regardless of diagnosis, and implications for the CTI.
- Discuss disease-specific prognostic indicators, commonly-related conditions, and hospice provision of medications.

Presentation 1 of 2: New and ever changing regulations for hospices continue to challenge us to improve our documentation, streamline our processes, and determine relatedness and coverage of diagnoses and medications. Join us to review general and disease specific prognostic indicators, enhance CTIs to support hospice eligibility, and explore common issues around determining diagnostic relatedness and hospice provision of medications. This session will include an up-to-date report on current and proposed regulations; development and structure of a persuasive CTI; and tools to help your program to determine relatedness of diagnoses and coverage of medications.

To Eat or Not to Eat: Managing Dysphagia at End of Life (FR435)

Lauren Buning, MS CCC-SLP, University of Kansas Hospital, Kansas City, KS. Kylie Bullock, MA L/CCC-SLP, University of Kansas Hospital Authority, Kansas City, KS.

Objectives

- Understand how the anatomy and physiology of the swallow mechanism is impacted by compensatory swallow techniques.

- Identify evidence-based considerations for patients choosing PO intake despite risk for aspiration pneumonia.
- Understand the role of the speech-language pathologist in management of patients with dysphagia receiving palliative services across the lifespan.

Dysphagia is a common diagnosis for many of our patients nearing end of life. Our goal within the session is to empower physicians along with other helping professionals to improve management of patients with swallow disorders receiving palliative services. We will help to develop a better understanding of the anatomy and physiology of the swallow mechanism to improve use of bedside compensatory swallow techniques as well as outline the patient populations that are appropriate for PO intake at end of life. As speech-language pathologists, we will outline our role to assist and develop an evidence-based toolkit with strategies to improve comfort with eating/drinking, reduce aspiration risk, and further prevent pulmonary disease.

Not Just Another Pretty Face: Botulinum Toxin Gives Symptom Control in Palliative Care a Facelift (FR436)

April Zehm, MD, Massachusetts General Hospital, Boston, MA. Mihir Kamdar, MD, Massachusetts General Hospital, Boston, MA.

Objectives

- Describe how botulinum toxin exerts its therapeutic effects.
- Summarize current literature regarding palliative uses of botulinum toxin.
- Recognize practical aspects of therapeutic botulinum toxin use in the palliative care setting.

To the public and most clinicians, the use of botulinum toxin is commonly associated solely with cosmetic indications. Surprisingly, the use of botulinum toxin is a novel yet underutilized therapeutic that can improve the quality of life for patients with refractory musculoskeletal and neuropathic pain syndromes, sialorrhea, and even depression. We will present the case of a woman with recurrent oral squamous cell carcinoma status after extensive head-and-neck surgery followed by concurrent chemoradiation whose course was complicated by debilitating muscle spasms and neck pain that was refractory to a multimodal therapeutic approach, and for which botulinum toxin was considered.

Botulinum neurotoxin is a potent toxin that can be used as an analgesic and muscle relaxant; it has emerged as both a primary and adjunctive treatment for musculoskeletal and neuropathic pain, spasticity and dystonia, migraines, sialorrhea, and many other disorders. We will review its mechanisms of action, potential benefits, risks, and barriers to its use, and our patient's response to treatment. We will then review common cancer- and treatment-related pain syndromes for which botulinum toxin may be helpful, including oromandibular dystonia, spasticity, post-mastectomy and post-thoracotomy pain, sialorrhea related to ALS and Parkinson's disease, and depression. We will analyze the current literature involving palliative uses of botulinum toxin, including results of recent randomized controlled trials of this therapy. We will also provide guidance regarding which patients will benefit most from this advanced symptom management strategy.

Transcutaneous botulinum toxin injection is becoming more readily available for patients suffering from disease- and treatment-related pain and other symptoms. Palliative care clinicians should understand its role, be aware of existing barriers to its use, and identify patients likely to respond.

Pediatric VAD: A Bridge to Nowhere—Lessons Learned as a Result of One Child's Suffering (FR437)

Carly Levy, MD, Nemours/Alfred I. duPont Hospital for Children, Wilmington, DE. Shylah Haldeman, MSN NP-C, Nemours/Alfred I. duPont Hospital for Children, Wilmington, DE. Laurel Stanley Glynn, MSW ACHP-SW LCSW OSW-C, Nemours/Alfred I. duPont Hospital for Children, Wilmington, DE. Ryan Davies, MD, Nemours/Alfred I. duPont Hospital for Children, Wilmington, DE. Michael McCulloch, MD, Nemours/Alfred I. duPont Hospital for Children, Wilmington, DE.

Objectives

- Describe via case report a pediatric ventricular assist device (VAD) implantation and review complications that arose when transplantation was no longer an option.
- Identify psychosocial factors that hindered care of patient and family.
- Discuss barriers to re-goaling and approaches to partnering with families in extreme circumstances.

Background. In 2013, 64 pediatric patients underwent ventricular assist device (VAD) implantation in the United States. To date, no preparedness planning guidelines exist for this population. We will present a case of VAD placement as a bridge-to-transplantation and discuss the lessons learned and practice change following the complications that arose when transplant was no longer an option.

Case Description. A 10-year-old male with an extracorporeal VAD suffered a debilitating stroke while awaiting cardiac re-transplantation. He was inactivated from the transplant list due to hemiparesis limiting his rehabilitation, progressive renal insufficiency, risk for recurrent stroke during repeat cardiac surgery, and the overall perceived low survival rate. His VAD was connected to a 500-pound machine, precluding both discharge from the hospital and a satisfactory treatment plan. This scenario fueled miscommunication, feelings of abandonment, and parental mistrust.

As his condition declined, his parents' relentless search for transplant became distressing to staff. The VAD, intended as a lifesaving measure, now became the source of his suffering. Our palliative care team was consulted and through weekly family/team meetings, helped rebuild trust, re-establish care goals, and address communication concerns.

Conclusion. This case revealed significant institutional issues related to communication, boundaries, and coordination of care for this patient population. Our heart failure/transplant and palliative care teams have subsequently formalized a partnership for all patients being considered for cardiac transplantation or VAD implantation. Together, we have revised the VAD consent process and made palliative care consultations a requirement. Routine family meetings occur to identify parental concerns early and facilitate transparent communication with their child's care team. A protocol has been established for patients and families struggling with prolonged inpatient rehabilitation. In the absence of evidence-based guidelines, we plan to share the details of our new procedures and provider and family survey results as a guide for other institutions.

Unbefriended: Medical Decision Making for the Incapacitated and Alone (FR438)

Eric Widera, MD FAAHPM, University of California San Francisco, San Francisco, CA. Beth Popp, MD, Maimonides Medical Center, Brooklyn, NY. Amy Davis, DO MS FACP FAAHPM, Drexel University and Main Line Health System, Bala Cynwyd, PA. Jason Kallestad, MD, University of Minnesota & Fairview Health Services, Edina, MN. Susan Nelson, MD, Franciscan Missionaries of Our Lady Health System, Baton Rouge, LA.

Objectives

- Describe the epidemiology of unbefriended older adults and how decisions are currently being made for these individuals.
- Adopt ways to decrease the risk of older adults from becoming unbefriended.
- Provide a clinical, ethical, and legal framework for decision making in unbefriended situations across the continuum of care, as well as be able to implement institutional mechanisms to ensure that adequate safeguards are in place to protect this vulnerable population.

Patients who have lost capacity to make medical decisions and who have no readily identifiable surrogate decision maker are known as "unbefriended" or "unrepresented" patients. Estimates range from 5% of ICU deaths and 3%-4% of LTC residents are unbefriended. These cases raise clinical, ethical, and legal questions about who should make decisions for these patients. Clinicians often use their best judgment on how to proceed, with little to no oversight. For example, in a landmark study by Doug White and colleagues, 81% of life-support decisions for unbefriended ICU patients were made without hospital or judicial oversight. This common practice fails to provide any protections for unbefriended patients, as physicians are at risk for introducing bias and other conflicts of interest into the decision-making. The unbefriended may eventually fall into the purview of a public guardian or conservator. However, in most jurisdictions this is a time consuming, expensive, and resource limited option that is ill suited for complex and often urgent treatment decisions.

This symposium will use lecture and breakout group discussion to give clinicians an approach to managing the growing epidemic of unbefriended older adults with a goal of ensuring that treatments are concordant with their preferences, values, and best interest. This symposium will 1) review the epidemiology of unbefriended older adults and how decisions are currently being made for these individuals who are dealing with serious illness; 2) discuss ways to decrease the risk of older adults from becoming unbefriended; 3) provide a clinical, ethical, and legal framework for decision making in unbefriended situations across the continuum of care, including hospital, long-term care, assisted living, and hospice settings; and 4) share institutional mechanisms to ensure that adequate safeguards are in place to protect this vulnerable population.

Consensus Guidelines for Methadone Safety and Effectiveness in Hospice and Palliative Care (FR439)

Mary Lynn McPherson, PharmD BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. James Ray, PharmD, University of Iowa, Coralville, IA. Mellar Davis, MD FCCP FAAHPM, Horvitz Center for Palliative Medicine at Taussig Cancer Institute, Cleveland, OH. Eduardo Bruera, MD FAAHPM, MD Anderson Cancer Center, Houston, TX.

Objectives

- Describe appropriate and inappropriate candidates for initiation or full conversion to

methadone based on risk factor assessment in patients with advanced illness.
- Describe methadone dosing strategies for opioid-naive and opioid-tolerant patients, including a full conversion to methadone and the role of methadone as an adjuvant analgesic.
- Describe consensus recommendations for pre-emptive and ongoing monitoring for methadone safety and efficacy in patients with advanced illness on hospice or receiving palliative care services.

Methadone has unique pharmacokinetic and pharmacodynamics properties that make it an appealing analgesic in treating pain in patients with advanced illnesses; however, these same properties render dosing and monitoring more demanding than other opioids. Consensus guidelines were published in 2014 by the American Pain Society and The College on Problems of Drug Dependence, in collaboration with the Heart Rhythm Society. A consensus-building meeting was held recently to determine the relevance of these published guidelines for patients receiving hospice care or palliative care services. Specifically, the group considered the intensity of recommended pre-emptive and continued monitoring (eg, ECG and other monitoring) for patients admitted to hospice care and patients receiving palliative care services, either concurrently with disease-modifying therapy or without disease-modifying therapy. Consensus was gained on characteristics of methadone-appropriate patients (both opioid-naïve and opioid-tolerant) and clinical situations that would indicate using methadone in more of an adjunctive role as opposed to completely switching to methadone. Recommendations were made regarding which risk factors should be considered prior to instituting methadone therapy, and when it is appropriate to obtain an ECG, and frequency of monitoring if appropriate. Dosing strategies for both opioid-naïve and opioid-tolerant patients were recommended, and recommended strategies when interacting drugs are present. A monitoring strategy to assess therapeutic effectiveness and potential toxicity was developed, including use of a sedation scale with action steps. The role of methadone as an adjunctive analgesic and dosing strategies also were discussed by the expert panel. Hospice and palliative care practitioners need guidance that is specific to this practice setting to maximize safety and efficacy of methadone. This consensus-building process will provide guidance to those who care for patients with advanced illness in the use of methadone.

Paper Sessions

Associations Among Timing of Palliative Care Consults and Family Evaluation of Care (FR440A)

Joan Carpenter, MN ACHPN CRNP, University of Utah, Berlin, MD. Joshua Thorpe, PhD MPH, University of Pittsburgh School of Pharmacy, Pittsburgh, PA. Megan Johnson, BA, Corporal Michael J. Crescenz, Veterans Administration Medical Center, Philadelphia, PA. Mary Ersek, RN FPCN, University of Pennsylvania, Philadelphia, PA. Meghan McDarby, BSN, Veterans Administration, Philadelphia, PA.

Objectives
- Describe the association between timing of palliative care consults and Veteran and family experience of end-of-life care.
- Identify opportunities to initiate palliative care consults earlier in the disease trajectory.

Original Research Background. Palliative care consultations (PCCs) improve end-of-life (EOL) care, although PCCs often occur too late to effect the best outcomes. There is limited evidence about the association between late PCCs and outcomes.

Research Objectives. To examine the associations between timing of PCCs and bereaved families' evaluation of care in the last 30 days of life.

Methods. The analysis was a cross-sectional study of 58,081 Veterans who died in one of 146 Veterans Affairs Medical Centers from October 2009-September 2012. The primary outcome was the Bereaved Family Survey Performance Measure (BFS-PM), reported as the percentage of bereaved family members (BFM) who rate EOL care as "excellent." Secondary outcomes were BFS subscale scores for communication and emotional support. Augmented inverse propensity score weighting was used to account for potential selection bias.

Results. Thirty-six percent (n=20,678) of decedents received a PCC in the last year of life, and 25% of those (n=5120) received a late PCC (i.e., first consult in the last three days of life). BFM of Veterans who received a late consult were significantly less likely to rate care as excellent when compared to Veterans who received an earlier consult (58% v 62%, $p<.001$). There were no significant differences in family ratings of communication and emotional support.Adjusted analyses showed that a late consult was associated with a 12% decrease (AOR: 0.88; 95% CI: 0.81-0.96; $p=0.006$) in the likelihood that BFM rated the overall care as excellent compared with earlier PCCs. Approximately 10% of the difference in outcomes was accounted for by facility. Factors predicting late consult included white (v. black) race, liver disease, congestive heart failure, and dying in an ICU.

Conclusion. Late PCCs are associated with lower BFM ratings of EOL care.

Implications for Research, Policy, and Practice. Strategies aimed at conducting PCC earlier in the illness may improve care outcomes.

Family Caregiver Grief and Depression Outcomes from the ENABLE III Randomized Controlled Trial (FR440B)

James N. Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham, Birmingham, AL. Andres Azuero, PhD, University of Alabama at Birmingham, Birmingham, AL. Kathleen Lyons, ScD, Dartmouth College, Hanover, NH. Jay Hull, PhD, Dartmouth College, Hanover, NH. Marie Bakitas, DNSc CRNP AOCN ACHPN FAAN, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Describe an early palliative care support intervention for family caregivers.
- Describe the relationship between the timing of early palliative care support for family caregivers and their grief and depression outcomes after care recipients' deaths.

Original Research Background. Little is known about how the timing of early palliative care (PC) support for advanced cancer family caregivers (FCGs) impacts grief and depression after care recipients' deaths. We conducted a randomized controlled trial (RCT) of a nurse-led, phone-based PC intervention for FCGs delivered at the time of care recipients' advanced cancer diagnosis (early group) or 12 weeks later (delayed group).

Research Objectives. Determine the impact of early vs. delayed PC support on FCG depression and grief outcomes after care recipients' deaths.

Methods. Early vs. delayed RCT (10/2010-9/2013) of 123 FCGs of advanced cancer patients in a rural, New Hampshire NCI-designated comprehensive cancer center and affiliated outreach clinics and a Vermont VA medical center receiving a multicomponent intervention (Project ENABLE) consisting of three weekly sessions, monthly follow-up, and a bereavement call. FCGs of persons dying during the study period completed the Center for Epidemiological Study-Depression scale (CESD) and the Prigerson Inventory of Complicated Grief-Short Form (PG13) 8-12 weeks after care recipients' deaths. Generalized estimating equations were used to compute group means, standard deviations, and between-group effect size differences.

Results. For care recipients who died (n=70), 44 FCGs (early: n=19; delayed: n=25) completed after-death questionnaires. Mean depression scores (CESD) for the early group was 14.6 (SD=10.7) and for the delayed group was 17.6 (SD=11.8). Mean grief scores (PG13) for the early group was 22.7 (SD=4.9) and for the delayed group was 24.9 (SD=6.9). Between-group effect size differences were not statistically significant (CESD: d=-.27, p=.38; PG13: d=-.36, p=.24).

Conclusion. Though statistically insignificant, the magnitude of the observed between-group differences for depression was small and for grief was medium.

Implications for Research, Policy, and Practice. Considering the small sample and the delayed group's mean depression score surpassing the clinical cutoff (CESD>16), the clinical relevance of these findings cannot be ruled out. Future early FCG PC interventions should continue to examine intervention effects on after-death outcomes.

The Strong One: The Experience of Fathers in Pregnancy with a Lethal Fetal Condition (FR440C)

Christopher Jons, MD, St. Patrick Hospital and Health Sciences Center, Missoula, MT. Erin Denney-Koelsch, MD, University of Rochester, Rochester, NY. Denise Cote-Arsenault, PhD RNC FAAN, University of North Carolina at Greensboro, Greensboro, NC.

Objectives

- Understand the basic themes of the experience of fathers in pregnancies with lethal fetal condition (LFD) and the roles they assume.
- Understand the potential impact of fathers' choices on the relationship.

Original Research Background. Diagnosis of a Lethal Fetal Diagnosis (LFD) in pregnancy is devastating for parents. While the broad themes of a couple's experience continuing pregnancy are beginning to be described, much of the focus has primarily reflected the mother's experience. Little is known of specific factors relating to the experience of fathers.

Research Objectives. To describe the unique experiences of fathers in pregnancies with a lethal fetal condition.

Methods. Longitudinal, phenomenological study of 16 mothers and 14 partners, in which parents were interviewed, twice during the pregnancy after a Lethal Fetal Diagnosis (LFD) and twice after the birth and death of the infant. Interviews were coded and analyzed by the entire research team.

Results. As the non-pregnant partner, physical disconnection permitted the father to choose his degree of attachment to the fetus and baby and his engagement with the mother and her physical and emotional needs. Some fathers chose to interact with and love their babies, making the most of their time while baby was alive. Others remained distant and self-protective of their emotional ties with the baby.

Specific roles that fathers adopted to varying degrees were identified: *Protector, Provider for Family, Partner in Shared Decision-Making,* and *Emotional Supporter of Mother.* The degree to which fathers engaged with the experience of the pregnancy, including the loss, impacted the development of a shared emotional experience for the couple, which influenced the outcome of the relationship.

Conclusion. There are several unique features to the experience of fathers in pregnancies with a lethal fetal condition, and there are several distinct roles that fathers play in their relationships with the fetus, baby, and mother.

Implications for Research, Policy, and Practice. Understanding the factors involved in a father's experience of LFD can help obstetrical and palliative care providers better support couples through the experience and aftermath of such a devastating loss, promoting relationship survival and even relationship growth.

Outpatient Pediatric Palliative Medicine: Complex Lives, Comprehensive Services (FR440D)

Rachel Vandermeer, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX. Glen Medellin, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX. Sandra Sanchez-Reilly, MD FAAHPM, University of Texas Health Science Center at San Antonio, San Antonio, TX. Jennifer Healy, DO, University of Texas Health Science Center at San Antonio, San Antonio, TX.

Objectives

- Identify the diagnoses and death rate found in an outpatient pediatric palliative care clinic.
- Describe the technology and community supports used by children with medical complexity and incurable illness.

Original Research Background. Pediatric palliative services nationwide enroll children with life-limiting, but not acutely life threatening chronic illness. Children receiving inpatient palliative services, the most prevalent service delivery model, have a survival rate of nearly 75% at one year. In response to the long survival rate of pediatric palliative care patients and the need for outpatient palliative services, University Health System (UHS) developed a medical home clinic that provides integrated palliative and primary care for children with medical complexity or incurable illness.

Research Objectives. To discuss the demographics and characteristics of a comprehensive outpatient pediatric palliative care clinic.

Methods. A retrospective chart review was performed for all patients seen in the UHS Comprehensive Care Clinic (UHS CCC) between September 2013 and February 2015. The main endpoints are predominant diagnoses categories, technology supports, community supports and death rate.

Results. In a 1.5 year period, the UHS CCC performed 2338 visits for 359 enrolled children, which averages out to 4.3 visits per patient per year. Sixty-six percent used a gastrostomy for nutrition, 25% had tracheostomy, 30.3% required ventilator support, and 56.9% received home health nursing. The death rate for this clinic population is 4.3 deaths per 100 patients per year. 4.8% were enrolled in concurrent hospice at some point over the study period. The breakdown of diagnoses is: 41.5% neuromuscular, 33.5% congenital, 5.9% cardiovascular, 5.3% oncologic, 4.3% gastrointestinal, 1.6% respiratory, and 8% other.

Conclusion. This demographic study describes the high complexity of outpatients receiving care in an outpatient pediatric palliative care clinic. The outpatient pediatric palliative population is dependent on both technology and community professionals. The death rate requires supporting patients at end of life.

Implications for Research, Policy, and Practice. Caring for palliative care children in the outpatient setting requires not only expertise in end-of-life care, but also in management of complex chronic conditions and primary care needs.

Trends in End-of-Life Care in Pediatric Hematology, Oncology, and Stem Cell Transplant Patients (FR441A)

Katharine Brock, MD, Harvard University, Boston, MA. Clare Twist, MD, Stanford University, Stanford, CA. Angela Steineck, MD, Stanford University, Stanford, CA.

Objectives

- Identify groups of patients in pediatric hematology/oncology/stem cell transplant who receive fewer palliative care and hospice services at the end of life.
- State which palliative care services and trends have improved over time in pediatric hematology/oncology/stem cell transplant patients studied at our single tertiary-care institution.

Original Research Background. Early discussion of goals of care, including introduction of palliative care, increases patient/family satisfaction and improves quality of life. Oncology and pediatric societies advocate for palliative care in all patients with life-threatening, complex illness, specifically cancer. Decisions about end-of-life care may be influenced by cultural and disease-specific features, and it may be changing over time.

Research Objectives. To evaluate associations of demographic variables (diagnosis, race, religion, language) with end-of-life characteristics (Phase I enrollment, Do-Not-Resuscitate (DNR) status, hospice utilization, location of death), and trends in palliative care services delivered to pediatric hematology, oncology, and stem cell transplant (SCT) patients.

Methods. In this single-center retrospective cohort study, inclusion criteria were patients aged 0-35 who died between January 1, 2002 and March 1, 2014 who had been cared for in the pediatric hematology, oncology, and SCT divisions. Univariate and multivariate models were used to evaluate associations. The era of 2002-2014 was divided into quartiles to assess trends over time.

Results. Of the 445 included patients, 64% of patients had relapsed, 45% were enrolled in hospice, and 16% had received a palliative care consultation. Patients who had brain or solid tumors enrolled in hospice ($p<0.0001$) and died at home more frequently than patients with leukemia/lymphoma ($p<0.0001$). Patients who received Phase I therapy or identified as Christian/Catholic religion enrolled in hospice more frequently ($p<0.0001$ and $p=0.03$, respectively). When patient deaths were analyzed over quartiles, the frequency of DNR orders ($p=0.02$), and palliative care consultation ($p=0.04$) increased over time. Hospice enrollment, location of death, and Phase I trial enrollment did not significantly change.

Conclusion. Despite increases in palliative care consultation and DNR orders over time, utilization remains suboptimal. No increase in hospice enrollment or shift in death location was observed.

Implications for Research, Policy, and Practice. These data will help target future initiatives to achieve earlier discussions of goals of care and improved palliative care for all patients.

Cancer Cachexia Assessment in a Specialist Palliative Care Inpatient Unit (FR441B)

Cliona Lorton, MB, Our Lady's Hospice and Care Services, Dublin, Ireland. Louise O'Halloran. Eimear Loftus, Student Trinity College, Dublin, Ireland. Shane Lyng Waterford, Trinity College, Dublin, Ireland. Declan Walsh, MD, Trinity College, Dublin, Ireland.

Objectives

- Name key considerations in the assessment of cachexia and application of these in a palliative care setting.
- Identify barriers to assessment of cachexia in palliative care and how these may be overcome.

Original Research Background. Cancer cachexia is associated with poor quality of life, increased cancer treatment morbidity, and reduced survival. Accurate assessment enables appropriate nutritional intervention. Multiple barriers to cachexia assessment exist in the palliative setting.

Research Objectives. The aim of this study was to examine current practice in a specialist palliative care unit (SPCU) and whether cachexia is accurately assessed, based on the international consensus definition of cancer cachexia (Fearon et al. Definition and classification of cancer cachexia: an international consensus. Lancet Oncol 2011;12:489-495).

Methods. Unified healthcare records of consecutive cancer admissions to the SPCU from September 2014 to February 2015 were retrospectively reviewed. Documentation of anorexia, catabolic drivers (C-Reactive Protein; CRP), functional status (Palliative Performance Scale; PPS), weight and weight change was sought as per the 2011 consensus. The symptom subsection (13 questions) of the Patient-Generated Subjective Global Assessment (PG-SGA) was used as a validated tool to record symptoms. Outcome of admission (death/discharge) was recorded. Statistics were generated with Microsoft Excel.

Results. 214 admissions were reviewed. Anorexia was documented in 68% (n=135). Median CRP was 47.8mg/L (range:0.6-456 mg/L). Median PPS was 40% (range:10-80%). Weight was documented in 19% (n=41). 13% (n=27) were asked about weight change; 95% (n=25) of them reported weight loss. Weight loss was quantified in eight cases. The word "cachectic" was applied to 47 admissions. Median number of symptoms was three (range:0-7 of 12 potential). 23% (n=49) were discharged home.

Conclusion. Nutritional assessment was neither comprehensive nor routine despite a high prevalence of abnormalities consistent with cachexia. Anorexia was common. Weight evaluation was infrequent. Symptom burden was high, and inflammatory markers were elevated.

Implications for Research, Policy, and Practice. Almost one quarter of patients were discharged and might have benefited from intervention. Screening tools and education are needed to prompt recognition and appropriate management of cancer cachexia in the palliative care setting.

Validation of Cancer Dyspnea Scale for Advanced Cancer Patients in a Tertiary Cancer Centre (FR441C)

Anuja Damani, MD, Tata Memorial Center, Mumbai, Maharashtra, India. Arunangshu Ghoshal, MD, Tata Memorial Center, Mumbai, Maharashtra, India.

Maryann Muckaden, MD (Radiation Oncology), MSc (Pall Med), Tata Memorial Hospital, Mumbai, Maharashtra, India.

Objectives

- Establish the validity of the Cancer Dyspnea Scale in vernacular languages for use in patients with advanced cancer with dyspnea in India.
- Determine the reliability of translated versions of the Cancer Dyspnea Scale measured by internal consistency.

Original Research Background. Dyspnea is difficult symptom to measure because of its subjective nature and multi-dimensionality. The 12-point multidimensional Cancer Dyspnea Scale (CDS) was developed in Japan by Tanaka et. al. for measurement of dyspnea in cancer patients. This is a self-rating, easy-to-administer scale for measuring the physiological and psychological distress due to dyspnea. It is validated in Japanese, English, and Swedish only.

Research Objectives.

1. Establish the construct validity, inter subscale correlation and convergent validity of the Hindi and Marathi versions of the Cancer Dyspnea Scale for use in advanced cancer patients with dyspnea in India.
2. Determine the reliability of translated versions of the Cancer Dyspnea Scale measured by internal consistency.

Methods. English version of the CDS was translated to Hindi and Marathi using standard forward-backward translation procedure, and a feasibility study for a new version was carried out in 10 patients. Study was approved by IRB and HEC. A total of 120 patients, newly registered with the department of palliative medicine, who fit into selection criteria, 60 for Hindi and 60 for Marathi, translated questionnaires were chosen. After obtaining informed consent, patients were asked to answer a set of questionnaires including the CDS (translated version), Visual Analogue Scale-Dyspnea. Only baseline measures were used.

Results. The results were separately analysed for both Hindi and Marathi versions of the CDS. The construct validity of both the translated versions, confirmed by doing factor analysis, was good, with good internal consistency. Convergent validity of the scales as correlated with Visual Analogue Scale was good [r=.714(Hindi) and .706(Marathi)], and the correlation was statistically significant. Both the versions had good internal consistency [Cronbach's alpha= .769(Hindi) and .771(Marathi)].

Conclusion. CDS-Hindi and Marathi versions are valid and reliable multidimensional scales to be used in a palliative setting.

Implications for Research, Policy, and Practice. Validation of the scale in other Indian languages and use in assessment of dyspnea in an indigenous population.

Assessing Associations Between Symptoms, Worry and Survivorship Care Planning Among Long-Term Cancer Survivors (FR441D)

Diana Tisnado, MPA PhD, California State University Fullerton, Fullerton, CA. Anne Walling, MD PhD, University of California Los Angeles, Los Angeles, CA.

Objectives

- Become familiar with the epidemiology of moderate to severe symptoms of concern to cancer survivors.
- Become familiar with the definitions, significance, and prevalence of components of a cancer survivorship care plan recommended by the Institute of Medicine.
- Identify and discuss implications of the association between recommended components of a cancer survivorship care plan and self-reported moderate to severe symptoms and worry.

Original Research Background. Nearly 14 million Americans are cancer survivors, and numbers are increasing. Common long-term and late effects include anxiety, depression, fatigue, pain, and others. To address potential long-term and late effects of cancer and its treatment, the Institute of Medicine (IOM) recommends that patients receive a survivorship care plan (SCP), a record of care received, a list of important disease characteristics, and a follow-up care plan incorporating available evidence-based standards of care.

Research Objectives. To assess prevalence of self-reported moderate to severe symptoms and worry and to test for associations with SCP receipt.

Methods. Data came from CanCORS II, a national study of lung and colorectal cancer care. Long-term survivors were diagnosed in 2004, and showed no sign of disease seven years post-diagnosis. We included 888 respondents to the CanCORS II Long-Term Survivor Survey. We examined moderate to severe pain (3, 4, or 5 on the SF-36 pain interference item), fatigue (<40 on the SF-36 vitality score), depressive symptoms (≥ 6 on CESD-8), and worry about recurrence. SCP receipt was defined as receipt of a treatment summary, follow-up care plan, or both components. Multivariable logistic regression was used to test for associations between SCP, symptoms and worry.

Results. In all, 26% had both SCP components; 27% had none. Moderate to severe pain was reported by 32% of colorectal and 42% of lung cancer survivors, fatigue by 15% of colorectal and 30% of lung cancer survivors, and depressive symptoms by 12% of colorectal and 16% of lung cancer survivors. Less than one-quarter (23%) reported worry about recurrence. Receipt of both SCP components was associated with lower odds of moderate to severe pain (OR=0.78, p=0.004), fatigue (OR=0.42, p=0.006), and depressive symptoms (OR=0.48, p=0.03), adjusting for demographics and health status.

Conclusion. Receipt of both SCP components is associated with lower symptom burden, but a minority of survivors receive both SCP components.

Implications for Research, Policy, and Practice. Future work should focus on identification and amelioration of barriers to SCP receipt.

3–4 pm

Concurrent Sessions

Swinging for the Fences: Managing Challenging Behaviors at End of Life (FR450)

Toni Cutson, MD, Duke University, Durham, NC. Katherine Ramos, MA MEd, Durham VA Medical Center, Morrisville, NC. Jamie Grant, LCSW, Durham VA Medical Center, Cary, NC. Michaelene Moore, MSN RN ANP-C ACHPN ACNS-C, Durham VA Medical Center, Durham, NC. Jessica Fulton, PhD, Durham VA Medical Center, Durham, NC.

Objectives

- Describe why it is important and how to differentiate challenging behaviors associated with dementia from those associated with other mental health disorders.
- Describe three key elements of effective behavioral interventions.
- Identify three strategies for increasing motivation, engagement, and collaboration with colleagues from other disciplines to increase the effectiveness of behavioral interventions.

Challenging behaviors (eg, care refusal, demanding behavior), stemming from serious mental illness, personality disorders, and/or dementia, at end of life can have an impact on patients' quality of life, relationships, and their ability to cope with dying. In community living or hospital settings, these behaviors also affect other patients' end-of-life experiences and the interdisciplinary team's ability to provide compassionate and effective care. Furthermore, teams may struggle to balance setting limits (or intervening behaviorally) with giving priority to death with choice and dignity. The first step toward systematically improving challenging behaviors is determining their etiology and function, through assessment of underlying physical processes and contributing psychiatric conditions and associated symptoms. The latter informs the ability to individually tailor and implement effective interventions that may differ significantly based on function and etiology of behavior (eg, demanding behavior associated with personality disorder versus dementia). While pharmacotherapy may be an appropriate adjunct to psychological intervention for certain patients (eg, with psychosis or mania), antipsychotics have limited efficacy (eg, Schneider et al., 2006) and are associated with increased risk of death among patients with dementia (Huybrechts et al., 2012). Nonpharmacologic behavioral approaches, such as STAR-VA (Karlin et al., 2011) used in VA nursing homes, are an efficacious but underutilized alternative (O'Neil et al., 2011; Karlin et al., 2014). While behavioral interventions are tailored based on behavior etiology and function, support and involvement of staff across disciplines are critical to the success of any behavioral intervention. Presented by a hospice interdisciplinary team (nurse practitioner, social worker, clinical psychologist, and physician), this session will expand on the previously described content using case examples to provide a framework for assessing and developing tailored behavioral interventions based on behavior etiology and function and will provide strategies for increasing motivation, engagement, and collaboration across disciplines.

"Can I Go Home on BIPAP?" Using NIPPV with Confidence: A Practical Guide to Implement Noninvasive Positive Pressure Ventilation for Symptom Management by the End of Life (FR451)

Anca Dinescu, MD, Washington VA Medical Center, Arlington, VA. Rahul Khosla, MD, VA Medical Center, Highland, MD. Pamela Harman, PhD, Veterans Affairs Medical Center, Washington, DC. Douglas Tillman, RRT, Veterans Affairs Medical Center, Washington, DC. Karen Blackstone, MD, George Washington University, Washington, DC.

Objectives

- Recommend and use appropriately the NIPPV in hospice settings.
- Understand, be able to recognize, and be able to design strategies to address larger system issues, at the organizational level, that pertain to the use of NIPPV use in end-of-life care.

The use of Non-Invasive Positive Pressure Ventilation (NIPPV) is well established in the treatment of obstructive sleep apnea (OSA), acute exacerbation of COPD, and pulmonary edema. Its use in the end-of-life arena is a developing phenomenon. The benefits of using NIPPV in palliative care settings revolve around relieving dyspnea and decreasing the work of breathing, reducing hypercapnia, and improving oxygenation, thus decreasing the use of narcotics and anxiolytics, which enables the patient to be more alert. At times, NIPPV can also be used as a temporary life-prolonging measure in specific situations by possibly reversing acute deterioration in patients with terminal disease.

Despite appealing overarching goals for use of NIPPV in hospice settings, (patient comfort, more time with family, and a dignified death), there are numerous practical system issues that preclude its wild use in hospice. Issues with settings and methods of delivery, maintenance, monitoring, discontinuation, and interaction with other aspects of care (eg, eating, communication) make the use of NIPPV confusing and challenging.

Nonetheless, a number of ethical questions add to the complexity of delivering high-quality NIPPV by the end of life.

Our session will provide a high-quality, evidence-based review of the available data, as well as practical clinical strategies developed by this interdisciplinary team of practitioners at the Washington, DC, VA. The presenters are specialists in pulmonary and critical care medicine, palliative care medicine, speech pathology, respiratory therapy, and nursing. This team provides routinely high-quality, compassionate NIPPV treatment for an extremely medically and socioeconomically complex VA population, including ALS patients. Through the use of case examples and with interactive audience participation, the team will present the latest evidence around the use of NIPPV by the end of life, with a focus on addressing practical systemic issues and ethical dilemmas that surround the topic.

Prognostication, Relatedness, and the Hospice Formulary: Where Are We, and Where Are We Going? Part 2 (FR452)

Robert Crook, MD FACP, Mount Carmel Health System, Columbus, OH. Judi Lund Person, MPH, National Hospice & Palliative Care Organization, Alexandria, VA. Joan Harrold, MD MPH FACP FAAHPM HMDC, Hospice & Community Care, Lancaster, PA. Rebecca Sears, MSN RN, Mount Carmel Health System, Columbus, OH.

Objectives

- Discuss disease-specific prognostic indicators for heart failure, COPD, chronic renal failure, and liver disease.
- Discuss commonly-related conditions and hospice provision of medications for heart disease, pulmonary disease, renal disease, and liver disease.

Presentation 2 of 2: New and ever-changing regulations for hospices continue to challenge us to improve our documentation, streamline our processes, and determine relatedness and coverage of diagnoses and medications. Join us to review general and disease-specific prognostic indicators, enhance CTIs to support hospice eligibility, and explore common issues around determining diagnostic relatedness and hospice provision of medications. This session will include an up-to-date report on current and proposed regulations; development and structure of a persuasive CTI; and tools to help your program to determine relatedness of diagnoses and coverage of medications.

Adolescents and Young Adults (AYAs) Living with Cancer: Why Palliative Care Fits Best (FR453)

Eric Prommer, MD HMDC FAAHPM, University of California Los Angeles, Los Angeles, CA. Mary Buss, MD, Beth Israel Deaconess Med Center, Newton, MA. Kelly Cooke, DO, ProHealth Care, Eagle, WI. David Hui, MD MS MSC, MD Anderson Cancer Center, Houston, TX.

Objectives

- Recognize the symptom burden in adolescents and young Adults (AYAs).
- Recognize the unique psychosocial concerns of the adolescent and young adult patient.
- Identify ways of integrating palliative care into the care of the adolescent and young adult with cancer.

An estimated 70,000 AYAs receive a cancer diagnosis each year in the US. The AYA is defined as patients aged 15-39 years at cancer diagnosis. The AYA age spans the gap between pediatric and adult healthcare providers. Cancer occurring during this age range affects patients' developmental trajectory with its impact on emotional growth (both positive and negative), physical development, and behavior. This population is at risk for a diverse array of cancers that exhibit unique behavior. Cancers in this age group include malignant epithelial neoplasms (eg, thyroid carcinoma, malignant melanoma), sarcomas, and malignancies involving reproductive organs. Leukemia exhibits less favorable cytogenics and has a less favorable outcome. Patients experience a wide array of emotional complications from their cancer diagnoses, such as learned decisional passivity or social anxiety because of extended social isolation or shrinkage in social network. These patients may have fertility concerns and/or young children needing special attention. AYA patients may existentially mature faster than anticipated. Teams managing these patients may experience problems with noncompliance, risky behavior, or patient isolation. Current cancer care models relegate these patients to either the pediatric or adult oncologic realm. Younger patients receive aggressive treatment at the end-of-life. Palliative care physicians become involved with these patients by their ability to manage symptoms and improve quality of life in all domains. This session will present, by way of research, didactic, and case presentations, an argument for the use of palliative care in the care of adolescents and young adults. The session will cover five main areas: 1) common symptoms experienced by the AYA; 2) common psychosocial issues associated with the AYA patient; 3) examples of palliative care intervention in AYA care; 4) practical recommendations regarding the emotional and behavioral issues associated with AYAs; and 5) approaches to the management of the young AYA survivor.

Why Are You So Scared? Managing Risk and Safe Prescribing of Opioids in Hospice and Palliative Medicine (FR454)

Andrew Esch, MD MBA, Great Lakes Palliative Care, Clarence, NY. Jaime Goldberg, MSW, Cedars-Sinai Medical Center, Los Angeles, CA.

Objectives

- Integrate formal risk assessment for substance use disorder when considering or using ongoing opioid therapy.
- Implement strategies for safe and appropriate pain management for the patient with serious illness of all risk levels.

Epidemic undertreatment of pain, the growing use of opioids for nonmedical purposes, and media attention on opioid misuse have had clinical implications for patients with serious illness.

Undertreatment of pain affects ALL patient populations with varied diagnoses. Opioid prescriptions have increased, but they are not necessarily getting to the seriously ill patients with palliative care needs. The implication for patients with cancer and/or serious illness is that they are too often undertreated due to clinician and/or patient fears. While there is an epidemic of pain, use of prescription pain relievers for nonmedical purposes (without a prescription) is now the second most common form of substance use disorder. Since 1999, prescription opioid overdoses, as a proportion of all deaths, have risen by 265% in men and by more than 400% in women. In 2015, there were more than 16,000 prescription painkiller deaths, and 2 million people reported using prescription opioids nonmedically for the first time.

This presentation will help hospice and palliative care clinicians to utilize formal risk assessment, recognize at-risk behaviors, risk stratify patients, distinguish substance use disorder from undertreatment of pain, and develop management strategies for all patients with serious illness, regardless of risk level.

Growing Up with Our Kids! Caring for Childhood Diseases You Will See as an Adult HPM Provider (FR455)

Sonia Malhotra, MD, Ochsner Medical Center Palliative Medicine, New Orleans, LA. Michelle Freeman, MD MEd, Penn State Milton S. Hershey Medical Center, Hershey, PA. Ashley Nichols, MD, University of Alabama at Birmingham Center for Palliative & Supportive Care, Birmingham, AL. Michael Barnett, MD MS, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Describe the prevalence, trajectory, and prognosis of four childhood diseases that adult hospice and palliative medicine providers can expect to see in their practice.
- Identify at least two challenges relating to symptom management, advance care planning, or coordination of care when caring for each of the four childhood diseases described, and provide tools to address each of these challenges.
- Discuss general principles in coordination of care when transitioning children with chronic, life-limiting illnesses to adulthood.

Children with chronic, life-limiting illnesses are living longer. As a result of improved technology and a better understanding of disease processes, many of these children are surviving into adulthood and transitioning from the pediatric medical world to adult care. Transitional care for young people with life-limiting illnesses is a complex issue. These young people often experience multiple, concurrent transitions, including a variety of organizational and illness transitions, as well as the adjustment from childhood to adulthood. Young adult patients must adapt to new healthcare providers, to new healthcare settings with different approaches to care, and (for some) to new responsibilities in medical decision-making. Adult and pediatric palliative care providers are well equipped to handle symptom management and challenges in care coordination in their respective patient populations; however, the bridge between pediatric and adult palliative care services is not well defined. Attendees will gain knowledge about issues specific to four commonly encountered diseases of childhood that adult hospice and palliative medicine (HPM) providers can expect to see in their practices: cystic fibrosis, congenital heart disease, muscular dystrophy, and pediatric cancer. We will describe challenges related to caring for each of these pediatric populations as they transition to adulthood, including issues involving symptom management, advance care planning, and coordination of care, and provide tools to manage these issues. This knowledge will help adult HPM providers to deliver quality care to these patients and their families as they are immersed in adult medical care. We will highlight the importance of growing up in the medical system, both as a patient and as a caregiver, and the challenge of transitioning to an adult model of care in the context of palliative medicine. We will discuss how to plan for this transfer of care in a patient/family-centered manner that promotes continuity and eases the anxiety for all involved.

Palliation Beyond Death: Face-to-Face Interdisciplinary Postmortem Review as a Tool to Mitigate Complicated Bereavement and Promote Legacy Building (FR456)

Erica Kaye, MD, St. Jude Children's Research Hospital, Memphis, TN. Daniel Mahoney, MD FAAP, Le Bonheur Children's Hospital, Memphis, TN. Joanna Lyman, MA CCLS, Le Bonheur Children's Hospital, Memphis, TN. Melody Cunningham, MD, Le Bonheur Children's Hospital, Memphis, TN.

Objectives

- Lead a discussion integrating evidence from the literature in support of face-to-face postmortem follow-up meetings with clinicians and bereaved families.
- Identify the components required to create, implement, and sustain a postmortem interdisciplinary program, as well as the barriers to successful programmatic execution and strategies for overcoming these barriers.
- Describe the ways in which postmortem interdisciplinary medical follow-up serves as an integral component of psychosocial bereavement support.

Palliative care does not end with death. Many palliative care programs offer bereavement support to families; however, few programs have formal infrastructure in place to offer all bereaved families face-to-face follow-up with an interdisciplinary clinical team for posthumous review of medical information, including autopsy results. Although the majority of bereaved families report a desire to meet with the clinicians who cared for their loved one, unfortunately, only a minority of families are provided an opportunity to participate in formal follow-up meetings. Bereaved families report that receiving postmortem information, such as autopsy results, aids in coping with grief, assuaging feelings of guilt, finding closure, and promoting legacy building. Particularly for those bereaved families who choose autopsy, the importance of coordinating a follow-up meeting to review postmortem medical information cannot be overstated. In this session, we will review the literature in support of postmortem conferences as an integral component of the provision of optimal bereavement support. Attendees will gain familiarity with the preferences of families and clinician regarding timing, location, and other components of postmortem follow-up meetings. We will review the topics that families and clinicians identify as most valuable to include in these follow-up sessions, including the benefits of reviewing autopsy results with bereaved families. We will discuss the requisite infrastructure to design, implement, and sustain a bereavement program that offers postmortem interdisciplinary follow-up sessions to all bereaved families with integrated sibling support. Attendees will gain understanding of the barriers to coordination of this type of program, including lack of infrastructure to facilitate initiation and planning, shortage of available staff, limited time, and inadequate reimbursement, with subsequent identification of strategies to overcome these barriers. Finally, we will review cases from our institutional experience to provide examples of how postmortem meetings can mitigate complicated bereavement, heal fractured family dynamics, and promote legacy building.

Home-Based Palliative Care: Translating a Research Model into a Primary Care Benefit (FR457)

Susan Enguidanos, PhD MPH, University of Southern California, Los Angeles, CA. Torrie Fields, MPH BA BS, Regence Blue Cross/Blue Shield, Portland, OR. Richard Brumley, MD FAAHPM, CareLink, LLC, Laguna Niguel, CA.

Objectives

- List the significant outcomes from the original home-based palliative care model.
- Identify key model elements to ensure fidelity and intervention elements that will be adapted in implementing the HBPC model in primary care.
- Describe the potential policy and healthcare transformational impact of integrating the HBPC program within an accountable healthcare system.

In this symposium, we will present a summary of an evidence-based model of home-based palliative care (HBPC) and describe how this model is being adapted to transform healthcare systems. Findings from two studies of the HBPC model, a randomized controlled trial and a comparison group study, demonstrated that patients enrolled in the HBPC group experienced significantly improved satisfaction with their health care, and those receiving HBPC were more likely to die at home, a site preferred by most Americans. Additionally, costs of care were about one-third lower for those receiving HBPC. Despite these promising findings, widespread implementation of this model has been hampered by poor alignment of reimbursement systems.

Regence Blue Cross/Blue Shield has adapted this model for implementation within primary care practices with accountable health agreements, providing a reimbursement benefit and financial incentive to support implementation and sustainability of this model. In this session, we will describe the core elements of the model that have been implemented, including maintaining an interdisciplinary team of a physician, nurse, social worker, and chaplain, inclusion of a 24-hour call center, and systems to monitor fidelity of the palliative care provided. Additionally, we will discuss model elements that have been adapted to better fit the primary care environment, as well as metrics that are being used to measure quality, costs, and patient experiences of the program.

Finally, we will discuss the impact of this project on policy and potential for healthcare transformation through expanded evidence and market pressures.

Upstream Palliative Care in a Busy Trauma Center Triggered by Application of an Objective Validated Frailty Scale (FR458)

Richard Miller, MD, Vanderbilt University Medical Center, Nashville, TN. Cathy Maxwell, PhD, Vanderbilt University, Nashville, TN. Mohana Karlekar, MD, Vanderbilt University Medical Center, Nashville, TN.

Objectives

- Describe the typical clinical trajectories for older adults admitted to a trauma intensive care unit who have clinically significant physical frailty and cognitive dysfunction measured by accepted validated scales.
- Describe a validated tool to measure physical frailty and cognitive dysfunction and delineate the steps in order to operationalize this tool into the clinical setting for all older patients admitted to the trauma service.
- Identify the benefits and challenges of integrating this tool into the clinical care of the older trauma patient for the trauma surgeons, the trauma nurses, patients, and families.

The elderly today comprise the vast majority of admissions not just to the acute care hospital but also to trauma centers nationally. The older adult, when admitted to a trauma intensive care unit (TICU), typically has an increased length of stay (LOS) and increased mortality as compared to younger individuals with similar injuries.[1,2] The frail elderly with cognitive dysfunction (FECD) as a sub-group have an even worse overall prognosis.[3] Based on data from a pilot study done in our institution, the FECD when followed over time had a 10% mortality at hospital discharge and a 25% overall mortality at 1 year. We concluded that an admission to the TICU for the FECD is a harbinger of significant morbidity and mortality, and this admission represents an opportune time to engage patients and families in conversations about their current health, prognosis, and goals of care (GOC).

Our institution conducted a quality improvement (QI) project with a three-fold aim; first, to increase consultation to palliative care specifically upstream along the disease trajectory for the FECD with the goal of educating families and patients on the significance of this admission to a patient's health and help delineate clear GOC; second, to determine the feasibility of trauma nurses' ability to routinely screen patients for cognitive dysfunction and physical frailty using a validated scale to identify at-risk patients; and, third, to determine what specific benefits and barriers patients, families, and trauma providers perceive when consulting palliative care.[4,5]

Our goals for this presentation will be to discuss how well we accomplished our aims, share our challenges in gaining acceptance of this new process among trauma providers and our palliative care team, and to discuss the positive impact of incorporating these upstream triggers in the FECD trauma population on clinical teams, patients, and families.

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Dying Alone: End-of-Life Care of the Quarantined Patient (FR459)

Rebecca Goett, MD, Rutgers New Jersey Medical School, Newark, NJ. Sangeeta Lamba, MD, Rutgers New Jersey Medical School, Newark, NJ. Paul DeSandre, DO, Emory University School of Medicine and Grady Hospital, Atlanta, GA. Tammie Quest, MD, Emory University School of Medicine, Atlanta, GA.

Objectives

- Identify the unique ethical and moral challenges faced by healthcare workers caring for dying patients with highly contagious and often fatal diseases based on lessons from two institutions that cared for Ebola patients.

- Describe the unique aspects of caring for those dying or the recently deceased from a highly contagious disease
- Discuss some strategies to support the needs of the family of the patient dying in quarantine.

The unique aspects of end-of-life care for a highly contagious patient are rarely discussed. With the recent Ebola epidemic, it is clear that such highly contagious, often fatal, illnesses are a global concern. Our healthcare system has not prepared us to care for patients dying of diseases that expose all caregivers to a high level of risk, even death. Support of the dying patient was feasible in prior epidemics such as influenza when healthcare workers and families were assured a level of protection. Ebola revealed that we were unprepared to support healthcare workers, dying patients, and their families in quarantine.

Medical training has an unwritten social contract that makes us fulfill the duty to provide healthcare in undesirable circumstances. But what happens to this moral and societal obligation when duty threatens the life of the healthcare worker? What happens when healthcare workers are ostracized due to their medical work? How do you help support the healthcare worker dealing with such moral, emotional, and ethical distress? How do you support a family that is denied the ability to talk to or touch the dying patient? How do you help balance family autonomy, cultural traditions, and honor of the recently dead with community safety? Emory University's association with the Centers for Disease Control and Prevention and University Hospital's proximity to Newark airport (one of the largest hubs for incoming passengers from West Africa) placed us on the national stage with the Ebola crisis. Several strategies we have used, such as 2-way phones, will be discussed. The panel will use expertise in emergency and palliative medicine and bioethics to discuss these unique issues at the end-of-life of the quarantined patient.

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

Joshua Barclay, MD MS MSC FACP, University of Virginia, Charlottesville, VA. James Ray, PharmD, University of Iowa, Iowa City, IA. Lee Klemptner, BSN RN, University of Virginia Health System, Charlottesville, VA. Paula Capobianco, MSW, University of Virginia Health System, Charlottesville, VA.

Objectives

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

Prescription drug abuse and mortality associated with substance abuse is a current national concern in the United States, even in the setting of hospice and palliative care patients. Strategies to prevent opioid abuse include screening for substance abuse, implementing prescription monitoring programs and urine drug screening, and using abuse deterrent pharmaceuticals. Abuse deterrent technologies, including physical barriers, aversion techniques, agonist/antagonist combinations, and modified delivery systems are under active development. The FDA is currently encouraging research on these pharmaceuticals, stating that the development of abuse resistant products is a "high public health priority." Legislation is being introduced to incentivize pharmaceutical companies to develop new abuse deterrent medications and the National Association of Attorneys General of the United States has requested that the FDA ensure that all generic extended-release opiates have tamper resistant properties, as well. Several concerns exist regarding the mainstream use of these medications, including adverse effects in patients with legitimate pain and suffering, significant increased costs to patients or healthcare organizations, legal liability for prescribers who use non-tamper resistant formulations when an abuse deterrent product is available, and the potential for discouraging the therapeutic use of opioids. This concurrent session will provide a review of current technologies; the current evidence for their use, benefits, and side effects; and will discuss evolving abuse deterrent methodologies and medications soon to be released. Through historic case examples and a review of the literature, we will discuss patient selection, cost considerations (including insurance and hospice formulary issues), drug availability, and techniques for surmounting clinical difficulties. Patient safety, including the prevention of abuse (a focus of legislation and law enforcement), is an important part of good symptom management. The understanding of abuse deterrent technology as a tool in this effort is essential for hospice and palliative care practitioners.

Paper Session

A Mixed-Methods Study of Multi-Ethnic, Multi-Lingual Patient-Reported Barriers to Receiving Quality Care at the End of Life (FR461A)

Vyjeyanthi Periyakoil, MD, Stanford University School of Medicine, Stanford, CA.

Objectives

- Gain an initial understanding of common barriers reported by multi-ethnic patients to receiving quality end-of-life care.

- Explore the benefits and burdens of using mixed methods in palliative care research.

Original Research Background. Ethnic populations suffer from disparities in receiving quality end-of-life care (EOLC).

Research Objectives. To empirically identify barriers reported by multi-ethnic patients and families in receiving quality EOLC.

Methods. Cross-sectional, mixed-methods study in Burmese, English, Hindi, Mandarin, Tagalog, Spanish, and Vietnamese recruited from multi-ethnic community centers in five California cities using a snowball sampling technique to accrue 387 participants: 261 women, 126 men; 133 Caucasian, 204 Asian Americans, 44 African Americans, and 6 Hispanic Americans. The main outcome was that multi-ethnic patients reported barriers to quality EOLC. Collected in Burmese, English, Hindi, Mandarin, Spanish, Tagalog, and Vietnamese, development cohort (72 participants) responses were analyzed qualitatively using grounded theory to identify the six key barriers to quality EOLC. New validation cohort (315 participants) responses were transcribed and translated and then back-translated for verification. The codes were validated by analyses of responses from 50 randomly drawn subjects from the validation cohort. All 315 validation cohort transcripts were coded for presence or absence of the 36 barriers.

Results. In the validation cohort, 39.4% did not and 60.6% did report barriers to receiving quality EOLC for persons in their culture/ethnicity. Age (χ^2= 9.15, DF=1, p=0.003), gender (χ^2= 39 6.605, DF=1,p=0.01), and marital status (χ^2= 16.11 DF=3, p=0.001) were associated with reporting barriers, and women <80 years were most likely to report barriers to receiving quality EOLC. Barriers reported were (1) finance/health Insurance barriers, (2) doctor behaviors, (3) communication chasm between doctors and patients, (4) family beliefs/behaviors, (5) health system barriers, and (6) cultural/religious barriers. Individual responses of reported barriers were analyzed, and only the participant's level of education (Friedman statistic= 2.16, DF=10, p= 0.02) significantly influenced choices.

Conclusion. Multi-ethnic patients greatly value quality EOLC, but unfortunately report several barriers to receiving such care.

Implications for Research, Policy, or Practice. Strategies need to be devised to use this work as a step in fostering further research and in initiating targeted policy changes to improve EOLC for diverse populations.

Developing a Culturally Tailored Palliative Care Program with Guidance from Rural African American and White Community Members: A Program by the Community for the Community (FR461B)

Ronit Elk, PhD, University of South Carolina, Columbia, SC. Joshua Hauser, MD, Northwestern University, Chicago, IL. Laura Reparaz, MS BS BS, University of South Carolina, Columbia, SC. Linda Emanuel, MD PhD, Education in Palliative Care and End-of-Life-Care Project, Chicago, IL. Sue Levkoff, ScD SM MSW, University of South Carolina, Columbia, SC

Objectives

- Gain an understanding of need for cultural tailoring in rural African American and white communities for palliative care (PC) programs.
- Hear about a new approach for developing a culturally tailored PC program in collaboration with the community that meets the common and unique needs of African American and white rural elders.
- Examine results that are common to both groups and those that are unique to African American or white.

Original Research Background. A culturally appropriate model of end-of-life care that takes into consideration the diverse cultural preferences of rural, terminally ill African Americans and whites is lacking.

Research Objectives. To develop a culturally tailored palliative care (PC) program with the guidance of African American and white community members that will meet the common and unique needs of rural elders at end of life. The goal of this second phase of a three-phase study is to gather input from African American and white community members into a future PC program.

Methods. In the tradition of Community Based Participatory Research (CBPR), a Community Advisory Group (CAG) of community leaders and family members who had recently lost a loved one was formed. The CAG met monthly for a year with the research team and systematically reviewed the qualitative thematic results of the end-of-life care preferences of African American and white caregivers who had participated in focus groups in Phase 1. Based on these preferences, CAG made recommendations for a PC program that would meet the common and unique needs of their communities.

Results. Recommendations that were common to both groups include: The Physician should elicit whether family wants to hear about prognosis and treatment and discuss these with compassion and consideration. Recommendations that were unique to African American group include: Physician should respect and state that God or a higher power, and not the physician, determines when the patient will pass. The physician should recognize and appreciate a family's determination to care for their loved one at home. The family's pastor is central, and his or her involvement is preferred to that of the hospice chaplain.

Conclusion. Developing a culturally tailored PC program in collaboration with the community is feasible and builds trust and ownership. Acceptability of the program will be a hospital-tested program in Phase 3.

Implications for Research, Policy, and Practice. This model can be used to develop culturally tailored PC programs across settings.

Facebook Advertising for Pediatric Oncology Research Recruitment (FR461C)

Terrah Foster Akard, RN PhD CPNP, Vanderbilt University Medical Center, Nashville, TN.

Objectives

- Describe Facebook advertising recruitment methods.
- Describe results from our Facebook advertising campaign.

Original Research Background. Social media is one strategy that may improve diversity and sample sizes in pediatric palliative care research. Studies have used Facebook advertising for participant recruitment, but these studies have rarely been conducted with pediatric palliative care or oncology populations.

Research Objectives. This study examined Facebook advertising for recruiting children with advanced cancer and their parent caregivers.

Methods. Researchers used Facebook advertisements to recruit children with relapsed or refractory cancer and their parent caregivers to participate in a digital storytelling project. The ads targeted the United States, individuals ages 18 years and up, and interest terms related to childhood cancer (e.g., "childhood cancer awareness," "cure childhood cancer," and names of leading children's hospitals). The ads contained a link to an electronic survey that included questions to screen for eligibility. Eligible participants continued to complete demographic information and provide their contact information (if willing to be contacted) to pilot a newly developed web-based digital storytelling intervention. All participants were eligible for a drawing of a $100 gift card.

Results. The successful Facebook campaign delivered advertisements over a 12 day period (12/18/14-12/30/14). The ads generated 110,211 impressions (number of times ads were shown to users), were shown to 86,156 people, and resulted in 839 website clicks to our survey. The campaign cost $536.92, averaging $0.64 per website click. Of 76 screened individuals, 37 were eligible, and 22 completed the survey.

Conclusion. Facebook advertising is a feasible strategy to recruit diverse samples of children with advanced cancer and their parents for research studies.

Implications for Research, Policy, and Practice. Researchers should pilot Facebook ads soon before large studies to stay up-to-date on evolving Facebook advertising campaigns. More research is needed to examine Facebook recruitment methods in other pediatric palliative care populations and to compare potential differences in face-to-face versus social media recruitment methods.

Good Mourning, YouTube! Grieving and Bereaving on the World's Most Popular Video Sharing Website (FR461D)

Shira Amdur, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX. Aparna Seetharama, MD, University of Texas Health Science Center at San Antonio, San Antonio, TX South Texas Veterans Health Care System, San Antonio, TX. Shuko Lee, MS, South Texas Veterans Health Care System, San Antonio, TX. Jeanette Ross, MD AGSF FAAHPM, University of Texas Health Science Center at San Antonio, San Antonio, TX. Sandra Sanchez-Reilly, MD FAAHPM, University of Texas Health Science Center at San Antonio, San Antonio, TX.

Objectives

- Assess YouTube as a resource for valuable and relevant information related to grief and bereavement.
- Explore various formats for information on grief and bereavement available on YouTube.

Systemic Review Background. YouTube is an easily accessible and widely sought tool among the general public (GP) to both receive and convey information. Little is known about what could be found as it pertains to grief/bereavement.

Aims.

1. To assess YouTube as a resource for valuable and relevant information related to grief and bereavement.
2. To explore various formats for information about grief and bereavement available on YouTube.

Methods/Session Descriptions. The first 150 videos available for each of the keywords "grief" and "bereavement" (300 videos total) were watched by two observers. Each video was assessed for 1) quality (useful, misleading, personal experience), 2) viewership, 3) producer (amateur vs. professional), 4) uploader (healthcare organizations, media/news, hospices, independent organizations - IO), and 5) target audience (GP, healthcare professionals, both).

Results. N=300. There were 88 videos described as "good quality" and 212 videos described as "misleading." Videos were on YouTube for 1,006 days (mean); duration of time on YouTube did not influence video quality. 69% of the misleading videos were amateur vs. 18.2% useful videos; 81.8% of useful videos were made by professional organizations ($p<0.0001$). Viewership of misleading videos was considerably greater (average of 348,115) when compared to useful videos (26,293). 72.7% of useful videos were uploaded by an IO, as opposed to hospices (3.4%), universities (3.4%), and healthcare institutions (13.6%). 99% of misleading videos were uploaded by an IO. Useful videos were uploaded by an IO and professionally made, though viewership was considerably smaller for these videos than for the misleading and usually amateur-made videos.

Conclusion. This study provides information available on YouTube with the search terms "grief" and "bereavement." Though there is a massive amount of misleading videos, there is also significant information related to educational/self-help resources, spiritual guidance, and personal experiences. It was surprising to find how vast an amount of helpful information came from an IO.

Implications for Research, Policy, and Practice. Given the potentially substantial audience that remains untapped, YouTube is an underutilized resource for the dissemination of information by hospices and healthcare organizations.

4:30–5:30 pm

Concurrent Sessions

Fast and Furious Palliative Care Education: Utilizing Fast Facts and Concepts to Deliver Just in Time Teaching (FR470)

Sean Marks, MD, Medical College of Wisconsin, Milwaukee, WI. Michelle Freeman, MD, Penn State Hershey Medical Center, Hershey, PA. Drew Rosielle, MD FAAHPM, University of Minnesota Medical School, Minneapolis, MN. Rene Claxton, MD MS, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Identify three educational barriers specific to palliative care that can be overcome via "just in time" teaching strategies.
- Learn five novel ways to incorporate Fast Facts and Concepts in your healthcare institution's Hospice and Palliative Medicine's educational mission.
- Demonstrate the peer review process, which underlies the reliability of published Fast Facts, to improve HPM education and scholarship.

In anticipation of a worsening clinician shortage in the field of hospice and palliative medicine (HPM), the delivery of efficient and effective palliative care education to non-palliative care clinicians will be important to the sustainability of the field. With the traditional lecture format of CME events or Grand Rounds, learners may gain a "confidence-competence gap" in which they develop an inflated confidence in their clinical HPM knowledge that reduces their motivation to improve their knowledge. More effective educational tools seize "teachable moments," ie, when a clinician is struggling with a palliative care related clinical issue, there is a high "tension" for the clinician to address the deficiency. Most available evidence based educational tools are too cumbersome to deliver the necessary education at the time of need. The Fast Facts and Concepts is a unique educational tool that provides an easily accessible and concise review of evidence-based palliative care information on relevant topics in the field of HPM. Their adaptability can foster "just in time teaching." This concurrent session will a) review the educational promise of just-in-time teaching; b) explore the published evidence demonstrating the educational effectiveness of Fast Facts and Concepts for clinicians in training and clinicians in practice; c) cite novel ways to utilize Fast Facts to promote palliative care education in a variety of settings of clinical practice; d) review the peer review process of Fast Facts and Concepts; and e) highlight recent advances and developments in Fast Facts in the domains of adult, pediatric, and geriatric HPM education. With this knowledge, participates will be able to incorporate Fast Facts and Concepts into their just in time teaching in novel ways that will enhance palliative care knowledge of their peers and trainees.

Statistics Tools to Make the Case for Your Hospice and Palliative Care Program (FR471)

David Casarett, MD MA FAAHPM, University of Pennsylvania, Philadelphia, PA. Melissa Aldridge, PhD MBA, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Apply simple techniques of data analysis to evaluate the impact of palliative care on costs.
- Use stratified analysis to demonstrate the impact of hospice and palliative care on 30-day readmissions and patient experience scores.
- Understand and use basic statistical software packages for analysis.

Background. Increasingly, hospice and palliative care programs are being asked to demonstrate their value and impact. For instance, programs are required to show their impact on hospital length of stay or costs. And other measures, such as 30-day readmissions or patient satisfaction, are also being added to the list of metrics by which hospice and palliative care programs are assessed.

It's essential that hospice and palliative care programs approach this analysis carefully, using appropriate techniques. Failure to use the right methods can produce misleading or inaccurate results, often significantly underestimating a program's benefits. Furthermore, it's essential to be able to guide other stakeholders (eg, health systems and payers) in conducting this analysis appropriately, so that discussions about hospice and palliative care's benefits use the same numbers.

Session. In this session, we will describe common errors of analysis and how to overcome them. We will discuss techniques of stratification, cohorts, and time series analysis that can be applied by anyone without formal statistical training. We also will provide an introduction to tools of data management that will enable attendees to conduct this analysis on their own.

Conclusion. Participants will gain concrete, usable skills of analyzing impact data for a hospice or palliative care program.

Let's Order Lunch Off the Beer List and Other Flagrant Medication Decisions in End-of-life Care (FR472)

Mary Lynn McPherson, PharmD BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Kashelle Lockman, PharmD, University of Maryland School of Pharmacy, Baltimore, MD.

Objectives

- List and explain why specific medications are considered to be potentially inappropriate for use by older adults in general, in specific disease states, in reduced renal function, and in combination with other medications.
- Describe a process used to evaluate the benefits and burdens of medications on the AGS Beers Criteria when used in the context of managing symptoms of advanced illness in older adults.
- Given a simulated case of an older adult receiving hospice or palliative care services, provide an informed decision regarding the use of potentially inappropriate medications selected to treat pain and non-pain symptoms.

The American Geriatrics Society (AGS) "Beers Criteria for Potentially Inappropriate Medication Use in Older Adults" is an often-cited resource regarding the selection of medications for older adults and is frequently used to guide therapeutic decision-making. The purpose of these criteria is to provide guidance regarding medications considered to be "potentially inappropriate" in general or in specific disease states, drugs requiring dosage adjustment in renal impairment, and drug-drug interactions. Medications are frequently used to manage pain and non-pain symptoms in older patients with advanced illness, and this frequently involves selection of medications considered to be potentially inappropriate per the Beers criteria. The guidelines clearly state that the intended application is for use in all ambulatory care and institutionalized settings of care for patients over 65, with the exception of hospice and palliative care. However, the guidelines offer prudent advice even in this clinical setting. For example, the AGS Beers Criteria provide a strong recommendation to avoid benzodiazepines, antipsychotic, and anticholinergic (antisecretory) medications in older adults, yet use of these drugs is practically the price of admission to hospice and palliative care. The purpose of this presentation is to summarize the 2015 AGS Beers Criteria, and, using a case-based approach, explore the benefits and burdens of medications on the list when used in the context of advanced illness. This will include medications used in older adults regardless of comorbid conditions, medications used in specific medical conditions, medications that should be used with caution or not at all in older adults, clinically important drug-drug interactions that should be avoided, and medications that should be avoided or dose-reduced in reduced renal function. This is an important presentation that will provide practitioners deeper insight into the benefits and burdens of potentially inappropriate medications often used to manage symptoms in advanced illness in older adults.

Palliative Care for Children with Comorbid Autism Spectrum Disorders (FR473)

Conrad Williams, MD, Medical University of South Carolina, Charleston, SCF. Kathleen Atmore, PsyD, Children's National Health System, Washington, DC.

Objectives

- Identify 3 core aspects of development unique to patients with autism spectrum disorders (ASD).
- Describe how developmental differences impact symptom assessment and pain behaviors in children with ASD who also have a serious illness.
- Develop two unique strategies to appropriately care for children with autism needing palliative care services due to comorbid serious illness.

Using a case-based approach, this session will aim to illustrate the unique aspect of providing palliative care for children with comorbid autism spectrum disorders (ASD). ASDs are neurodevelopmental disorders characterized by social deficits, communication difficulties, repetitive behaviors, and sensory issues. The prevalence of autism has increased markedly in the past several decades. Certain medical conditions are more common in children with ASDs, including epilepsy and genetic abnormalities. Additionally, mortality rates are 3-10 times higher in patients with ASDs than the general population. With the increasing prevalence of autism, palliative care teams are likely to care for patients with ASDs and a comorbid serious illness.

Because children with autism have profound limitations in communication and social reciprocity, their experiences with medical care are unique and can be challenging. Providing a thorough palliative care assessment and delivering needed services is often an immense undertaking that can be quite stressful for all involved in care. The healthcare experience for all three stakeholders—patient, family, and medical providers—presents unique challenges; however, positive results can be obtained with advanced planning. The session will also discuss strategies for providing effective communication and care for children with autism who have a family member with a serious illness.

This session will provide concrete strategies that can enhance care provided to patients with ASDs and a comorbid serious illness and their families. By recognizing and addressing the particular needs of patients with ASDs, palliative care providers can develop trusting and productive relationships with patients and families that can allow for delivery of optimal palliative care. Participants in this session will learn how to develop an interdisciplinary care plan that will optimize the healthcare experience for all involved in the care of patients with autism and their families in the face of serious illness.

Poetry and Pain Management: The Art of Deeply Listening to Patients (FR474)

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

Objectives

- Create a plan of care for appropriate patients that include using poetry or creative writing as a healing modality.
- Identify two methods of improving communication/listening skills with patients.

We have the cognitive understanding that palliative care is patient-centered and addresses the whole person: body, mind, heart, spirit. Yet, truly addressing the deeper issues of psychological and spiritual distress in our patients is challenging. It may be helpful to develop strategies to think "outside of the box" and facilitate the creative process to guide our patients and ourselves. For some people, creating visual art or making music is, in itself, a necessary part of the healing process. For others, creative writing (including poetry) can help express the metaphors of intense suffering. Listening to poetry can be a salve to the spirit, soothing wounds that morphine or ativan cannot heal. In this 1-hour session, we will share stories of clinicians and patients using the power of poetry as a healing modality, as well as conduct several experiential exercises to help clinicians access the voice of their own "inner healer." In the words of John Fox, Director of the Institute for Poetic Medicine, "When someone deeply listens to you, your bare feet are on the earth, and a beloved land that seemed distant, is now at home within you."

Building a Feedback Culture: How to Teach Your Team to Give and Receive Feedback for Maximal Performance and Growth (FR475)

Juliet Jacobsen, MD, Massachusetts General Hospital and Harvard University, Boston, MA. Vicki Jackson, MD MPH FAAHPM, Massachusetts General Hospital and Harvard Medical School, Boston, MA. Todd Rinehart, LICSW ACHP-SW, Massachusetts General Hospital, Boston, MA.

Objectives

- Understand how an individual's mindset about feedback affects how feedback is received.
- Explore how to receive feedback effectively as well as how to prepare others to optimally receive feedback.
- Reflect on ways to build a feedback culture in the work environment to promote team function, resilience, and retention.

Feedback is essential for optimal performance and growth but many people lack training in how to give and receive feedback. Drawing from recent research, including work on positivity and mindset, this session will explore how an individual's baseline thought habits and orientation to feedback influence how they are able to receive and utilize feedback. Participants will learn and practice evidence-based techniques for both giving and receiving feedback, and will learn how to optimally prepare others to receive feedback. Finally, participants will reflect on how to incorporate feedback into work culture to build an environment that promotes individual resilience and growth, team function, and staff retention.

Heart Problems, Easy Fixes: Practical Solutions for Overcoming Challenges in Conducting Palliative Care Research, Quality Improvement, and Clinical Practice in Heart Failure (FR476)

Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. David Bekelman, MD MPH, University of Colorado, Denver, CO. Marie Bakitas, DNSc CRNP AOCN ACHPN FAAN, University of Alabama at

Birmingham, Birmingham, AL. Laura Gelfman, MD MPH, Icahn School of Medicine at Mount Sinai, New York, NY. Nathan Goldstein, MD FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Identify a variety of potential pitfalls in translating existing models of palliative care research, quality improvement, and clinical interventions for heart failure.
- Explore solutions for overcoming challenges encountered while conducting research, clinical practice, and quality improvement in heart failure palliative care.

More than 5.5 million Americans currently live with heart failure (HF). Despite improved survival, approximately 50% of patients will die within 5 years of diagnosis. Patients with HF suffer from high symptom burden, psychological distress, and dramatic functional limitations, impairing patient and caregiver quality of life.

Given that the evidence base for HF palliative care (PC) is in its infancy, no established model of PC exists for this growing population. Unfortunately, our oncology-dominant approach to PC will not seamlessly translate to meet the needs of patients with HF. Distinctive characteristics of HF, such as its unpredictable trajectory, and the complexities of cardiac devices merit evaluation of how PC should be designed for HF to ensure maximal benefits.

Using examples from our own work, this multidisciplinary, multi-institutional panel of PC professionals will highlight lessons learned from research, clinical implementation, and quality improvement related to HF PC. Drs Kavalieratos and Gelfman will share pitfalls encountered while conducting qualitative and quantitative research on the role and effectiveness of PC in HF. Dr Bakitas will discuss her experiences with translating proven oncology PC interventions for HF populations. Relevant to researchers and clinicians alike, Dr Goldstein will discuss the challenges of identifying HF patients with high palliative needs. Lastly, Dr Bekelman will share insights on developing an embedded outpatient HF PC clinic.

By the end of this interactive session, participants will appreciate the idiosyncrasies of conducting research, clinical care, and quality improvement in HF PC. Panelists will share pearls of wisdom from our own experiences that can be leveraged by participants to enhance their local efforts. Participants are encouraged to come ready with questions and challenges to be discussed in a moderated question-and-answer session. Through shared learning and networking, this forum will nurture future work to meet the palliative needs of individuals affected by HF.

Long Term Collaboration for Building Sustainable Palliative Care in Belarus (FR477)

Kathleen Doyle, MD, Massachusetts General Hospital, Boston, MA. Debra Skoniecki, ACHPN CNP MSN, Brigham & Women's Hospital, Rowley, MA. Galina Gheihman, HBSc, Harvard Medical School, Boston, MA.

Objectives

- Describe how to conduct a palliative care needs assessment in a foreign country to understand attitudes, knowledge gaps, current practice, and drug availability.
- Understand how to develop, test, and implement a palliative care curriculum that is comprehensive, at an adequate difficulty level, and culturally appropriate.
- Identify ways to maintain a long-term relationships to further palliative care education and development in a middle income country like Belarus.

The WHO and the Worldwide Palliative Care Alliance recently mapped supply and demand for palliative care worldwide, finding that only 10% of the 20.4 million people who need palliative care currently receive it. A major barrier to meeting that need is insufficient education of healthcare workers in palliative care.

Over the last decade, palliative care has attracted significant interest from the government of Belarus, with the first adult hospice founded in 2005 and palliative care introduced into the National Healthcare Law in 2013. However, the country faces a shortage of healthcare providers trained in palliative care. We will report on the experience of developing and implementing a palliative care curriculum in Belarus.

To develop the curriculum, we first conducted a needs assessment that examined physician knowledge of and attitudes toward palliative care, the legal status of palliative care, drug availability, and other topics. We utilized past in-country experience, a literature review, a questionnaire, and interviews with Belarusian colleagues. Based on the needs assessment, we developed, modified, and translated a 25-lecture curriculum that was comprehensive, at an adequate difficulty level, and culturally appropriate. A team of four clinicians taught the curriculum in Belarus to an audience of physicians and healthcare administrators. The course was well-received—participants were satisfied, reported a better understanding of palliative care, and improved their skills and confidence in managing symptoms and discussing prognosis.

We have continued our collaboration with Belarusian colleagues. New governmental policies have passed that promote palliative care. We are currently preparing a virtual teleconference as well as a second in-person palliative care education workshop for both physicians and nurses. The materials we developed also may be used for education courses beyond Belarus. Ultimately, we hope that our experience provides encouragement and resources for the continued promotion of palliative care education and development worldwide.

When Worlds Collide: Decision Making and Palliative Care for Patients with Mental Illness (FR478)

Stephanie Harman, MD, Stanford University, Stanford, CA. Gary Hsin, MD FAAHPM, VA Palo Alto Health Care & Stanford University, Palo Alto, CA. Edward Kilbane, MD, Case Western Reserve University, Cleveland, OH.

Objectives

- Utilize an ethical framework to approach decision making for patients with mental illness who lack capacity to make medical decisions, with consideration to legal boundaries.
- Discuss a practical approach to identify when concurrent mental health issues alter the course of a curable disease and hinder the delivery of life-saving treatments.
- Understand when a mental illness alone can become terminal in the absence of concurrent life-threatening medical illness.

Patients with mental illness have a higher incidence of comorbid medical diseases than the general population. There are considerable ethical and practical challenges in the treatment of medical disease in this patient population, particularly with regards to decision making and determining prognosis. Clinicians are often faced with decisions to limit treatment options, which can result in significant distress to the patient and care providers, both in pursuing the standard of care or in feeling forced to alter it. A multidisciplinary approach can help achieve coordinated care and informed decision making while addressing the palliative care needs of these patients.

In this session, we will examine archetypal cases in which a patient's mental illness alters the normal treatment planning for a serious medical illness and discuss the role that palliative care can play in aligning the care plan with individualized goals in this patient population. First, we will look at the ethical and legal complexities of decision making and surrogacy when a patient with mental illness lacks the capacity to make decisions regarding treatment. The second major scenario we will address pertains to when concurrent mental health issues alter the course of a curable disease. Third, we will discuss the challenges related to the approach to the patient whose mental illness becomes a terminal one, in the absence of comorbid medical illness, such as in the case of untreated psychiatric illness or delirium.

Persuasive Proposal Development 101: How to Convince Others to Fund Your Program, Your Research, or Your Clinical Initiatives (FR480)

Krista Harrison, PhD, Capital Caring, Falls Church, VA. Jon Furuno, PhD, Oregon State University College of Pharmacy, Portland, OR. Thomas LeBlanc, MD MA, Duke University School of Medicine, Durham, NC. Arif Kamal, MD, Duke Cancer Institute, Durham, NC. Betty Ferrell, PhD MA FAAN FPCN, City of Hope, Duarte, CA.

Objectives

- Describe common ways to capture the quality and importance of an idea in a proposal and ensure it is easily understood by reviewers.
- Describe common proposal weaknesses and why those weaknesses diminish a proposal's impact and likelihood of success.
- Use the best practices and common errors outlined in the presentation to improve the quality of attendees' own proposals.

Innovation and evolution in the conduct of hospice and palliative care takes many forms, including QI projects, community-based clinical programs, or research initiatives. Funding is often a requirement for translating ideas into practice, often on the basis of a written proposal. Whether the target audience is the leadership of a healthcare organization or an NINR study section, proposals are opportunities to make compelling arguments conveying the significance, importance, and methods by which we propose to improve care. However, a poorly written proposal can also stop a great idea in its tracks.

In the proposed 1-hour session, five experts with backgrounds in quality improvement, clinical program development, and research will discuss essential elements of a compelling proposal. This will provide insight into the black box of proposal reviews by administrators and funders. New leaders may be asked to write proposals for initiatives without formal training in proposal writing or without having had opportunities to participate on review panels. The high failure rate and trial-and-error process of proposal writing may be a major barrier to further advancement in the field.

This session will begin by outlining key ingredients of successful proposals, including a compelling elevator pitch, measurable aims, pilot data, and feasible outcomes. We will present common evaluative methods for proposals, from the NIH-style grant rubric to the more informal criteria of healthcare leadership. Panelists then will review and discuss 3-6 proposals exemplifying best practices and common errors. The audience will join the review process through polling techniques and question and answer opportunities. Dr Krista Harrison will speak about demonstration project proposals. Dr Jon Furuno will speak about research funding for junior investigators. Dr Kamal will discuss QI and business proposals. Dr LeBlanc will talk about the Palliative Care Research Cooperative group and foundation funders. Dr Ferrell will discuss nursing research and the advancement of clinical leaders into research investigators.

Paper Session

Difficult Conversations: Discussing Prognosis with Children with Cystic Fibrosis (FR481A)

Julia Saunders, BA, University of North Carolina at Chapel Hill, Chapel Hill, NC. Mary Prieur, PhD, University of North Carolina at Chapel Hill, Chapel Hill, NC. Michelle Walter, DO, University at Buffalo, State University, Buffalo, NY. Drucy Borowitz, MD, University at Buffalo, State University, Buffalo, NY. Elisabeth Dellon, MD, University of North Carolina School of Medicine, Chapel Hill, NC.

Objectives

- Describe how and when individuals with cystic fibrosis learn about prognosis with a life-limiting disease, specifically its progressive nature and the median life expectancy.
- Describe the emotional impact of initial communication about prognosis with cystic fibrosis, a life-limiting genetic disease.
- Acquire new language for initiating conversation about prognosis with individuals with a life-limiting disease as well as a general age-based timeline for when to initiate prognosis conversations.

Original Research Background. No published studies address how patients with cystic fibrosis (CF) receive and perceive education about disease prognosis. Related research suggests a need for more information and strategies for coping with this burdensome disease and its limited life expectancy.

Research Objectives. To describe patient, parent, and provider experiences with communication about prognosis and the emotional impact of initial communication and to elicit recommendations for improving communication.

Methods. Semi-structured interviews were conducted with 18-25-year-olds with CF, parents of the 18-25-year-olds, and CF care providers at two CF centers. Thematic analysis of responses was conducted by the research team.

Results. Thirteen patients, eight parents, and seven CF care providers (five physicians, one nurse, and one social worker) participated. More than half of patients (54%) learned about prognosis independently, not from a parent or provider. Fear and sadness were common emotional responses. All groups recommended in-person, individualized communication, describing this discussion as a “milestone” in disease self-management. Most patients (77%) and parents (86%) felt a provider should initiate communication about prognosis. Providers described uncertainty about when to address prognosis and how to instill hope while sharing information. Limited time, lack of confidence in addressing this topic, waiting for patient cues, and protecting parents were the top barriers to communication. While providers expressed concern about affecting mood and adherence, most patients reported that learning about prognosis did not negatively affect their outlook (79%) and that effects on adherence were often positive.

Conclusion. Patients with CF and their parents and providers acknowledge challenges communicating about prognosis. Patients desire earlier, individualized, in-person communication. Standardized provider prompts to initiate communication about prognosis would ensure all patients are appropriately aware of prognosis. Age-appropriate educational materials could be used to facilitate conversations between patients, families, and providers.

Implications for Research, Policy, and Practice. Though CF-focused, the themes elicited from this research can be applied to communicating prognosis in other life-limiting childhood illnesses.

Advance Care Planning and HIV in the Post-Antiretroviral Therapy Era: A Narrative Review (FR481B)

Aroonsiri Sangarlangkarn, MD MPH, Thai Red Cross AIDS Research Center, Queens, NY. Jessica Merlin, MD, University of Alabama at Birmingham, Birmingham, AL. Rodney Tucker, MD MMM FAAHPM, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL. Amy Kelley, MD MS MSHS, Mount Sinai School of Medicine, New York, NY.

Objectives

- Provide a general overview of the post-ART landscape and its effects on advance care planning (ACP) among the HIV-infected population.
- Review up-to-date research evidence on challenges in ACP among the HIV-infected

population as it relates to the inpatient and outpatient setting.
- Brainstorm how providers across multiple disciplines can work together to provide effective ACP in the HIV-infected population.

Systematic Review Background. Since the advent of antiretroviral therapy (ART), HIV has transitioned from a rapidly fatal illness to a chronic disease with multi-morbidity, and providers are faced with an emerging population with unique advance care planning (ACP) needs.

Aims. To provide a narrative review of existing studies on ACP in adult HIV-infected patients in the post-ART era.

Session descriptions. Original studies describing ACP for adult HIV-infected patients post-ART (1996-present) were identified through searches of PUBMED, EMBASE and PsychINFO, excluding non-English and legal/social work articles. Nine studies met the selection criteria. They were conducted between 1996 and 2013, with study size ranging from 47 to 2864 patients. Most studies consisted of young, white, male patients with less than college education in the outpatient setting, and they had poorly defined definitions of ACP. The prevalence of ACP was variable (36-54% end-of-life communication, 8-47% advance directive). Lack of ACP was most commonly associated with less severity of illness, followed by non-white race, drug use, younger age, female sex, low education, low income, and social isolation. Providers reported limited time/energy and inadequate preparation/training as barriers to ACP.

Conclusion. Existing literature on ACP in the post-ART era is limited. The prevalence of ACP in HIV-infected patients is low in vulnerable subgroups (non-white race, drug users, those of lower socioeconomic status, socially-isolated patients), but higher with increased age, severity of illness, or multimorbidity. Providers also report logistics and inadequate preparation as barriers to ACP. More research is needed to effectively increase ACP among HIV-infected patients.

Delivering More, Better and Earlier Goals of Care Conversations to Seriously Ill Oncology Patients in the Clinical Setting (FR481C)

Joanna Paladino, MD, Dana-Farber Cancer Institute, Boston, MA. Daniela Lamas, MD, Brigham and Women's Hospital, Boston, MA. Joshua Lakin, MD, Dana-Farber Cancer Institute, Boston, MA. Samantha Epstein, BS, Dana-Farber Cancer Institute, Boston, MA. Rachelle Bernacki, MD MS FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives
- Understand the need for a systematic approach to having more, better, and earlier conversations about patient values and priorities in serious illness.
- Describe the ways in which preliminary data are demonstrating early success of intervention processes.

Original Research Background. Patients with serious illness routinely receive treatments that are not aligned with their goals. Earlier clinical conversations about patients' values and priorities are associated with more goal-concordant care and improved quality of life, but these conversations often happen too late or not at all.

Objectives. Evaluate clinician adoption and acceptability of the serious illness intervention. Determine the frequency, timing, and quality of goals-of-care documentation before death.

Methods. Cluster-randomized trial including oncology clinicians and their patients. Systematic intervention includes: clinician identification of patients at high risk of death in a year using the "surprise" question; 2½ hour clinician training on the Serious Illness Conversation Guide; email trigger/reminder; and EMR documentation. Preliminary chart review extracted goals-of-care conversations for deceased patients in intervention and control.

Results. 90 oncology clinicians: 47 intervention; 43 control. Of 47 intervention clinicians, 46 were trained and rated the training as effective (4.3/5). 97% of trained clinicians who were triggered then adopted the Conversation Guide and found it acceptable (4.2/5). 342 patients enrolled: 176 intervention; 166 control; 38% died (n=131). Among patients who died, preliminary chart review showed that more goals-of-care conversations were documented before death in intervention compared to control (92% versus 70%, p=0.0037); intervention conversations took place three months earlier than control (median 143 days versus 63 days, p=0.0008). In addition, conversations were more patient-centered (95% versus 45%, $p<0.001$) and more readily retrievable in the EMR (68% versus 28%, $p<0.001$).

Conclusions. Preliminary data about the Serious Illness Care systematic approach demonstrated strong clinician adoption and acceptability. The intervention resulted in more, better, and earlier conversations and documentation about patient values and priorities in the medical record.

Implications for Research, Policy, or Practice. The serious illness care intervention may be a scalable solution to facilitate more, better, and earlier goals-of-care conversations with seriously ill patients in the outpatient clinical setting.

Discussing Prognosis and Incurability with Advanced Cancer Patients in the Hospital (FR481D)

Sasha Jones, BA, Northwestern University Feinberg School of Medicine, Chicago, IL. Kenzie Cameron, PhD, MPH, Northwestern University Feinberg School, Chicago, IL. Melanie Smith, MD, Northwestern University Feinberg School of Medicine, Chicago, IL. Frank Penedo, PhD, Northwestern University, Chicago, IL. Rashmi Sharma, MD MHS, University of Washington, Seattle, WA.

Objectives

- Describe discussion content regarding prognosis and incurability in inpatient end-of-life (EOL) discussions.
- Compare physician and patient/family statements about prognosis and incurability.

Original Research Background. Advanced cancer patients often have poor understanding about prognosis and incurability. End-of-life (EOL) discussions provide an opportunity for physicians to improve patient understanding, and they frequently occur in the hospital. However, little is known about the content of these discussions.

Research Objectives. To explore the content of physician-patient EOL discussions in the hospital.

Methods. Via daily contact with oncology, hospitalist, and palliative care services, we identified advanced cancer patients with an upcoming EOL discussion. Discussions were audiotaped, transcribed verbatim, de-identified, and coded in MaxQDA by two of three coders using a constant comparative approach. Discrepancies were resolved by consensus. Key themes related to discussion of prognosis and incurability are reported.

Results. Of 21 recorded discussions, nine were with non-Hispanic white and 12 with black patients. Patient mean age was 59.5 years (SD=13.9); 10 patients were female. Sixteen discussions were done with family present. All but one discussion included a palliative care attending physician or fellow; five discussions also involved an oncology fellow or attending. Prognosis was addressed in 15 discussions, primarily by physicians; most statements focused on acknowledging uncertainty. Physicians provided a quantitative estimate in three discussions; one physician first asked if the patient wanted an estimate. One patient and two family members explicitly asked the physician about prognosis. Incurability was addressed in 12 discussions, and most involved the physician explicitly stating that the patient's cancer was incurable. Four patients expressed understanding of having incurable disease; three instances were in response to the physician asking about disease understanding.

Conclusion. Physicians frequently discussed prognosis, but most statements focused on acknowledging uncertainty and did not provide a quantitative estimate. Incurability of disease was discussed in approximately half of discussions, with physicians more likely to broach the topic than patients.

Implications for Research, Policy, and Practice. Opportunities to improve communication about prognosis and incurability exist in the inpatient setting.

4:30–6 pm

Interactive Educational Exchange (FR482)

The Weight of Pain: What Does a 10 on the Pain Scale Mean? An Innovative Use of Art in Medical Education to Enhance Pain Management (FR482A)

Bonnie Marr, MD, Johns Hopkins Hospice & Palliative Medicine Fellowship Program, Baltimore, MD. Jay Baruch, MD, The Alpert Medical School of Brown University, Providence, RI.

Objectives

- It is our hypothesis that clinician training in metacognition builds awareness for the roles of observation and communication in the formation of perception and can ultimately influence decision-making in pain management.

Background. Clinicians practice pain management in an environment where the goal of treating pain is made challenging by opioid addiction and abuse. Treating pain is complex and based on the clinician's perception of the patient's pain. Metacognition is the awareness and understanding of one's own thought processes. Often this is lacking in pain management and unconscious biases guide decision-making. Art offers a unique platform for engaging these processes and can aid in the development of metacognitive skills.

Methods. Two sessions were held at a museum in collaboration with museum educators. Attending physicians, residents, and mid-level providers from the Emergency Medicine department were invited to the first session with 14 participants total, and the second session was expanded to include the Palliative Care and Internal Medicine departments with 17 participants total. In the first session participants viewed one of two pieces of artwork and discussed how their observations changed as information was revealed about the artist. At the second session, based on feedback, participants viewed two pieces of artwork. At the first work of art, they developed a question. They subsequently were asked to answer this question based on their observations about the second piece. These discussion points opened up the opportunity for participants to discuss how they dealt with uncertainty when they had to answer a question with limited information. A discussion with all participants present took place at both sessions to relate their experiences with the art to pain management. Optional surveys were distributed at both sessions. The first called for narrative responses and the second offered "yes/no" selections with the option for narrative.

Results. Tables containing data available. Results for Session One: Participant Responses to Narrative-Based Questions. When asked, "Has the session helped you think differently about communication?" 92% provided positive responses. When asked, "Will you make changes based on this session?" 77% responded positively. When asked, "Do you see a link between what you learned about observation and the evaluation of pain?" 85% responded positively. When asked, "Would you be interested in future sessions?" 100% responded positively. Results of Survey for Session Two: Participant response based on selection choices of "Yes" or "No." When asked, "Has this session helped you think differently about communication?" 81% responded "Yes." When asked, "Has this session helped you think differently about making observations?" 100% responded "Yes." When asked, "Do you feel observation and communication play a role in pain management?" 100% responded "Yes." When asked, "Do you think this event will lead to a change in your clinical practice?" 62% responded "Yes." When asked, "Would you recommend this session to a colleague?" 100% responded "Yes."

Discussion. Pain is multidimensional and highly individualized both for the person experiencing it and the care provider striving to treat it. Metacognition is an important element of pain management and often difficult to tease out through traditional medical education. Provider responses indicated that our sessions using artwork as a means of opening up discussion about how we communicate and make observations enabled them to start thinking differently about these elements of our practice and could see a definite link with pain management. Furthermore, the majority indicated that it likely will change their practice in some capacity. All participants at both sessions responded they would be interested in future sessions or would refer a colleague. These important elements demonstrate that a relatively low-budget educational intervention utilizing the humanities has the capacity to potentially generate change in an extremely important aspect of our practice: pain management.

Conclusion. Art has the capacity to aid clinicians in examining their perceptions and communication; elements of daily practice that they agree impacts delivery of analgesia. Providers report that training in metacognition has the capacity to change practice behaviors as they pertain to pain management.

TeamTalk: Interprofessional Team Development and Communication Skills Training (FR482B)

DorAnne Donesky, PhD ANP-BC, University of California, San Francisco, CA. Tom Reid, MD, University of California, San Francisco, CA. Denah Joseph, MA, University of California, San Francisco, CA. Wendy Anderson, MD MS, University of California, San Francisco, CA.

Objectives

- Appreciate the roles of medicine, nursing, and spiritual care in discussing prognosis and goals of care.
- Develop the internal capacities and apply core communication and teamwork skills to navigate individual and group discussions of prognosis and goals of care with seriously ill patients and their families.

Background. Clinicians in medicine, nursing, and spiritual care work together in providing palliative care. Integrating interprofessional training into professional education programs is limited by logistical challenges such as conflicting schedules, identifying the best learner levels to train together, and availability of learners from multiple disciplines.

Methods. Three afternoon workshops were required of all trainees in the palliative care and geriatric MD fellowships (N=8), advanced practice nursing (N=8), and spiritual care (N=9). The first session was a large group exercise focused on experiencing common themes and different perceptions of each discipline. The second session introduced role play in small groups with trained actors focused on previously learned skills and discipline-specific communication strengths. The third session provided opportunity to practice team dynamics and shared leadership in a family meeting with the goal of fostering interprofessional collegiality. Learner's confidence for ten skills necessary for difficult clinical communication was rated on a 0-10 point numeric rating scale. Qualitative evaluation was elicited during focus groups and written evaluations after the final session.

Results. Learners' confidence in the ability to bring a difficult conversation to a productive conclusion (6.13 ± 2.06 to 7.75 ± 0.78, p=.01) and use of associations and metaphors as a means to understand and appreciate what the patients and families say (5.94 ± 2.18 to 7.31 ± 1.92, p=.01) improved after the three sessions. Learners reported that the workshops gave them new respect and trust for each discipline while recognizing overlapping skills. They developed self confidence in their own skills and recognized when each discipline might take the lead in the conversation. Negative biases about other disciplines were uncovered and addressed.

Discussion. Although learners were chosen who all had recent experience with patient care, differences between skill levels were perceived as a barrier. Physicians perceived that other disciplines had less clinical experience, nurses expressed a lack of confidence in their abilities, and spiritual care providers were pleased to be included in the training. For the next iteration of the process, learners recommend additional focus on correcting negative biases and more time in the small group setting.

Conclusion. One learner described this experience as "the most valuable learning experience for me during my graduate education."

Interdisciplinary Case Management Experience in Palliative Care (FR482C)

Barbara Head, PhD CHPN ACSW FPCN, University of Louisville School of Medicine, Louisville, KY. Mark Pfeifer, MD, University of Louisville School of Medicine, Louisville, KY. Tara Schapmire, PhD, University of Louisville School of Medicine, Louisville, KY.

Objectives

- Define an interdisciplinary team and explain how it differs from other teams or groups.
- List the essential components of good communication skills in palliative care.
- Critique a family meeting.
- Participate as a team member in developing an interdisciplinary plan of care.

Background. Interdisciplinary communication, collaboration, and teamwork are essential components of palliative care. Yet students of healthcare professions are seldom taught the necessary skills and even less often allowed to practice those skills in a safe setting with students and faculty from other professions. In an effort to overcome this educational deficit, we developed and implemented the Interdisciplinary Case Management Experience (ICME), which is mandatory for fourth year medical, fourth year BSN, master's level social work students and chaplaincy residents.

Methods. Each session involves approximately 40 students who are broken into teams of 6-8 students representative of the four disciples and facilitated by a faculty member. After introductions and an icebreaker activity directed at overcoming discipline stereotypes, the group is led in a general discussion of the benefits and burdens of team work. The students are then introduced to the case of a palliative care patient via a written case description, video vignettes of individual team member interactions with the patient and family, and a videotaped family meeting. Through the use of evidence-based behavioral checklists and discussion activities, the students learn to evaluate provider communication skills and plan for and then critique a family meeting. In the culminating activity, students work on their own to create an interdisciplinary plan of care for the patient followed by feedback from an observing faculty member.

Results. Over 900 students at the University of Louisville have completed an ICME session. Quantitative evaluation using a pre/post-test design indicated that students made significant improvements on two standardized instruments: the Self-Efficacy for Interprofessional Experiential Learning Scale and the End-of-Life Professional Caregiver Survey. Qualitative feedback revealed that students appreciated the experiential aspects, especially the opportunity to observe palliative teams at work and practice team-based skills with other learners.

Discussion. While there are many challenges involved in establishing interprofessional learning experiences for students from multiple disciplines, the outcomes justify the effort.

Conclusion. This three hour interactive experience has resulted in student growth in palliative care knowledge and skills and their ability to respect, collaborate with, and learn from other disciplines.

A Curriculum to Teach and Assess Patient Handoffs in Palliative Medicine Training Programs (FR482D)

Nina O'Connor, MD, University of Pennsylvania, Philadelphia, PA. Neha Darrah, MD, Cedars-Sinai Medical Center, Los Angeles, CA.

Objectives

- Develop and validate a template for patient handoffs from the hospital to hospice.
- Create an interactive didactic to teach this handoff to physicians and nurses in training.
- Develop a direct observation evaluation tool for hospital to hospice handoffs that meets ACGME requirements for handoff assessment.

Background. Patient handoffs are an increasingly emphasized skill in medical and nursing education. The Accreditation Council for Graduate Medical Education (ACGME) includes transitions in care as one of the key components of their Clinical Learning Environment Review (CLER) program. All hospice and palliative medicine fellowships must demonstrate curricula to teach and evaluate handoffs. Palliative medicine nurse practitioners and hospice nurses also perform handoffs regularly. Traditional handoff tools emphasize transitions that may not apply in hospice and palliative medicine (floor to ICU, day shift to night shift). In addition, these handoff tools lack content that is unique to hospice and palliative medicine.

Methods. Seven hospice physicians, nurse practitioners, and nurses were interviewed to determine core content for a hospital to hospice handoff. This content was used to create a handoff template. The same hospice providers reviewed the handoff template for validation. The handoff template was taught to two groups of palliative medicine fellows and one group of internal medicine residents using an interactive didactic and role play. Feedback was obtained to further refine the handoff template. A direct observation assessment tool was then developed to mirror content in the handoff template.

Results. The hospital to hospice handoff template and didactic received positive evaluations from palliative medicine fellows and residents. The direct observation assessment tool was successfully implemented in a palliative medicine fellowship to meet ACGME requirements for handoff assessment.

Discussion. ACGME requirements for handoff education and assessment must be adapted to hospice and palliative medicine. The hospital to hospice handoff is an ideal handoff to emphasize in palliative care education because it requires trainees to determine which information is relevant for patients with comfort-focused goals. It can also be formally assessed to meet ACGME requirements for the CLER program.

Conclusion. Our comprehensive curriculum (hospital to hospice handoff template, didactic with role play, direct observation assessment tool) fulfills requirements and also ensures smooth transitions from the hospital to hospice. It can be easily adapted to other disciplines including nurses and advanced practice providers.

Clear Conversations: A Comprehensive Curriculum to Facilitate Translation of Skills Learned in Simulated Settings to Improve Communication in Real Clinical Encounters (FR482E)

Kristen Chasten, MD, Henry Ford Hospital, Detroit, MI. Rana Awdish, MD, Henry Ford Hospital, Detroit, MI. Michael Mendez, MD, Henry Ford Hospital, Detroit, MI. Dana Buick, MD, Henry Ford Hospital, Detroit, MI. Maria Kokas, PhD, Henry Ford Hospital, Detroit, MI.

Objectives

- Apply a protocol for deliberate practice of communication skills in real encounters with the aid of a mobile app and online template.
- Demonstrate at least two communication skills learned in simulation (eg, ask-tell-ask, empathic response, open-ended question to elicit patient values) in a real clinical encounter.

Background. Communication skills training with simulated patients has gained traction in many academic centers as a way to improve communication skills. However, the optimal method to facilitate translation of skills learned in simulated settings to improve communication in real clinical encounters has not been described.

Methods. We developed a comprehensive communication skills curriculum for physicians in the ICU that consists of (1) simulation-based communication skills workshops for ICU fellows, residents, and attending physicians; (2) standardized pre- and post-family meeting team huddles following a template in a mobile app, which includes setting a communication goal and getting specific feedback; (3) online evaluation template to record family meeting feedback as a procedure; and (4) mandatory family meetings within 72 hours for all patients in the ICU with APACHE IV mortality >30%. We conducted a prospective cohort 2-week pilot study. We implemented the curriculum in one ICU unit and compared it to another geographically distinct ICU unit where the attending, fellow, and residents had not received simulation training or training on other aspects of the curriculum. Our main outcome measure was family satisfaction with physician communication in the ICU using a 10-question modified HCAPS survey. A secondary outcome was trainee self-perceived preparedness for end-of-life communication tasks in the ICU pre and post intervention.

Results. Patients in the intervention group (n=15) scored significantly higher on satisfaction with physician communication than the control group (n=16) (p=0.0178). Trainees in the intervention group showed significant improvement in self-perceived preparedness in communication skills between pre and post intervention in expressing empathy, responding to families who deny the seriousness of their loved one's illness, and discussing spiritual issues. There were no significant differences pre and post intervention in the control group.

Discussion. This comprehensive communication curriculum combining simulation-based training, deliberate practice at the bedside with the aid of a mobile app and online evaluation template, and mandatory early family meetings for high risk patients was associated with improved patient satisfaction with physician communication in the ICU and increased trainee preparedness for difficult communication tasks.

Conclusion. This communication curriculum could serve as a model for optimal inpatient communication skills training for residents and fellows across all disciplines.

Practice Makes Permanent: VitalTalk Techniques for Drilling Communication Skills (FR482F)

Stephen Berns, MD, Beth Israel Hospital, Icahn School of Medicine at Mount Sinai, New York, NY. Caroline Hurd, MD, University of Washington, Harborview Medical Center, Seattle, WA. Julia Carl, NP, Icahn School of Medicine at Mount Sinai, New York, NY. Anna Roshal, MD, Washington University, St. Louis, MO. Elizabeth Lindenberger Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Identify key behaviors for patient-centered communication.
- Practice using these techniques for easy and challenging situations.
- Recognize which behavior is useful for a given situation.
- Provide a safe environment with which learners can practice and receive feedback.

Background. When acquiring a new skill, whether it is playing an instrument or a sport, a learner starts with a basic set of principles formatted into drills that are systematically repeated until they are integrated into muscle memory. Literature tells us that after practicing drills, learners can apply and adapt these skills to real life situations more readily, building a repertoire as they develop from novice to expert. Much of the literature for communication training related to serious illness has focused on simulated practice sessions for teaching these important skills. This method, however, can be a significant investment in faculty development, time, and money. We propose that skill based drills can be an important part of teaching learners the foundations of communication skills and can be less resource intensive.

Methods. We have several drills that we use with a variety of different learners including physician trainees, RNs, and social workers. The skills we drill vary from responding to emotions, introducing palliative care, and asking about patient medical goals. A drill is designed for small group learning—up to 8 individuals. Each drill consists of 25 minutes of practice. A drill consists of 3 rounds: (1) designed for learners to familiarize themselves with the words and concepts, (2) designed for learners to identify what behavior matches the right situation, and (3) designed for learners to draw on their own experiences and challenges and apply it to the newly learned behaviors. Throughout the drills, the faculty provides feedback and redirection when the learner does not use the correct behavior.

Results. Written and oral feedback from learners have suggested that drills are "fun," consolidate language for the learners, and make the "harder tasks easier." Faculty have commented that learners are more comfortable using skills in simulated scenarios than when they did the simulated scenarios without prior drills. Faculty, however, have noted that not all skills are drillable and that some skills are either not commonly used or not applicable to most situations.

Discussion. Communication skill drills can help learners automate fundamentals helping to free up processing capacity so that learners can be more creative when they need to be. Drills take a shorter time then simulated play, and all learners can participate on an ongoing basis. Not all skills can be used as drills. One rule recommended in the literature is to identify the 20% of skills one could practice that will deliver 80% of the value.

Conclusion. Drills can be an efficient method in teaching communication skills that can help consolidate fundamental behaviors in a fun and challenging way.

SATURDAY, MARCH 12

7–8 am

Early-Riser Concurrent Sessions

New Drugs and Drug News: The 411 and Implications for Palliative Care (SA500)

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

Objectives

- Describe the approved indications, unapproved uses, common adverse effects, and drug interactions for a list of new drugs approved by the FDA in 2015.
- Describe the burden-to-benefit ratio and the role of the medication in caring for patients with advanced illness for each new relevant medication approved in 2015.
- Analyze important drug alerts and breaking drug news and their relevance to drug therapies commonly used in hospice and palliative care patients.

Up to 100 new drugs are approved every year by the US Food and Drug Administration (FDA). Some of these are new molecular entities, while others are new formulations, new indications, generic drug approvals, or labeling revisions. Even if a drug is a "new" molecular entity, it may not be "improved" over molecular entities already commercially available. In caring for patients with advanced illnesses, practitioners must make prudent drug therapy choices. Part of this decision-making process is a careful assessment of the burden-to-benefit ratio, including the financial burden of using each medication.

This concurrent session is a follow-up to a previous year's very popular update on new drugs. For relevant drugs approved in 2015, participants will learn about the FDA-approved indication for using the medication, unapproved uses of the medication (particularly as it applies to palliative care patients), whether it is a controlled substance and the schedule (if appropriate), adverse effects, major drug interactions, dosing, and financial implications of drug procurement and monitoring, if relevant.

Participants will learn what "NDA Chemical Type" (eg, new molecular entity, formulation, manufacturer, indication, or OTC switch) and "Review Classification" (priority, or standard review; orphan drug status) was assigned by the FDA. If available, participants will also learn the "new drug comparison rating" (1-5 scale; 5 being highest in terms of drug importance). Most importantly, the participant will learn about the role of the new agent in caring for patients with advanced illnesses and how this medication compares with medications already available.

Public health advisories and drug-related updates related to end-of-life care also will be discussed along with their impact on caring for palliative care patients. Inappropriate use of medications in hospice or palliative care patients may result in suboptimal symptom management. This is a session that every healthcare professional needs to attend!

We're Drowning and Now They Want Us to Start a Clinic! Managing Demands, Growth, and Priorities in Resource Limited Hospitals (SA501)

Rebecca Yamarik, MD, FAAHPM, TrinityCare Hospice, Cerritos, CA. Solomon Liao, MD FAAHPM, University of California Irvine Medical Center, Orange, CA. Kate O'Malley, MS RN GNP, California HealthCare Foundation, Oakland, CA. Carol Wanke, BS, Sharp HealthCare, San Diego, CA.

Objectives

- Successfully build a robust palliative care services in a control fashion that balances growth and burnout.
- Submit successful proposals to health system administrations and philanthropy foundations.
- Prioritize the competing needs of palliative care: outpatient vs inpatient, primary palliative care vs consultations.

Palliative care consult services have been rapidly growing in US hospitals, approaching a 300% increase in the last 15 years. It is now widely accepted that palliative care increases patient and family satisfaction as well as lowers hospital costs while improving patient survival and quality of life. With this fantastic growth have come challenges in how to manage it and grow the service while maintaining appropriate resources to provide it.

This session will take the form of a panel discussion involving palliative care physicians who have experience in public, private, and academic hospitals; a senior program officer with a major healthcare funding organization; and an executive of a major healthcare system. After reviewing the status of palliative care growth in California, we will pose questions during the session as well as open it up to the audience to participate.

Questions to be discussed during the session will include the following:

- Should outpatient or inpatient palliative care be prioritized?
- Should other physicians be trained to provide primary palliative care to patients and families vs performing traditional palliative care consult services?

- If providing good palliative care is part of good medical care, why should payers pay extra for it?
- How do we make the case to payers and to hospitals to expand palliative care services?

We will discuss strategies that have been successful for palliative care services in hospitals with limited resources and share the patterns behind that success. Finally, we will discuss techniques for submitting funding requests to health systems and foundations that lead to success.

"The Doctor Is In": The Role of Child Psychiatrists in Pediatric Palliative Care (SA502)

Vanessa Battista, MS RN CPNP, The Children's Hospital of Philadelphia, Philadelphia, PA. Jennifer Minarcik Hwang, MD MHS, The Children's Hospital of Philadelphia, Philadelphia, PA. Pamela Mosher, MD MDiv, IWK Health Centre, Toronto, ON, Canada. Anna Muriel, MD MPH, Dana-Farber Cancer Institute & Brigham Women's Hospital, Boston, MA.

Objectives

- Define a collaborative model between pediatric palliative care teams and child psychiatry.
- Demonstrate knowledge of psychotropic medication use in children with advanced illness.
- Recognize when the involvement of child psychiatry is warranted in specific pediatric palliative care cases.

Prioritizing quality of life (QOL) and decreasing suffering in children and adolescents with life-limiting illness are necessary components of pediatric palliative care (PPC). Care teams are increasingly interdisciplinary, yet what is often missing is the presence of a consulting child psychiatrist. Suffering is often viewed in terms of physical symptoms, but the psychological needs of children with advanced illness often require the specific expertise of child/adolescent psychiatrists. Collaborative models are rare; rarer still are PPC teams with dedicated psychiatrists available to guide assessment, diagnosis, and treatment in this unique pediatric population. Few child psychiatrists are specifically trained to manage children with advanced illness or end-of-life symptoms, while many may feel ill-equipped to do so.

Through a combination of didactic presentation, case-based discussion, and interactive audience participation, attendees will achieve a new and deeper understanding of psychiatric issues and management challenges facing PPC patients/families and care teams. The presentation will include an overview of a model of collaboration between child psychiatry and palliative care teams; discuss a range of psychotropic medications used in children/adolescents with advanced illness; and review cases where child psychiatry consultation proved essential to patient management.

Participants will gain familiarity with the vital role of the child psychiatrist in palliative care cases; review psychopharmacologic interventions for symptoms in PPC; and appreciate the range of circumstances faced by PPC teams that may be best managed through consultation with psychiatry.

Empowering Bereaved Parents in the Development of a Comprehensive Bereavement Program (SA503)

Jennifer Snaman, MD, St. Jude Children's Research Hospital, Memphis, TN. Deena Levine, MD, St. Jude Children's Research Hospital, Memphis, TN. Justin Baker, MD FAAHPM, St. Jude Children's Research Hospital, Memphis, TN.

Objectives

- List innovative aspects of the bereavement program at St. Jude Children's Research Hospital (St. Jude) that will be presented with the help of bereaved parent mentors.
- Describe the content and implementation of the various components of the bereavement program at St. Jude, including the paired mentor program, bereaved parent-developed resource manual, communication cards, and videos.

The death of a child poses special challenges to both bereaved families and staff. Each individual's grief journey is unique and ongoing; however, common themes and support systems help to define successful bereavement services. Bereaved parents who have experienced the loss of a child have special insight and can help to identify the key components necessary for the development and implementation of a comprehensive bereavement program.

The bereavement program at St. Jude Children's Research Hospital begins with anticipatory bereavement services prior to death. Following the child's death, a trained bereaved parent mentor is offered and available. These mentors have been trained how to identity and triage abnormal or concerning behaviors and how to obtain additional psychosocial support for at risk families. Additionally, bereaved parents have created a resource manual with parent and sibling with recommended books, websites, and other helpful references. Parents developed a booklet containing reflective pieces and video describing difficult moments in their grief journey to provide a support to other parents and staff. Finally, they designed and illustrated communication cards to be sent to all bereaved families at key time points during the first 13 months after a child's death.

This session will explore the development and implementation of the unique parent-developed bereavement policy and program at St. Jude Children's Research Hospital. A case scenario will help demonstrate the components of a proactive, comprehensive bereavement plan. The addition of bereaved parents to this session will give the parents a chance to describe their own grief journey and the goals of the program from their perspective. The innovative nature of this program, with multiple components of the parent-driven comprehensive bereavement program, can serve as a paradigm for the development of other programs and for the field of hospice and palliative medicine as a whole.

The 13 Most Debated Questions About Using Steroids in Patients with Advanced Cancer Experiencing Pain and Nausea: What We Do and What the Evidence Recommends (SA504)

Patrick White, MD, University of Pittsburgh Medical Center, Pittsburgh, PA. Janet Bull, MD HMDC FAAHPM, Four Seasons, Flat Rock, NC. Mary Mihalyo, PharmD BS BCPS CGP CDE, Duquesne University, Steubenville, OH. Elizabeth Blaney, MD, University of Pittsburgh Medical Center, Pittsburgh, PA. Denise Stahl, MSN ACHPN, University of Pittsburgh Medical Center, Pittsburgh, PA.

Objectives

- Name the most commonly used corticosteroid, its dosing frequency, and treatment duration for the treatment of painful bone metastases.
- Risk stratify patients appropriately for gastric prophylaxis in patients with advanced cancer receiving corticosteroids.
- Assess patients for side-effects when starting corticosteroids.

Corticosteroids are one of the most commonly added therapies by hospice and palliative care providers. There is considerable variation among providers when prescribing corticosteroids for the treatment of pain and nausea in patients with advanced cancer. Little evidence-based research exists to guide treatment decisions, with current guidelines relying predominately on expert opinion.

This presentation will use an interactive, interdisciplinary format to review three common clinical scenarios involving patients with advanced disease. By combining the perspectives of two hospice Chief Medical Officers, a gastroenterologist, a pharmacist, and a hospice and palliative care nurse, we hope to review both existing and new information that can help guide decision-making on 13 commonly debated questions. These include: What are the differences in side-effect profiles among steroids? What patients appear to benefit most from corticosteroids? What is the optimal steroid dosage and how should the dose be divided? When and what gastric protection is indicated in treating patients with corticosteroids? What areas of the nursing assessment are especially critical when starting a patient on steroids?

We will obtain audience participation to these questions, share new results from more than 750 members of the Academy who contributed to the first national survey to examine practice patterns among providers treating patients with symptomatic bone metastases, and provide current evidence from a review of the literature. On leaving this presentation, providers will be able to 1) name three differences in the side-effect profiles of commonly prescribed steroids; 2) name the most commonly prescribed steroid, dosage, and duration for the treatment of painful bone metastases; 3) describe when gastroprotection is indicated and identify the odds ratio for gastrointestinal bleeding among various risk groups; 4) describe the evidence for the use of corticosteroids in nausea; and 5) name three important areas of assessment for patients started on corticosteroids.

8:15—10 am

Plenary Session

State of the Science: Update in Hospice and Palliative Care (104)

J. Nicholas Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham, Birmingham, AL. Cardinale B. Smith, MD PhD, 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 the attendee cares.

The objective of this session is to review the 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, pre-clinical studies, retrospective studies, open-label trials, case-series, instrument validation studies, and confirmatory analyses.

The papers selected for presentation at this session were chosen from among studies meeting the above criteria with an attempt to appeal to the broad interests of Assembly attendees.

10:30–11:30 am

Concurrent Sessions

AAHPM Scientific Research Award Winner: A Learning System to Optimize Care for People with Advanced Illness (SA510)

Amy P. Abernethy, MD PhD FAAHPM, Flatiron Health, Inc., New York, NY.

Objectives

- Describe the key features of a learning health system (LHS).
- Describe new features of an LHS needed in order to meet the unique needs of palliative care.
- Describe the ways that clinical trials, health care quality monitoring, and educational programs fit together in an LHS.

Palliative care patients and their families deserve a system of coordinated research and high quality clinical care that informs—and is informed by—the other and that leads to iterative meaningful improvements in care outcomes that matter. In response, a learning system for palliative care has been forming. First, new methods for conducting high-quality research in this vulnerable population were needed; methodological innovations include enhancements to study design, participant recruitment, and outcomes measures. Contemporary palliative care clinical trials can address practical questions like optimal management of refractory dyspnea, terminal secretions, or existential distress. Second, technology infrastructure is evolving, allowing for standardized data collection, storage, linkage, analysis, and reuse. Palliative care data systems can collect information most meaningful to palliative care (eg, symptoms, physical functioning, quality of life, caregiver burden). Third, a national network of researchers formed, coordinating with clinicians, quality monitoring efforts, and international groups. Working together, we prioritize research questions, match studies to generalizable patient populations, and shorten the time to answers. Fourth, quality measures reinforce best practice; new measures incorporate lessons learned, in concert with the clinical trials. Fifth, efficient evidence dissemination is made possible through new routes. Continuing education activities quickly transfer important innovations to our palliative care workforce. And finally, outreach to healthcare policy-makers guides clinical policy and financing. Over the last decade, elements of this circuitous learning system for palliative care have been conceived, implemented, tested, (sometimes jettisoned), and refined. In addition to methodological innovation, elements such as the Palliative Care Research Cooperative Group (PCRC), QDACT data standards, *PC-FACS,* and Virtual Learning Collaborative have been coordinated. Federal, philanthropy, and industry sponsors have invested. Overall, together, we are defining a responsive model for evidence development and implementation in palliative care that advances clinical practice and research. This is learning healthcare.

Utilizing Telemedicine in Hospice: A Strategy for Reducing Hospital Heart Failure Readmissions and Improving Hospice Access for Complex Cardiac Patients (SA511)

Cleanne Cass, DO FAAHPM, Hospice of Dayton, Dayton, OH. Ruth Thomson, DO FACOI HMDC FAAHPM, Hospice of Dayton, Dayton, OH. Lynda G. Weide, RN BSN CHPN, Hospice of Dayton, Dayton, OH.

Objectives

- Discuss the use of a telemedicine monitoring system and specialized clinical protocols in successfully managing high risk cardiac patients in a hospice program.
- Discuss strategies for successful hospice collaboration with community cardiologists and hospital heart failure committees and the importance of analytics and information technology to program success.

In order to improve end-of-life care for patients with heart failure, hospices must be able to successfully collaborate with community cardiologists and hospital heart failure committees. To achieve this collaboration, hospices need both innovative programs and a track record of proficient patient management.

This session will provide a blue print for developing a program of specialized cardiac care that meets both of these goals. The role of telemedicine, clinical protocols, and staff education in advanced cardiac case management will be reviewed. The use of analytics and information technology in providing data to demonstrate program effectiveness will be discussed.

Rearranging the Toes on My Baby: Full-time Physicians Making Routine Visits as Part of the Hospice Home Care Team (SA512)

Charles von Gunten, MD FACP FAAHPM, Ohio Health, Columbus, OH.

Objectives

- Explain the rationale for a full-time physician as a member of a home hospice team.
- Describe the outcomes of an effort to put physicians on home hospice teams.
- Describe barriers to implementation.

Facts and Assumptions. Hospice care is proven to be the best care for the dying. The "sweet spot" for value is 90-120 days. All patients expected to die should receive hospice care, leading to the need to manage more patients who are more complex in their homes with a less experienced staff. 70% of referring physicians don't want to remain the attending physician. Regulatory changes require "doctor" documentation; teaching nurses to think and document like physicians is a fool's errand. Sick patients need to see a physician every 30 days and as needed. Current patterns of late referral are partially a result of hospices teaching local communities what is the "right" hospice patient and time for referral.

Hypothesis. A doc on a team will improve care, permit hiring less experienced nursing staff, improve referring relationships that will lead to earlier and more referrals. Billing for direct patient care services plus $3 per patient day from the per diem will cover the costs of the added physicians.

Results. Hospice teams have fixed cultures that are hard to change. Sustained effort and time is needed to manage the change. Support for a physician practice must be built within the hospice infrastructure. Financial results have continued to improve over the time course of the implementation phase. A qualitative assessment of achievements and challenges are discussed with interdisciplinary members of a home hospice team.

Palliative Care and the Diffusion of Innovation (SA513)

Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Gain familiarity with the science of the diffusion of innovation and how it applies to palliative care.
- Recognize specific actions necessary to formalize palliative care as a routine and sustainable component of the US healthcare system.

The science of the diffusion of innovation has identified a predictable pattern of uptake and spread the S-curve. Emerging from the experience and accomplishments of the hospice movement, the growth and momentum of the palliative care movement closely tracks the S-curve in terms of recognition, access, and formalization. This session will review the evidence that palliative care has been established as a routine part of organized medicine; identify the actions the field needs now to formalize and sustain these gains; and link these steps to the five conditions of effective diffusion of innovation and collective impact: common agenda; mutually reinforcing activities; shared measurement systems; continuous communication to build trust; and strong backbone support organizations.

Scrambler Therapy for Chronic Neuropathic Pain (SA514)

Thomas Smith, MD FACP FASCO FAAHPM, Johns Hopkins Medical Institutions, Baltimore, MD. Angela Starkweather, PhD RN, Virginia Commonwealth University, Richmond, VA. Patrick Coyne, MSN APRN ACHPN FAAN, Medical University of South Carolina, Charleston, SC.

Objectives

- Review current clinical evidence, correlational scientific findings, and ongoing randomized clinical trials for Scrambler Therapy in the management of refractory neuropathic pain.
- Describe how the therapy is done, including common mistakes and expert pointers.

Pain remains one of the most common clinical problems and causes of debility, disability, and lost productivity. (Simon L, 2012; Institute of Medicine 2011) Neuropathic pain is particularly vexing as relief is often incomplete and associated with significant medication side effects. Spinal cord stimulation is effective, with pain reductions of 50%-90% reported in well-designed randomized trials (Deer TR, 2014) but is invasive, permanent, and expensive (over $75,000/implant.) Scrambler Therapy (ST) is a new way of relieving pain by giving artificial nerve impulses to simulate "non-pain" information along the damaged pathways to repair damaged nerve pathways, capturing the nerve pathways much like spinal cord stimulation. Clinical efficacy has been demonstrated with 14 published studies showing relief of pain from a minimum of 25% up to 95% at one month, with no side effects (Majithia, Smith, Loprinzi, in press). Specific examples include over 50% reduction in chemotherapy-induced neuropathic pain, numbness, and tingling (Smith TJ, 2010; Pachman D, 2014); 50%-95% reduction in post-herpetic pain (Smith 2013; Ko YK, 2013); over 50% reduction in low back pain in a randomized sham controlled trial (Starkweather A, 2015); and 91% reduction in pain in PHN, failed back syndrome, and spinal cord stenosis (Marineo G, 2012). There is good evidence for a "learning curve" that explains why experienced treaters have the best results. (Pachman D, 2014) Some correlational science includes dramatic reduction in mRNAs for pain-involved NGF, GDNF, and others (Starkweather A, 2015); observations that antidepressant (eg, gabapentin) (Moon YJ, 2014) use is associated with less effect postulated by less neuronal repair and sustained changes in fMRIs of the brain. (Ko, in press.) Several governments, including Korea and the Eurozone, now fully reimburse for therapy but ST is relatively unknown in the U.S. We will review the evidence, ongoing sham-controlled trials, and illustrate how it works in real time.

Use of Advanced Life Support Technology in Patients with Life Threatening Degenerative Conditions (SA515)

David Steinhorn, MD FAAP FAAHPM, University of California at Davis Medical Center, Sacramento, CA. Rachel Thienprayoon, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Rani Ganesan, MD, Rush University Medical Center, Chicago, IL. Joel Frader, MD, Lurie Children's Hospital, Chicago, IL.

Objectives

- List at least three advanced life support modalities commonly considered by patients with irreversible organ failure of 1) lung, 2) heart, and 3) neuromuscular system. Modalities discussed will include ventilator, tracheostomy, VADs, long-term IV vasoactive medications, and novel cellular-based therapies, and organ transplantation is not an option.
- Explore family views of the use of advanced technologies in supporting patients who have life-threatening progressive loss of vital function.

THE PRO ARGUMENT FOR ADVANCED TECHNOLOGY SUPPORT: The attendee will be able to articulate two or three common goals or justifications that families have in using artificial, life prolonging therapies for their children whose natural disease is incurable and would be imminently fatal, and in whom organ transplantation is not an option.

THE CON ARGUMENT FOR ADVANCED TECHNOLOGY SUPPORT: The attendee will be able to articulate two or three reasons why some families have chosen not to use artificial life prolonging therapies for their children whose natural disease is incurable and imminently fatal.

Parents and children who live with chronic and degenerative medical conditions are frequently called upon to make difficult choices regarding the artificial prolongation of life. By their natures, most of these conditions are fatal. Yet, as technical medicine advances, some patients and parents may feel compelled to sustain life at any cost, while others may choose to avoid such therapies in the face of worsening quality of life. As palliative providers, it is important to have an appreciation of how families have approached such decisions, and how, in retrospect, they view the impact of their choices on fundamental issues such as family relationships and the child's quality of life. This session will provide an opportunity for palliative providers to understand how medical communication affected such choices and how our role in such conversations might be improved. Risks and benefits of life-prolonging modalities will be discussed, including the known morbidities and the known and unknown potential to provide more time for a patient. Families will participate in this session. A central aim of this session is to highlight the active pursuit of meaning for one's life and that of one's family, and how the value of artificial life-prolonging therapies differs among families of children with progressive illness.

Palliative Care Research in Vulnerable Populations (SA516)

Toni Glover, PhD GNP ACHPN, University of Florida College of Nursing, Gainesville, FL. Diana Wilkie, PhD RN FAAN, University of Florida College of Nursing, Gainesville, FL. Gloria Bonner, PhD MSN RN, University of Illinois Chicago College of Nursing, Chicago, IL. Gail Keenan, PhD RN FAAN, University of Florida College of Nursing, Gainesville, FL. Yingwei Yao, PhD, University of Florida College of Nursing, Gainesville, FL.

Objectives

- Characterize recent palliative and end-of-life research involving vulnerable populations, including ethnic/racial minorities, the oldest-old (patients 85+ years of age), and the provision of palliative care in inner city areas.
- Relate research findings on palliative care research in vulnerable populations to clinical care.

Palliative care research has experienced phenomenal growth over the last decade; yet gaps in knowledge remain. This session focuses on palliative care research involving vulnerable populations, including ethnic/racial minorities, the oldest-old (85+ years), and the provision of hospice care in inner city areas.

Factors that influence end-of-life treatment decisions made by caregivers for relatives with dementia warrant research. Dr. Bonner will review an empirically based education program to teach African American caregivers of loved ones with advanced stage dementia the skills needed to make informed treatment decisions. Results demonstrate the value in coordinating end-of-life educational activities with mega-churches in the African American community.

The oldest-old are the fastest growing segment of the older population. Pain outcomes and the interventions nurses utilize for the hospitalized oldest-old are not well described. Dr. Glover will present findings from the Hands-on Automated Nursing Data System (HANDS) dataset. The sample included 4470 patients 85+ years of age from four hospitals. Fall prevention and pain management were the most common nursing interventions. A third of the sample had a pain-related nursing diagnosis. By virtue of advanced age, multiple comorbidities, and reduced physiologic reserve, the oldest-old comprise a vulnerable population in which a palliative approach to care is warranted.

Dr Wilkie's team will present findings on the implementation of an Internet-based intervention to improve pain care for hospice patients with cancer. Using Internet-enabled tablets, patients and caregivers report pain and pain barriers and those in the experimental group receive tailored multimedia education. The hospice nurse receives a daily e-mail with a link to the patient's pain data and, for those in the experimental group, the nurse also receives decision support for improving pain control. A total of 105 patient-caregiver dyads have participated in the ongoing study. Preliminary results are informative for implementing mobile health research in hospice settings, especially those serving minority patients.

Paper Session

Use of Hospice Among Patients with Advanced Heart Failure: A Descriptive Analysis (SA517A)

Laura Gelfman, MD MPH, Mount Sinai School of Medicine, New York, NY. Melissa Aldridge, MBA PhD, Icahn School of Medicine at Mount Sinai, New York, NY. Stanley Moore, BS, Self-employed, Bonny Doon, CA. Christopher Murtaugh, PhD, Visiting Nurse Service of NY, New York, NY. Nathan Goldstein, MD FAAHPM, Mount Sinai Hospital, New York, NY.

Objectives

- Characterize the symptom burden, functional status and healthcare utilization in a sample of Medicare beneficiaries with advanced heart failure (HF).
- Compare the healthcare utilization of patients with advanced heart failure who enroll in hospice and those who do not.

Original Research Background. Patients with advanced HF experience high symptom burden, rates of hospital readmission, mortality and costs. Increasing HF hospitalizations is associated with increased mortality. Yet little is known about the minority of patients with advanced HF who receive hospice.

Research Objectives. To compare the symptom burden, functional status and healthcare utilization of Medicare beneficiaries with advanced HF who did and did not enroll in hospice.

Methods. We conducted a longitudinal cohort study of Medicare beneficiaries in 2009-2010 who had two HF hospitalizations within six months, with the second hospital stay ending with discharge to home health care and then death within six months. We conducted bivariate analyses to compare utilization between second HF discharge to death of those who did and did not enroll in hospice.

Results. A total of 7,810 older adults met our inclusion criteria; 3,298 (42.2%) enrolled in hospice. The mean number of days from second HF discharge to hospice enrollment was 67.7 days (SD 47) and average hospice length of stay was 22.4 days (SD 29.9). Prior to enrollment, those who ultimately enrolled in hospice had similar functional status (independent in 4.13 versus 3.82 ADLs, $p<0.001$), shortness of breath at rest (13.1% versus 12.3%, $p = 0.21$), and pain all of the time (6.5% versus 6.7%, $p = 0.38$), compared with those who did not enroll. In the six months following second HF discharge, hospice enrollees had fewer hospitalizations on average compared with those who did not enroll (1.69 versus 1.93, $p<0.001$) and a lower prevalence of in-hospital death (3.4% versus 56.8%, $p<0.001$).

Conclusion. Those who do and do not enroll with hospice have similarly poor functional status and high symptom burden. Those who receive hospice have fewer hospitalizations and are less likely to die in the hospital.

Implications for Research, Policy, and Practice. Expanding hospice enrollment for HF patients could improve outcomes for this population.

Who Refers to Hospice? A Comparison of Referral Rates by Whether the Attending Physician is Hospitalist, Non-Hospitalist General Practitioner, or Specialist (SA517B)

Claire Ankuda, MD, University of Michigan, Ann Arbor, MI. Susan Mitchell, MD MPH, Harvard University, Hebrew SeniorLife, Boston, MA. Pedro Gozalo, PhD, Brown University, Providence, RI. Vincent Mor, PhD, Brown University, Providence, RI. Joan Teno, MDMS Brown University, Providence, RI.

Objectives

- Describe the characteristics of physicians who refer to hospice.
- List at least three areas of research need in hospice referral patterns.

Original Research Background. Little is known about the role of type of attending physician in hospice referral at the time of hospital discharge for nursing home (NH) residents.

Research Objectives. We compared hospice referral rates between inpatient physician types (non-hospitalist generalist, specialist and hospitalists) in hospitalized NH residents with advance cognitive impairment (ACI) and severe functional impairment.

Methods. Retrospective cohort of NH residents with minimum data set (MDS) assessments completed within 120 days of a hospitalization between 2000 and 2010. All persons had ACI with four activities of daily living (ADL) impairments on MDS assessment. The cohort was from a random 20% sample of Medicare beneficiaries. A hospital fixed-effect model was used to examine the association of the type of physician and degree of fragmentation with referral to hospice. This model adjusted for resident characteristics, cognition, functional status and diagnosis prior to admission.

Results. We captured 130,833 hospitalizations of Medicare beneficiaries with advanced cognitive impairment who were residing in NHs between 2000 and 2010 (mean patient age of 83.6, 68.0% female, 74.3% white, 70.2% one-year mortality). Of the hospitalizations that involved only one type of provider acting as the attending physician, the primary provider for that admission was a non-hospitalist general practitioner, a hospitalist, or a specialist in 67.4%, 25.6% and 7.1% of admissions respectively. Hospitalists had 1.44 increased odds of hospice referral compared to non-hospitalist generalists (95% CI 1.31-1.58). Specialists were not statistically significantly different from non-hospitalist generalist.

Conclusion. Hospice referrals for NH residents with ACI are more likely when the attending physician is a hospitalist.

Implications for Research, Policy, and Practice. Hospitalists, a growing class of physicians, are more likely to appropriately refer NH residents with a high 1-year mortality to hospice at hospital discharge.

A Review of Hospice Characteristics and Patient Outcomes Associated with Exceeding the Medicare Hospice Annual Aggregate Reimbursement Cap (SA517C)

Thomas Christian, PhD, Abt Associates, Cambridge, MA. Joan Teno, MD MS., University of Washington, Seattle, WA. Pedro Gozalo, PhD, Brown University, Providence, RI. Michael Plotzke, PhD, Abt Associates, Cambridge, MA.

Objectives

- Describe the rate of hospices exceeding their aggregate cap and characteristics associated with above-cap status.
- Describe the rate of hospice patients discharged alive and with hospice stays over 180 days in above-cap status providers compared to below-cap status providers.

Original Research Background. The total payments hospice providers can receive are limited to an annual cap amount. Little is known about risk factors for exceeding this cap and how above-cap status affects patient outcomes.

Research Objectives. To identify institutional characteristics associated with exceeding the cap and whether above-cap status affects the risk of live discharge from hospice and long hospice elections.

Methods. We used hospice claims from 2005-2014 to estimate hospice providers' cap statuses each reporting year. A logistical regression was estimated to identify institutional correlates of cap status. Additionally, within-hospice logistical models were used to estimate whether exceeding the cap is associated with the likelihood of being discharged from hospice alive or hospice stays exceeding 180 days.

Results. Hospices are more likely to exceed their cap if they were newer (22.1% Medicare certified in 2010s vs. 1.1% certified in the 1980s; AOR 4.15, 95% CI 3.05-5.64), for-profit (19.4% for-profit vs. 2.3% non-profit; AOR 3.04, 95% CI 2.60-3.56), and smaller (24.5% 0-49 annual patients vs. 9.2% 100-249 annual patients; AOR 3.13, 95% CI 2.82-3.47). Exceeding the cap is associated with an increased risk of live hospice discharge (43.4% above-cap vs. 18.0% below-cap; AOR 1.18, 95% CI 1.07-1.30) and discharge after more than 180 days (25.4% above-cap vs. 11.0% below-cap; AOR 1.47, 95% CI 1.32-1.64). When hospices have received 40-60% of their aggregate cap, 18.6% of discharges are alive; when hospice have received 100-120% of reimbursements, 42.4% of discharges are alive, and when 150%+ of the cap has been received, 76.9% of discharges are alive.

Conclusion. Newer, smaller, and for-profit hospices are more likely to exceed their cap. Cap risk increases the likelihood of live discharges and stays exceeding 180 days.

Implications for Research, Policy, and Practice. Additional monitoring is needed to understand the reasons hospice providers exceed their cap, provider behavior responses to cap risk, and any cap effects on hospice patient outcomes.

Comparing Medicare Utilization Pre- and Post-Hospice Admission Across Primary Hospice Diagnoses (SA517D)

Thomas Christian, PhD, Abt Associates, Cambridge, MA. Joan Teno, MD MS, University of Washington, Seattle, WA. Pedro Gozalo, PhD, Brown University, Cambridge, MA. Michael Plotzke, PhD, Abt Associates, Cambridge, MA.

Objectives

- Understand how pre-hospice spending rates compare to utilization (in days on average) of the Medicare hospice benefit.
- Understand how pre-hospice spending rates compare to Medicare's per diem payments to hospices.

Original Research Background. Relatively little is known about how pre-hospice Medicare utilization compares to spending after hospice election. At present, no case-mix system exists in the Medicare hospice benefit to differentiate payments among patients.

Research Objectives. To compare daily estimates of total Medicare utilization immediately prior to hospice admission with *per diem* payments during hospice election across common hospice principle diagnoses.

Methods. Retrospective cohort study of hospice users that died during Federal Fiscal Year 2013. We used Medicare hospice and non-hospice Part A, B, and D claims to estimate average daily total Medicare utilization in the 180, 90, and 30 days prior to hospice admission for patients classified at hospice admission with a primary diagnosis of Alzheimer's, dementia, and Parkinson's; CVA/Stroke; cancers; chronic kidney disease; heart diseases; lung diseases; or all other hospice diagnoses.

Results. In the 180 days prior to hospice admission, median daily estimates of total Medicare utilization ranged from $66.84 (Alzheimer's, dementia, and Parkinson's) to $217.46 (chronic kidney disease); national average $117.73. In the 30 days prior to hospice admission, median daily Medicare utilization ranged from $105.24 (Alzheimer's, dementia, and Parkinson's) to $466.25 (chronic kidney disease); national average $266.84. Among all diagnoses, the median daily estimates of pre-hospice Medicare utilization for Alzheimer's, dementia, and Parkinson's hospice admissions were consistently below the 2013 routine home care *per diem* rate of $153.45. Average lifetime hospice utilization ranged from 27.3 days (chronic kidney disease) to 119.3 days (Alzheimer's, dementia, and Parkinson's); national average 73.8 days.

Conclusion. Daily Medicare payments for beneficiaries with Alzheimer's, dementia, and Parkinson's were less than *per diem* payments during hospice election; hospice enrollment beneficiaries with these neurological conditions exceeded average enrollment lengths of all other diagnoses.

Implications for Research, Policy, and Practice. Additional monitoring is needed to understand if hospice patients require different resource needs and if hospice payments are appropriately aligned with those requirements.

Noon—1 pm

Critical Conversations—Professional Implications of Public Interest in Physician-Assisted Death (SA519)

Constance Dahlin, ANP-BC ACHPN FPCN FAAN, Hospice and Palliative Nurses Association (HPNA). Jonathan Keyserling, JD, National Hospice and Palliative Care Organization (NHPCO). Jason Morrow, MD PhD, University of Texas Health Science Center, San Antonio, TX. Joseph Rotella, MD MBA HMDC FAAHPM, American Academy of Hospice and Palliative Medicine (AAHPM).

Objectives

- Describe positions on physician-assisted death (PAD) and how they were developed for three national organizations representing providers of end-of-life care (AAHPM, HPNA, and NHPCO).
- Outline ethical and practical concerns for providers who receive requests for PAD.
- Identify resources to help providers respond to requests for PAD in an ethical, effective, and safe manner.

With the recent legalization of Physician-Assisted Death (PAD) in California, one-sixth of the US population now resides in states where PAD is a legally sanctioned option. Public interest in PAD is high and there are active efforts to legalize it in many more states. Providers of end-of-life care increasingly receive requests for hastened death. These requests pose complex professional challenges and call for careful exploration of underlying suffering and mobilization of the best possible interdisciplinary palliative care for the patient and family.

In this special session, leaders from AAHPM, HPNA, and NHPCO will present their organizations' positions on PAD and outline their processes for developing and updating the positions. Dr. Jason Morrow, chair of the AAHPM Ethics Special Interest Group, will then moderate a town-hall style panel discussion inviting brief questions and comments from the audience. The discussion will focus on:

- Clarification of the intent and meaning of position statements to represent the field.
- Identification of ethical and practical challenges for hospice and palliative care professionals responding to requests for PAD.
- Explanation of resources to help providers respond to requests in a manner that is effective, ethical, and safe for both patient and provider.

1:15—2:15 pm

Concurrent Sessions

The Practice of Palliative Medicine in Developing Countries—Part Three (SA520)

Ama (Kyerewaa) Edwin, MBChB; MPhil' D.Bioethics, Korle Bu Teaching Hospital, Accra, Ghana. Tatiana Fernández Dávila Sisters Hospitallers' Guadalupe Clinic, Quito, Ecuador. André Filipe Junqueira dos

Santos, MD PhD, Clinics Hospital of the Ribeirao Preto Medical School, Cravinho, Brazil.

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.

Using Film to Foster Empathetic Partnerships Between Care Providers and Family Caregivers (SA521)

Jennifer Drost, DO, Summa Health Systems, Akron, OH. Steven Radwany, MD FAAHPM, Summa Health System, Akron, OH. Erin Scott, MD, Summa Health System, Akron, OH. Deborah Damore, MTS BCC ACPE, Summa Health System, Akron, OH. Margaret Scott, MA, Child Development, Akron, OH.

Objectives

- Understand the importance of provider awareness and support of family caregivers.
- Recognize the importance of engaging caregiver narratives and link safe spaces that allow learners to connect empathically with caregivers.
- View the caregiver film and identify ways it may be incorporated into training programs for interprofessional education.

Fragmentation in the US healthcare system has frayed the critical relationships among caregivers and healthcare providers. Yet, caregivers are on the frontlines managing complicated chronic illnesses, assisting with day-to-day functioning, and providing direct palliative care to manage symptoms and improve quality of life. While meeting loved one's needs, caregivers navigate an increasingly complex and confusing health system. Students and providers receive little, if any, training on the vital role caregivers play on the healthcare team and how effective partnering optimizes patient care throughout the illness trajectory and at end-of-life. Building Caregiver Partnerships Through Innovative Health Professions Education is an Arthur Vining Davis Foundations' funded effort to create effective provider-caregiver partnerships that serve the needs of patients suffering from complex serious illness.

The educational initiative centers on a film that tells the compelling caregiving journeys of four families. It was crafted to heighten awareness while triggering learner emotions in response to these remarkable narratives. The film can be highly effective in evoking personal responses that can translate into clinical practice. The key issue is to construct a safe space in which learners sense they have permission to be vulnerable as they explore their feelings about caregiving and the death of loved ones. This safe space includes establishing an accepting environment for an invitational discussion utilizing appropriate debriefing strategies. Instructors model the empathic partnering approach through their interaction with learners in this context of shared vulnerability.

The session will begin with the film, followed by a panel of healthcare providers, caregivers, and a chaplain. Panel members will share their perspectives and provide educational tools intended to help diverse trainees connect empathically with family caregivers for optimal palliative care. They will discuss ways in which the film has been utilized effectively for a variety of learners. Attendees will further explore strategies for learner training within their institutions.

Extracorporeal Membrane Oxygenator Withdraw Protocol: Avoiding Chaos (SA522)

Todd Barrett, MD, Cedars-Sinai Health System, Los Angeles, CA.

Objectives

- Present the results of ECMO patient tracers and an institutional needs assessment, which was used to create a withdraw policy.
- Show audience members a video of ECMO withdraw in the SIM lab to display the results of our streamlined process.
- Share the ECMO policy and educational handouts to help institutions create their own policies and education modules.

The use of extracorporeal membrane oxygenators (ECMO) is increasing in the United States. It has been used consistently in the pediatric patient populations for decades. In recent years, VenoVenous ECMO has become standard of care for refractory adult respiratory distress syndrome at quaternary care centers. In addition, VenoArterial ECMO is being used for viral cardiomyopathy, failed cardiotomies, and as a temporary bridge to transplant. With survival on VV ECMO at 60% and VA ECMO at 40%, there are growing numbers of Americans dying after ECMO withdraw.

The process of ECMO withdraw is complex. Tracer patients at our health system have as many as 15 family members and 25 clinicians involved in the discontinuation. Technology withdraw often involved multiple medical devices and multiple teams of providers, leading to poor communication and increased distress. Death is unique and sudden following discontinuation, which adds additional moral distress for family members and members of the care team.

Our institution conducted a needs assessment across multiple departments and constructed an ECMO withdraw protocol with an accompanying ECMO education program. Our goal for the initiative was to improve clinical efficiency, improve staff knowledge about ECMO withdraw to change attitudes and values, and ensure patient comfort at end of life.

"Why Do I Still Hurt?" An Integrated Model of Survivorship and Palliative Care (SA523)

Marcin Chwistek, MD FAAHPM, Fox Chase Cancer Center, Philadelphia, PA. Nicole Ewerth, BSN CHPN OCN, Fox Chase Cancer Center, Philadelphia, PA. Sheila Gallagher Amrhein, MSW, Fox Chase Cancer Center, Philadelphia, PA. Barbara Ebersole, MA, Fox Chase Cancer Center, Philadelphia, PA.

Objectives

- Identify the 3 most common pain syndromes in cancer survivors and describe their underlying pain mechanism.
- Discuss factors influencing psychosocial distress in cancer survivors living with chronic pain.
- Describe key components, challenges, and opportunities in developing a patient and family centered survivorship plan for patients with cancer related pain.

The late- and long-term effects of cancer and its treatment leave an expanding population of cancer survivors struggling with transitions into survivorship. The multidisciplinary palliative care team is ideally positioned to manage and coordinate care for these patients. Cancer survivors in the US today number 13.7 million with 5%-10% experiencing pain severe enough to cause functional impairment. Certain subpopulations of cancer survivors are disproportionately affected. Chronic postmastectomy pain can affect up to 50% of breast cancer survivors with more than 30% of patients reporting above average pain 10 years after treatment. Pain in cancer survivors is typically neuropathic in nature and is challenging to treat, requiring a multidisciplinary approach. A combination of pharmacotherapy, physical therapy, psychosocial interventions, complementary therapies, and interventional approaches is frequently needed. There is a paucity of data related to long-term management of pain in cancer survivors, especially regarding the role of long-term opioid use. Oncologists and primary care physicians are often not prepared to handle the most complex cases and access to pain specialists is limited. The risk of new or recurrent disease is ever present, requiring comprehensive assessment of new or worsening pain reports. Persistent pain in cancer survivors is a source of significant distress and compounds the emotional and psychosocial suffering related to the cancer diagnosis and treatment. Fear of recurrence is pervasive despite favorable prognosis. The informational needs of survivors with chronic pain vary, but health professionals must acknowledge its impact and educate patients about this neglected issue. Expanding roles in care coordination for survivors, technological advances, and new survivorship models involving rehabilitation services and community based care for survivors may optimize survivorship care. Integrating survivorship care and palliative care can mitigate barriers to care and facilitate development of a patient- and family-centered plan for survivorship.

Developing Institutional Medical Marijuana Guidelines: Understanding Law and Science (SA524)

Ilana Braun, MD, Dana-Farber Cancer Institute, Boston, MA. Lida Nabati, MD, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Understand the therapeutic potential of medical marijuana.
- Understand the legal issues surrounding use of medical marijuana in the United States and use this to guide development of institutional policies around its use.

Background. Federally illegal, medical marijuana is permissible in 23 states and the District of Columbia. The scientific evidence for cannabis' therapeutic potential is limited, yet expanding.

Methods. Spearheaded by a department of psychosocial oncology and palliative care, a large network of hospitals in Massachusetts assembled a multidisciplinary workgroup to generate institutional guidelines for medical marijuana. This workgroup completed comprehensive scientific literature reviews before generating guidelines reflective of this evidence base as well as federal and state legal climates.

Results. Providers who recommend medical marijuana assume a small degree of legal risk.
Registered marijuana dispensaries offer nonpharmaceutical–grade cannabis products.
The scientific evidence for these products is limited, yet expanding. There is a lack of coherence between the scientific evidence and regulations in several states. The immature evidence base does not negate cannabis' exciting therapeutic potential.Discussion: Our enterprise's medical marijuana guidelines remind providers that they need not issue certifications; encourages them to exhaust conventional symptom management first; advises prudence with regard to patients with milder forms of qualifying conditions or conditions without strong evidence; requests that providers avoid certifying regularly or as the bulk of practice; asks that they communicate to patients indications, risks, benefits, and alternatives; recommends that they warn against operating heavy machinery while under the influence; encourages consideration of baseline and/or periodic drug testing and, in the case of patients with addiction history, psychiatric consultation; and emphasizes the need for caution if history of psychosis. Finally, the guidelines outline that network hospitals will neither dispense marijuana nor allow it in any form on hospital premises.

Conclusions. The evidence to support the use of medical marijuana is limited but highly relevant to hospice and palliative medicine providers. Institutional guidelines may be developed to help providers reconcile seeming contradictions and deficiencies in law and science.

Finding Their Voice: Advance Care Planning for Children and Young Adults Without Decision-Making Capacity (SA525)

Amy Downing, MD, The Children's Hospital of Philadelphia, Philadelphia, PA. Dana Dombrowski, MSW LSW, The Children's Hospital of Philadelphia, Philadelphia, PA. Vanessa Battista, MS RN CPNP, The Children's Hospital of Philadelphia, Philadelphia, PA.

Objectives

- Explore their own personal struggles and be able to list five barriers frequently cited when considering advance care planning (ACP) for children with complex chronic conditions who cannot communicate their wishes.
- Apply newly acquired concepts in ACP to their patients with complex chronic conditions and limited communication abilities.

Children with severe lifelong medical complexity, resulting from a variety of causes, including birth trauma or prematurity, congenital malformations, or any number of genetic or metabolic conditions, are a growing population within children's hospitals. Many lack the ability to communicate their wishes and fears, thus relying on others to make their most important medical decisions. Palliative care professionals may be consulted at various stages along their unpredictable trajectory. While both clinicians and families recognize the need for advance care planning (ACP) in this population, several unique characteristics of this group make such planning complex and challenging.
With audience participation, we will discuss both the evidence-based and collectively identified unique medical and psychosocial aspects of this population that are often barriers to conducting advance care planning. We will then introduce a framework for ACP that has specific application to this unique population. This framework will address the cited barriers, draw upon the recognized strengths of these children and their families, and tend to the specific needs these families have expressed. Key concepts will include recognizing and addressing provider bias, promoting a focus on goals and values, early introduction and consistent usage of a benefit versus burden framework for decision-making, recognizing that this process is almost never black and white, and the importance of building trusting relationships and having ongoing conversations.
We will use cases to further illustrate how this framework can be applied to some of our most challenging consults. In particular, we will explore the consideration of tracheostomy placement for chronic respiratory failure. As a group, we will practice applying these newly acquired concepts to a scenario that is both common to, and especially challenging for, many pediatric palliative care programs.

Practicing Between a Rock and a Hard Place: Managing Pain in Opioid-Dependent Patients (SA526)

Amy Davis, DO MS FACP FAAHPM, Drexel University School of Medicine, Bala Cynwyd, PA. Mary Lynn McPherson, PharmD BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD.

Objectives

- Define what is meant by "opioid tolerant," including the FDA's definition and both legitimate and illicit use of opioids.
- Describe pain management options for patients receiving opioid agonist therapy for a history of substance abuse (eg, buprenorphine or methadone).
- List two ways patients with substance dependence or abuse in the palliative care setting may be clinically different from those without these issues.

Substance abuse and physical dependence are prevalent in the United States. According to the National

Institute on Drug Abuse, in 2012, 17.7 million Americans (6.8% of the population) had dependence on or abuse of alcohol, 4.3 million met criteria for marijuana, and 2.1 million for prescription pain medication. The number of people older than 50 years with these issues is steadily rising. This population has a higher likelihood of facing serious illness while also battling substance dependence or abuse. As a result, their prevalence in the palliative care setting is expected to increase significantly. Medications are commonly used to treat or control addiction. Some of these may be unfamiliar to palliative care practitioners or are used in ways that are unique to addiction therapy. In addition, some of the medications commonly used in symptom management may need to be avoided, adjusted, or more closely monitored when prescribed to those with substance dependence or abuse issues. Participants will learn the definition of "opioid tolerant" and will be able to provide several examples, including both legitimate and illicit opioid use. We will review the medications more commonly used to treat or control addiction, describe how they may need to be adjusted in the palliative care setting for safety or for symptom management, and discuss the appropriateness of discontinuing them when receiving hospice care. We will also review some of the unique clinical challenges common in symptom management in those with active or past substance dependence or abuse issues. This presentation will have a strong practical emphasis for immediate application in clinical practice.

Paper Session

Puerto Rican Emergency Department Clinicians' Knowledge, Practice and Attitudes Regarding Family Witness Resuscitation (SA527A)

Maria Ramos, MD, Emory University, Atlanta, GA. Juan Zequeira Diaz, MD, Maimonides Medical Center, Brooklyn, NY. Gabriel Galíndez De Jesús, BS, University of Puerto Rico School of Medicine, San Juan, Puerto Rico. Danielle Moulia, MPH, Emory Palliative Care Center, Atlanta, GA. Tammie Quest, MD, Emory University School of Medicine, Atlanta, GA.

Objectives

- Explain family witness resuscitation and the current evidence base.
- Describe emergency department clinicians' knowledge, feelings, and attitudes regarding family witness resuscitation.

Original Research Background. Family witness resuscitation (FWR) is the monitored admittance of family members while their loved one is undergoing cardiopulmonary resuscitation. While scientific findings and professional medical organizations, such as the American Heart Association (AHA), support FWR, little is known about clinician acceptance of the practice.

Objective. The objective of this study is to assess Puerto Rican Emergency Department (ED) clinicians' knowledge, practice and attitudes regarding FWR.

Methods. A self-administered survey of clinicians' knowledge, practice and attitudes regarding FWR was distributed to a convenience sample of on-service clinicians at 11 Puerto Rican EDs in 2014. Chi square tests ($p<0.05$) were used to compare clinicians' response by profession and previous experience with FWR.

Results. Of the 278 clinicians who completed the survey, roughly half were registered nurses (47.8%; n=133) and half were physicians (52.2%; n=145). While over half (61.9%; n=172) of clinicians were familiar with the American Heart Association guidelines on FWR, 50.3% (n=140) of clinicians were opposed to the practice. Top concerns about FWR were team performance anxiety (65%; n=153) and family distress interrupting the code team (60.4%; n=168). Clinicians with any previous experience performing FWR were significantly ($p<0.05$) more likely to be in favor of FWR than clinicians with no experience performing FWR (49.6% vs. 4.4%, respectively). Physicians were also significantly ($p<0.05$) more likely to favor FWR than registered nurses (39.6% vs. 13.6%).

Conclusion. Despite scientific evidence to support FWR, our study found Puerto Rican ED clinicians' acceptance of the practice to be mixed. Physicians and clinicians who had first-hand experience with FWR were more likely to support the practice.

Implications for Research, Policy, and Practice. Through further advocacy and staff training that focuses on practice, we believe that FWR could be a valued practice in the ED.

Measuring What Matters: Documenting Resuscitation Preferences (SA527B)

Shannon Haliko, MD, University of Pittsburgh Medical Center, Pittsburgh, PA. Jessica Fesz, RN, MSN, University of Pittsburgh Medical Center, Pittsburgh, PA. Marianne McConnell, RN, University of Pittsburgh Medical Center, Pittsburgh, PA. Winifred Teuteberg, MD, University of Pittsburgh, Pittsburgh, PA.

Objectives

- List three potential problems when developing palliative care domains for electronic medical record (EMR) implementation.

- Design a method for operationalizing the palliative quality metric of resuscitation preference documentation using EMR.

Original Research Background. AAHPM's Measuring What Matters has targeted documentation of patients' resuscitative preferences. To operationalize this measure, we first conducted an iterative quality improvement investigation of electronic medical record (EMR) enhancements in our health network that is serving more than 170,000 inpatients per year. Enhancements were designed to 1) increase access to advanced care documents (ACD) and 2) streamline inpatient code status order documentation.

Research Objectives. To provide a description of code status order entry practices and demonstrate the effect of related EMR enhancements.

Methods. Cross-sectional analysis was performed for inpatients at two academic hospitals from 2012 to 2014 to determine code status at discharge. An EMR alert prompting code status order was instituted at the mid-timepoint at one hospital. Descriptive data was generated in relation to age, number of admissions, and code status type.

Results. During the lead in period, most inpatients (> 97%) did not have a code status documented. Though one of the hospitals is a tertiary center for cancer treatment, the rates and ages of patients discharged with a "limited" or "comfort measures only" code status were similar. After alert implementation, absent orders were reduced by 3% but coincided with a reciprocal 3% increase in full code orders. Scheduled audits provided insight to utilization practices, but formal evaluation will occur at one year post implementation, October 2015.

Conclusion. These findings reflect poor documentation practices for inpatient resuscitation preferences. Further, simple alerts are ineffective at generating meaningful change. We estimate that more than 50,000 patients were at risk of receiving healthcare incongruent with documented preferences.

Implications for Research, Policy, and Practice. The magnitude of this problem, as well as our commitment to primary palliative care, has fueled the next phase: 1) order entry with POLST format paired with discussion documentation and 2) on-site efforts to address individual and group barriers.

Self-Reported Health and Preferences for Disclosure of Medical Information (SA527C)

Sabiha Kazi, MD, Mount Sinai School of Medicine, New York, NY. Amy Kelley, MD MS MSHS, Mount Sinai School of Medicine, New York, NY. Carla Boutin, MD, Weill Cornell Medical College, New York, NY. Neha Nagpal, BS, Weill Cornell Medical College, New York, NY. Michelle Mendiolaza, BA Candidate, Weill Cornell Medical College, New York, NY.

Objectives

- Understand that individuals' health status may affect their desire for medical information disclosure.
- Individuals who report a lower state of health may desire more family involvement in disclosure of health information.

Original Research Background. Advanced care planning is widely recognized as being beneficial, particularly when reassessed periodically over the course of illness. Preferences regarding health information disclosure may impact advanced care planning behaviors. Currently, little is known about the relationship between health status and individuals' preferences for disclosure and how this may influence individualized counseling for advanced care planning.

Methods. This mixed-methods study examined the relationship between self-reported health status and desire for medical disclosure. Diverse adults (n=62) aged 55 and older were recruited from primary care clinics and senior centers and via snowball sampling in New York City. Individuals that were currently or previously enrolled in hospice, those with terminal diseases, and non-English speakers were excluded. Demographics, self-reported health, and qualitative data regarding preferences for disclosure of medical information were collected and coded.

Results. Thirty-nine percent described their health as "excellent/very good," 34% stated "good," and 27% answered "fair/poor." As the self-reported state of health declined, so did the percentage of participants who reported a preference to be told about an illness if they "were to become very sick": 42%, 29%, and 19%, respectively. Further, participants reporting "fair/poor" health frequently desired family involvement (81%), specifically their adult children (41%), in medical disclosure.

Conclusion. These results suggest that preferences for medical disclosure may change in relation to health status or increased personal experience with illness. Participants in fair or poor health may be more aware or accepting of family during illness, and thus they may be more likely to include or defer to family during health information disclosure.

Implications for Research, Policy, and Practice. Health status and personal experience may influence an individual's preference for medical disclosure over the course of an illness. These preferences must be assessed over time in the context of effective, patient-centered advanced care planning.

Outcomes of In-Hospital Cardiopulmonary Resuscitation in Patients with Chronic Kidney Disease (SA527D)

Fahad Saeed, MD, University of Rochester, Rochester, NY. Jean Holley, MD, Carle Physician Group and University of Illinois at Urbana-Champaign, Urbana, IL.

Objectives

- Learn about the outcomes of cardiopulmonary resuscitation (CPR) in chronic kidney disease (CKD) patients.
- Learn about the outcomes of CPR in CKD patients who are ≥75 years of age.

Original Research Background. Advance care planning including code status discussion is an essential part of the medical care of patients with chronic kidney disease (CKD). There is little information on the outcomes of cardiopulmonary resuscitation (CPR) in these patients.

Research Objectives. We aimed to compare the following CPR-related outcomes in CKD patients with the general population by using Nationwide Inpatient Sample (NIS): (1) survival to hospital discharge; (2) discharge destination; and, (3) length of hospital stay.

Methods. We analyzed data from Nationwide Inpatient Sample (NIS 2005- 2011), including patients with and without CKD who had undergone in-hospital CPR. Baseline characteristics, in-hospital complications, and discharge outcomes were compared between the two groups. Chi-square for categorical and t-test for continuous variables were used in the univariate analysis to build logic regression analyses models to analyze CPR-related outcomes.

Results. 71,961 CKD patients underwent in-hospital CPR compared to 323,620 patients from the general population. Unadjusted in-hospital mortality rates were higher in CKD patients (72 % versus. 75%, p=<.0001) on univariate analysis. After adjusting for age, gender, and potential confounders, CKD patients had higher odds of mortality: odds ratio 1.24, 95 % CI 1.11-1.3, p=<.0001. Hospitalization charges and length of stay were also greater in CKD patients. There was no overall difference in post-CPR nursing home placement between the two groups. In a separate sub-analysis of CKD patients ≥75 years, higher odds of in-hospital mortality {1.30(1.20-1.42), P <.0001} and likelihood of nursing home discharge {1.60(1.36-1.89) <.0001} were noted.

Conclusion. CKD patients have poor survival after CPR compared to the general population. Mortality is even higher in CKD patients who are ≥75 years of age.

Implications for Research, Policy, and Practice. Our findings can be used to facilitate patient/provider dialogue regarding code status in patients with CKD. Further studies are needed to analyze post-in-house CPR functional status, quality of life, and long-term outcomes.

2:30—3:30 pm

Concurrent Sessions

The Worst Possible Sorrow…and a Most Treasured Gift: Ways that Palliative Care and Palliative Care Providers Can Support Organ Donors and Their Families and Organ Transplant Candidates Awaiting Donation (SA530)

Rebecca Aslakson, MD PhD, Johns Hopkins Hospital, Baltimore, MD. J. Randall Curtis, MD MPH, University of Washington, Seattle, WA. Clint Burns, RN, The Johns Hopkins Hospital, Rising Sun, MD.

Objectives

- Describe the process that occurs prior to transplantation of deceased donor organs and the opportunities for support from primary and specialty palliative care.
- Define an "organ procurement organization" (OPO) and describe its role in the donation and transplantation process.
- List four different ways that palliative care providers can partner with care providers during the organ donation process.

Since the first successful kidney transplants in the 1950s, the specialty of organ donation has grown with donors now able donate up to six organs (kidneys, liver, heart, lungs, small bowel, and pancreas) and with an average of 79 people receiving an organ each day in the US and another 21 people dying each day while waiting for transplant. In 2013, there were 121 272 people in the US on the waiting list for a transplant, and 28 954 candidates actually received transplants. Organ donation is understandably a highly emotional time for all parties; there are many opportunities for palliative care and palliative care providers to improve care for transplant donors and their family members, transplant recipients, and peri-transplant clinicians. In this session, we will discuss the different types of organ donation (deceased donor, including donation after brain death and donation after cardiac death, living-related donor, living-unrelated donor)—what and who are involved and where donations typically occur (ie, most deceased donor transplants involve donors who are admitted to critical care units); the roles of different individuals in the process (ie, what is an "organ procurement organization"); and where opportunities exist for better palliative care delivery, particularly for the family members of donors and potential donors.

What Are the Limits of Parental Authority? Pediatric Bioethics and the Law (SA531)

Liza-Marie Johnson, MD MBE MPH, St. Jude Children's Research Hospital, Memphis, TN. Katherine Steuer, JD, St. Jude Children's Research Hospital, Memphis, TN. Amy Campbell, JD MBE, University of Memphis, Memphis, TN. Justin Baker, MD FAAHPM, St. Jude Children's Hospital, Memphis, TN.

Objectives

- Distinguish between the "best interest standard" and "the harm principle" in the evaluation of familial medical decision making in pediatrics and analyze the strengths and weaknesses of each.
- Identify key legal cases in pediatrics and explain their impact on practice standards for clinicians providing medical care to children.

Understanding the intersection of bioethics and the law is essential for providers caring for complex or chronically ill children. Medical decision making has shifted from a paternalistic model to one in which capitated adults are allowed wide license to make medical decisions for themselves. In adhering to this model, clinicians sometimes have to allow decisions that might be considered "the wrong decision" or a "bad decision," given the belief that adult patients have the right to autonomous medical decision making.

Infants and children lack the ability to make autonomous medical decisions and parents are allowed broad discretion in medical decision making because we believe parents have the right to manage the liberty interests of their children. In our society, we believe it is a parental responsibility to promote their children's best interests and minimize harms. Parents are given significant leeway to make decisions they believe are consistent with the beliefs and values of their family unit. Children develop maturity to participate in medical decision making as they age, creating a triangle of decision making between patient, parent, and provider, which may raise additional complexities.

Respect for the autonomy of the family unit in regard to medical decision making is not absolute. State intervention may be required when parental decision making is perceived to significantly violate a child's best interest or put them at risk of serious harm. The decision to make a referral to child protective services or to pursue a court order in this context of concern for medical neglect is often distressing to families and providers. Certain paradigm legal cases such as that of Prince v Massachusetts or the Baby Doe cases provide guidance to clinicians who encounter ethical dilemmas while caring for a pediatric patient. Understanding the intersection of bioethics and the law is essential for providers caring for complex or chronically ill children.

Community-Based Palliative Care: Care Transitions and Beyond (SA532)

Bernard Lee, MD, Metropolitan Jewish Health System, New York, NY. Myra Glajchen, DSW, Metropolitan Jewish Health System, New York, NY. Lara Dhingra, PhD, Metropolitan Jewish Health System, New York, NY.

Objectives

- Describe the conceptual and pragmatic elements of an innovative model of transitional care for patients with advanced illness.
- Identify the critical elements of the High-Touch model of palliative care and link clinical interventions to outcomes.
- Describe the impact of an interdisciplinary High-Touch model of community-based specialist palliative care through the experience of a patient with advanced heart failure.

Palliative care in the United States has been characterized by recognition as a medical specialty, rapid growth in programs, and proliferation in the development of diverse models. However, with a rapidly aging population, workforce shortages, lack of access for some patients, and a new policy impetus toward community-based palliative care, novel models with sound clinical and research outcomes are urgently needed to promote access and ensure quality. This presentation will highlight best clinical and research practices using two different models of palliative care, transitional care, and the High Touch model of palliative care. First, Dr Myra Glajchen, a palliative care educator and researcher, will describe a novel model of transitional care for older patients with advanced illness, highlighting complex practical tasks, emotional challenges, and systems problems; and share innovative tools and practices, including an interdisciplinary approach, templated assessment, handoffs and community-based intervention and links between the hospital and community-based settings. Second, Dr Lara Dhingra, a palliative care researcher and psychologist, will highlight the essential clinical and program components of the High-Touch model of palliative care, linking research findings from a large dataset of palliative care patients to best practices and clinical outcomes. Third, Dr Bernard Lee, a palliative care specialist, will illustrate the impact of the High-Touch model on a patient with advanced medical illness and complex needs, tracing the patient experience from diagnosis through hospitalization, discharge, community-based care, and hospice. Participants will be asked to identify clinical and systems barriers in the case and engage in treatment decision-making, drawing upon challenging clinical scenarios in their own practice. Audience members will emerge with new knowledge about models of care and steps for translating important research findings into their own practice with implementation tools and best practice guidelines for maintaining the patient in the home setting.

Get Pumped! Palliative Inotropes in Advanced Heart Failure Across the Continuum of Care (SA533)

AAHPM Pharmacotherapy SIG Endorsed. Renee Holder, PharmD BCPS CPE, Medstar Washington Hospital Center, Washington, DC. J. Hunter Groninger, MD FAAHPM, Medstar Washington Hospital Center, Washington, DC. Joan Panke, MA NP ACHPN, MedStar Washington Hospital Center, Washington, DC. George Ruiz, MD, MedStar Heart Institute, Bethesda, MD. Malgorzata Sullivan, MD, Capital Caring, Washington, DC.

Objectives

- Describe the role of inotropic therapy in patients with advanced heart failure.
- List the barriers associated with providing inotropes in end-of-life care settings.
- Develop a community-based strategy for transitioning a patient receiving palliative inotropes to home care or hospice care that addresses actual and perceived barriers.

Patients with advanced heart failure can have limited therapeutic options due to disease severity or burden of comorbid conditions. Continuous infusion of inotropic therapy outside the hospital setting may offer increased quality of life and reduced symptom burden, coupled with a limited prognosis. However, challenges regarding drug selection, coordinating care setting transitions, administration, duration of therapy, and patient and provider acceptance may arise in clinical practice. In this concurrent session, heart failure, palliative, and hospice specialists discuss the multiple moving parts involved in transitioning a patient throughout the care system with inotropic therapy. Comparisons between dobutamine and milrinone from a pharmacologic and pharmacoeconomic perspective will be discussed as well as administration and monitoring issues surrounding continuous, titratable cardiac medications in various care settings. An example of a weaning protocol developed in collaboration with heart failure and palliative specialists will be shared with the audience. We will shed light on the congruence and conflicts of inotropes with hospice philosophy and present details on coordinating transitions and managing patient expectations when palliative inotropes are part of the care plan.

"I've Got This Vet..." Transitioning Hospice Care for Veterans Between VA and Community Hospice Agencies: Rules of the Road (SA534)

Gary Hsin, MD FAAHPM, VA Palo Alto Health Care & Stanford University, Palo Alto, CA. Laura Blue, BSN RN, Department of Veterans Affairs Palo Alto HCS, Burlingame, CA. Sheila Kennedy, MSW LCSW, VA, Menlo Park, CA.

Objectives

- Understand current rules and regulations for VA hospice and palliative care benefits, including the Veterans Choice Program.
- Understand the processes by which veterans are referred to community and how to enroll and transition veterans for VA care.

The Veterans Health Administration (VHA) operates under specific rules and regulations set forth by the federal government. While there are similarities to other government programs such as Medicare, there are also significant differences. Primarily, the VHA is a healthcare provider (outpatient, inpatient, home care, nursing home care) and works with community agencies for services it does not provide, such as home hospice care. Understanding the evolving rules and regulations, including pertinent aspects of the Veterans Access, Choice, and Accountability Act (2014), will help to ensure the smooth transitions of care between community agencies and the VA. We will highlight the "rules of road," where the regulations are clear but will also point out those areas where regulations are not. We will discuss the role of hospice veteran partnerships (HVP). We will review the process by which veterans are referred to the community, including payment, and how they are referred for care in the VA system. We will also discuss the evolving area of access to palliative care in the home and outpatient setting.

"They Got How Much Methadone?" What We Learned About How to Best Respond to Opioid Dosage Errors (SA535)

Maria Wharton, BSN RN CHPN, Hospice of the Chesapeake, Pasadena, MD. Elisabeth Smith, BSN RN CHPN, Hospice of the Chesapeake, Pasadena, MD.

Objectives

- Describe the risks associated with dosage errors for both long-acting opioids such as methadone and short-acting opioids such as morphine.

Participants will be able to describe appropriate assessment components and frequency of assessment after an opioid dosage error and develop an appropriate plan of care based on the type and amount of opioid involved in the error.
- Describe the components of a protocol outlining the safe and appropriate use of narcan in opioid tolerant patients with pain along with the risks of using narcan for full reversal of opioids in opioid tolerant patients with pain.

Despite robust teaching, opioid dosage errors occur in the hospice and palliative care setting. This presentation will explore the components of a robust opioid teaching plan, including patient teaching tools. We will review the risks associated with opioid dosage errors based on the type of opioid (short or long acting) and the patient's history of opioid use and discuss appropriate follow up for each type of dosage error. Narcan is not always the answer. We will share the protocol we developed in response to a methadone dosage error.

Should Tomorrow Be? Ethical and Medical Challenges of Spinal Cord Injury Patients and the Need for Multidisciplinary Palliative Medicine Support (SA536)

Stacie Levine, MD FAAHPM, University of Chicago, Chicago, IL. Kristi Kirschner, MD, University of Illinois, Chicago, IL. Malini Goel, JD MALD, Director of documentary, *Should Tomorrow Be*, Schererville, IN.

Objectives
- Describe the management of pain and non-pain symptoms that are unique to spinal cord injury patients.
- Discuss management of ethical issues encountered when caring for spinal cord injury patients, particularly decisions to withdraw ventilator support.
- Discuss the impact spinal cord injury has on caregivers and the important role multidisciplinary palliative medicine plays in caring for the entire family unit.

The estimated incidence of spinal cord injury (SCI) in the US is 12 000 new cases/year. Depending on location and extent of the injury, symptoms range from muscle weakness to paralysis, and include respiratory muscles, autonomic instability and dysreflexia, disruption in bladder and bowel function, sexual dysfunction, neuropathic pain, and loss of sensation. Pressure ulcers, depression, infections, and physical dependency are common sequelae. The financial and emotional stress on patients and families can be significant, particularly as insurance provides limited community support. Higher level SCI patients, in particular, are often dependent on others for physical care, including ventilator management. It is not uncommon for such patients to contemplate withdrawal of respiratory support at some point after this sudden life-changing event. Such discussions generate many emotions and challenges, not only for the patient and families, but also the care team supporting them. There are several cases in the literature that highlight ethical issues when these difficult and permanent decisions are made. What are unique features when determining decision-making capacity in patients with high SCI? How does one honor a patient's autonomy while considering all aspects of the decision-making process, including the views of the surviving family members? Which members of the healthcare team should be involved? This session will begin with a short documentary, *Should Tomorrow Be*, filmed by the daughter of an Indian-American physician who sustained a fall at home, resulting in complete cervical SCI with ventilator dependency. When home care proves difficult, and he develops worsening comorbidities, including pain, he requests withdrawal of ventilator support. Following the film, a panel of discussants comprising a palliative medicine physician, physiatrist with SCI expertise, and the 132#patient's daughter will review the ethical and medical concerns revealed and the important role of multidisciplinary palliative medicine support in assisting patients and their families.

Staring into a Broken Mirror: Posttherapeutic or Traumatic Disfigurement (SA537)

Faith Young, MD, Thomas Jefferson University Kimmel Cancer Center, Cherry Hill, NJ. Kelly Cooke, DO, ProHealth Care, Eagle, WI. William C. Jangro, DO, Thomas Jefferson University, Philadelphia, PA.

Objectives
- Understand the multi-dimensional difficulties faced by patients who have experienced a change in physical appearance and body image.
- Identify normal adaptive stages after disfigurement.
- Recognize predictors of psychosocial disturbance.

Patient Quote: “People seem to think I've changed because my face has.”

Body image is central to the successful navigation of social as well as private functioning. Changes in self-perception are often profound in the setting of posttherapeutic or posttraumatic disfigurement, with a visible or perceived mismatch between their “normal” body and a “new” one. The persons affected by this mismatch may have experienced burns, traumatic amputation, therapeutic amputation or resection, chemotherapy, or radiation-associated changes. The circumstances leading to, and the type of changes experienced, require adaptation in terms of physical functionality and also psychosocial adjustment. The family unit or support groups of the affected individual are also affected by the physical changes and the necessity to adapt to differing physical and social experiences. This session will highlight our understanding of the adjustment process after traumatic (such as military related injury) or posttherapeutic disfigurement (such as that seen in oncology). We will define and explore common themes affecting patients who experience an altered body image, including self-care, grooming, habituation, and socialization.

The ability to identify and support patients and families facing, recovering from, or navigating a disfiguring experience is enhanced by an understanding of normal adaptive and coping strategies. Circumstances (pre- and post-event) known to impact adjustment to changes in body image will be reviewed. It is particularly important to be able to predict or recognize maladaptation. Familiarity with this topic, and with proven treatment strategies or resources for our patients, enhances our ability to give practical advice, provide emotional support, and to mobilize appropriate referrals or interventions.

Paper Session

A Survey of Staff Knowledge of Suicide Risk Factors, Evaluation and Management at a Large Non-Profit Hospice (SA538A)

Allison Jordan, MD, Hospice and Palliative CareCenter, Winston Salem, NC. Kevin Patterson, MD, University of Pittsburgh, Pittsburgh, PA. Patrick White, MD, University of Pittsburgh Medical Center, Pittsburgh, PA. Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Explain hospice suicide prevalence.
- Identify risk factors for suicide by specialty.
- List staff preferences for learning about mental health.

Original Research Background. Hospice patients are at heightened risk for suicide; however, the extent of staff knowledge regarding evaluation and management of patients who are suicidal is unknown.

Research Objectives. The purpose of the study was to determine level of staff training in mental health and their knowledge of evaluation and treatment of suicidal ideation.

Methods. Anonymous 20-item survey distributed via email and on paper to hospice nurses, nursing assistants, social workers, and chaplains who conduct home visits at a large non-profit hospice in southwestern Pennsylvania. All survey responses of interest were categorical in nature and were summarized with frequencies and percentages. Cross-tabulations showed relationships between responses, and significance was tested using a two-sided Fisher’s Exact Test.

Results. Eighty-seven staff members responded—a 72% response rate. Twenty-five percent had no mental health training. Thirty percent of employees reported exposure to suspected suicides, and 20% were involved in confirmed cases. More than two-thirds (67.8%) of all staff were not able to identify four risk factors for suicide, with certified nursing assistants (77.3%) and social workers (77.8%) the least proficient. Years of hospice experience did not influence proficiency (p = .568). Staff with mental health training were more likely to ask questions about suicidal plans and means (p=.042), previous suicide attempts (p=.001), and presence of firearms (p=.34). All staff requested more training in mental health, with interactive lectures being the preferred educational format.

Conclusion. Variation exists among hospice care providers in their knowledge about mental health and suicide.

Implications for Research, Policy, and Practice. More education is needed for hospice staff to recognize risk factors for suicide.

It’s Like Heart Failure: It’s Chronic and It Will Kill You: Exploring Hospice and Palliative Care Clinicians’ Experiences with Burnout (SA538B)

Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Daniel Siconolfi, MPH, Johns Hopkins Bloomberg School of Public Health, Pittsburgh, PA. Janet Bull, MD HMDC FAAHPM, Four Seasons, Flat Rock, NC. Karen Steinhauser, PhD, Duke University Medical Center, Durham, NC. Arif Kamal, MD MHS, Duke Cancer Institute, Durham, NC.

Objectives

- Discuss burnout, as identified and described by current hospice and palliative care clinicians, and its implications on the hospice and palliative care discipline.
- Identify potential ameliorating and protective factors against burnout applicable to the hospice and palliative care clinical workforce.

Original Research Background. Clinical palliative care is stressful, with self-reported burnout rates as high as 62% among clinicians. To date, there has been scant qualitative investigation into the causes, ameliorators, and effects of this pervasive phenomenon. Alarming as such statistics may be, quantitative estimates in isolation cannot disentangle the predisposing, situational, and protective factors related to one's experience of burnout; absent rigorous mixed-methods appraisal of the lived experience of burnout, feasible solutions to address burnout may be out of reach.

Research Objectives. To explore sources, implications, and solutions vis-a-vis burnout among hospice and palliative care (HPC) clinicians.

Methods. During the 2014 AAHPM/HPNA Annual Assembly, we conducted three semi-structured focus groups on the following topics: personal narratives of burnout, how burnout differs within HPC, and strategies to mitigate burnout. Two investigators independently analyzed data using template analysis, an inductive/deductive qualitative technique.

Results. We interviewed 20 HPC clinicians (14 physicians, 4 advanced practitioners, 2 social workers). Participants were 65% female; overall, 55% had practiced for 0-5 years, 30% for 6-20 years, and 15% for 21+ years. We observed variability in sources of burnout between clinician types and by practice settings (i.e., hospice or palliative care). Common sources of burnout included: increasing workloads, tensions between non-specialists and HPC specialists, and regulatory issues. Interviewees proposed anti-burnout solutions including: promoting the provision of generalist palliative care by colleagues, frequent rotations on-and-off service, and organizational support for self-care modalities. Participants expressed grave concerns about the stability of the HPC workforce and concerns of providing high-quality palliative care in light of a distressed, overburdened discipline.

Conclusion. Complementing recent survey data, our results illustrate the alarming prevalence, severity and potential ramifications of burnout on the HPC workforce. Additionally concerning is the paucity of protective structures and policies to attenuate burnout.

Implications for Research, Policy, and Practice. Our data underscore the imperative for intense attention to identify multi-level interventions to mitigate HPC burnout.

A Tale of Two Cities: Results of the ENABLE CHF-PC Early, Concurrent Palliative Care Heart Failure Feasibility Trial (SA538C)

Marie Bakitas, DNSc CRNP AOCN ACHPN FAAN, University of Alabama at Birmingham, Birmingham, AL. James N. Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham, Birmingham, AL. Elizabeth Kvale, MD, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL. Alan Kono, ND, Dartmouth Hitchcock Medical Center, Lebanon, NH. Salpy Pamboukian, MD, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Gain greater knowledge about how to pilot an early concurrent palliative care intervention for advanced heart failure patients and caregivers.
- Gain greater knowledge of regional differences in patient/caregivers' palliative care understanding and completion of intervention activities.

Original Research Background. Heart failure (HF) guidelines recommend early initiation of palliative care (PC) for individuals with advanced HF. Following a formative evaluation/intervention development study, we developed ENABLE CHF-PC (**E**ducate, **N**urture, **A**dvise, **B**efore **L**ife **E**nds Comprehensive Heartcare for Patients and Caregivers) a concurrent, telehealth PC intervention to increase PC access to medically-underserved and rural HF patients and their family caregivers.

Research Objectives. To determine: 1) feasibility of recruiting/retaining 25 patient-caregiver dyads for 24 weeks and 2) necessary modifications to intervention protocol procedures and materials.

Methods. Two-site (UAB, Birmingham, Alabama and Dartmouth-Hitchcock, Lebanon, NH), single-arm pilot feasibility trial. Inclusion criteria: Class III/IV or Stage C/D HF; age >64 years; English-speaking. Patients receive an in-person PC consultation, six nurse-coach phone sessions, and monthly check-in calls. Caregivers receive four nurse-coach phone sessions and monthly check-in calls. Quality of life, depression/anxiety, and resource use outcomes were collected at baseline and at 12 and 24 weeks.

Results. Feasibility: We recruited 50 patients (UAB=22; Dartmouth=28) and 42 caregivers (UAB=17; Dartmouth=25). Participants were: patients—average age 72, female—42%, and non-white (16%), and caregivers—average age 65, female-83%, non-white (14%). Race and religion were significantly different between sites. Patient and caregiver measure completion rates were 98%. Attrition (excluding death n=3) was 18% (patients) and 12% (caregivers). Dartmouth reached the recruitment goal. UAB site challenges included: 1. dyads' limited understanding of PC; 2. dyads' issues in keeping scheduled data and intervention calls; 3. health literacy barriers; and 4. investigators' recruitment "learning curve." Study modifications included revised recruitment strategies, materials for low literacy, and measures. Longitudinal outcomes were summarized and will be reported.

Conclusions. We encountered regional differences and refined strategies for advanced HF recruitment/retention, addressed intervention materials' literacy issues that have been implemented in the ENABLE CHF-PC RCT.

Implications for Research, Policy, and Practice. Formative evaluation/intervention development studies are critical and should be required prior to conducting larger efficacy/effectiveness clinical trials.

Identifying the Impact of Palliative Care Interventions: A Systematic Review (SA538D)

Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Jennifer Corbelli, MD MS, University of Pittsburgh, Pittsburgh, PA. Natalie Ernecoff, MPH, University of North Carolina, Chapel Hill, NC. Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA. Yael Schenker, MD, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Identify the current evidence for palliative care interventions to improve patient and caregiver outcomes in seriously ill populations.
- Identify common methodological limitations among randomized controlled trials of palliative care interventions.
- Identify priority areas for future research in palliative care.

Systemic Review Background. A 2008 systematic review described sparse evidence in support of palliative care; however, several high-impact trials have been conducted since then. Increasing calls for adoption of palliative care in serious illness warrant systematic re-examination of the evidence base.

Aims. We sought to characterize the structure, processes, outcomes, and quality of randomized controlled trials (RCTs) of palliative care interventions in serious illness.

Methods/Session Descriptions. With the aid of a research librarian, we searched the Medline, EMBASE, CINAHL, and Cochrane databases from inception through February, 2015. We included RCTs of interventions comprised of ≥2 palliative care domains (as outlined by the National Consensus Project for Quality Palliative Care) and conducted in seriously ill adult populations. Eligible studies reported on ≥1 of the following predefined outcomes: patient quality of life (QOL), patient symptom burden (physical and psychological), satisfaction with care, advance care planning, mortality, healthcare utilization, costs, caregiver QOL, and caregiver burden. Two investigators independently screened, reviewed, extracted data from, and assessed the quality of each record using standardized criteria; disagreements were resolved by discussion or expert adjudication. We identified 6,143 records; 54 (0.009%) articles met all inclusion criteria, representing 41 trials.

Conclusion. Substantial heterogeneity exists in the design, content, and outcomes of palliative care interventions, limiting the ability to pool results. The greatest evidence for the benefit of palliative care was found regarding: satisfaction with care (78% of studies favoring palliative care), patient QOL (63%), and caregiver burden (63%). Interventions were less often associated with benefit regarding: symptoms (35%), mortality (25%), and caregiver QOL (20%). Common methodological limitations included inadequate description of intervention content; poor recruitment and follow-up; inconsistent use of outcome measures, many of which were not designed for seriously ill populations; and, flaws in intent-to-treat analyses. We will discuss priorities for future research, including the need to define a common core of high-priority outcome measures and to investigate "active ingredients" of interventions.