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

February 22-25, 2017 • Phoenix, AZ

Wednesday, February 22

8 am—5 pm

AAHPM & HPNA Preconference Workshops

Hospice Medical Director Update and Exam Prep (P01)

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

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.

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

Robert M. Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA. Anthony Back, MD, University of Washington, Seattle, WA. James Tulsky, MD FACP FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

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

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

2017 AAHPM Fellowship Directors Program: Building a Community of Educators (P04)

Jane deLima Thomas, MD FAAHPM, Harvard Medical School, Dana-Farber Cancer Institute, Boston, MA. Anthony L. Back, MD, University of Washington School of Medicine, Fred Hutchinson Cancer Research Center, Seattle, WA. Jillian Gustin, MD, Ohio State University Wexner Medical Center, Columbus, OH. Vicki A. Jackson, MD MPH FAAHPM, Harvard Medical School, Massachusetts General Hospital, Boston, MA. Juliet Jacobsen, MD DPH, Harvard Medical School, Massachusetts General Hospital, Boston, MA. Lindy H. Landzaat, DO, University of Kansas Medical Center, Kansas City, KS. Stacie K. Levine, MD FAAHPM, The University of Chicago, Chicago, IL. Vanessa Neri, LCSW, VA Palo Alto Health Care System, Palo Alto, CA. Vyjeyanthi Periyakoil, MD, Stanford University School of Medicine, VA Palo Alto Health Care System, Stanford, CA. Christian Nicole Smith, MPA, The University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Identify and exchange funding strategies for fellowship programs.

- Become familiar with current work on palliative care Curricular Milestones and provide feedback and input for further development.
- Design approaches for maximizing effectiveness in using interprofessional faculty and in teaching interprofessional learners.
- Develop resiliency curricula for fellows and faculty.

The fellowship directors program will provide participants with the opportunity to learn about the latest advances in specialty-level palliative care education, to engage in shaping the educational standards that define the field, and to develop connections with other palliative care educators. Four main topics will be covered this year: finding sources of funding for fellowship programs; vetting the palliative care curricular milestones; maximizing the interprofessional aspect of palliative care training programs for both faculty and fellows; and developing resiliency curricula for faculty and fellows. In addition, there will be shorter discussions about some of the more administrative aspects of fellowship program management, such as the Match, activities of the Residency Review Committee (RRC), and changes in fellowship program start dates in other specialties.

A major aim of this year's program is to create and enhance relationships between participants. To that end, every session will have interactive portions designed to increase collaboration and build community, with the hope that those connections can continue to provide opportunities for collaboration and support throughout the year.

8 am—5:30 pm

Palliative Nursing Leadership Intensive (P05)

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

Objectives

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

Leadership within palliative nursing is not defined or grounded by level of nursing practice nor education but rather on qualities. Leadership in hospice and palliative nurses is present throughout the spectrum of nursing roles such as nursing assistant, licensed vocational/practical nurse, registered nurse, and advanced practice registered nurse. Many organizations have focused time and resources to enhance leadership skills in their staff. These initiatives usually focus on dedicated nurse leadership positions, such as administrators, managers, directors, or executives. However, leadership extends beyond these roles. Nurses with higher levels of motivation lead in many areas besides a designated leadership position. Leadership in palliative care is characterized by leading others with a clear vision of palliative care initiatives, motivating and inspiring others to achieve excellence in care, positively relating to others to create healthy work environments, and changing the behavior of others to work collaboratively in palliative care (Speck 2006). These leadership qualities may be attained by any nurse at any level from the bedside nurse, the nurse group leader or organizer, to the nurse in a designated leadership position. The skills of these nurse leaders focus on a broad view of nursing and the ability to respond to change proactively, rather than reactively, in anticipating the future landscape (Wolf 2012). More specifically, the nurse leader must first assess their personal leadership capabilities prior to moving towards team development and competence. Through didactic, role play, and interactive media, this session will articulate the value of palliative nursing leadership, describe the characteristics of leaders, explore leadership of nurses at all levels of nursing practice, across the spectrum of nursing including clinical, management, education, research, and policy, and delineate necessary skills of the palliative nurse leader.

The Shifting Sands of Palliative Care: Maximizing Clinical, Economic and Humanistic Outcomes Across the Continuum of Care (P06)

Mary Lynn McPherson, PharmD MA BCPS CPE, University of Maryland, Baltimore, MD. Diane E. Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY. Kathryn A. Walker, PharmD BCPS CPE, MedStar Union Memorial Hospital, Baltimore, MD. Joanne G. Kuntz, MD, Emory Healthcare, Atlanta, GA. Margaret L. Campbell, PhD RN FPCN, Wayne State University, Detroit, MI. Christopher D. Kearney, MD, MedStar Palliative Care, Baltimore, MD. Vincent Vanston, MD HMDC FAAHPM, Cooper University Hospital Palliative Medicine, Moorestown, NJ. Balu Natarajan, MD DC HMDC, Seasons Hospice & Palliative Care, Chicago, IL. Martha L. Twaddle, MD HMDC FACP FAAHPM, JourneyCare, Glenview, IL. Joanne Reifsnyder, PhD ACHPN®, Genesis HealthCare, Rehoboth Beach, DE. Joan K.

Harrold, MD MPH FACP FAAHPM, Hospice & Community Care, Lancaster, PA.

Objectives

- Analyze the continuum of palliative care venues that are available to patients with an advanced illness.
- Differentiate strategies to optimize clinical, humanistic and economic outcomes throughout the palliative care continuum of care.
- Given an actual or simulated case of a patient with an advanced illness, apply strategies to facilitate a seamless transition in palliative care.

This highly engaging full-day preconference will take learners on a journey that spans the entire continuum of palliative care. We will follow complex patients who receive palliative care from the Emergency Department, the Intensive Care Unit, hospital, long-term care, outpatient palliative care, home-based hospice and inpatient hospice. Participants will learn strategies to maximize clinical, economic and humanistic (quality of life) palliative care outcomes in each practice setting. Clinical strategies will include both discussion of pharmacologic and non-pharmacologic interventions. Data regarding cost effectiveness for each practice setting will be discussed (where available), and other strategies that aim to maximize quality of life will be discussed as well. For more traditional settings of hospice and palliative care, participants will learn about emerging practice trends. Participants will also gain insight and learn skills about delivering palliative care in newer practice models such as the Emergency Department, the ICU and the outpatient arena. Importantly, we will use active learning strategies to emphasize best practices for transitioning patients between palliative care settings. These strategies will aim to position patients and providers to achieve optimal clinical, humanistic and economic outcomes throughout the transition. Learners will leave with practical skills they can implement immediately in their practice.

ACHPN® Certification Review: Advanced Practice Registered Nurse (P07)

Kerstin Lappen, MS ACNS-BC ACHPN FPCN, Minnesota Oncology, Minneapolis Clinic, Minneapolis, MN. Peggy Bishop, MSN ACNS-BC AOCN ACHPN, Sentara Martha Jefferson Hospital, Charlottesville, VA.

Objectives

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

The purpose of this HPNA Endorsed ACHPN® Review Course is to promote education of the APRN seeking augmentation of their professional development through specialty hospice and palliative advanced registered nursing certification. This one-day provider-directed, provider-paced live intensive course is designed to assist with preparation for the advanced hospice and palliative nurse certification exam through didactic course presentation with active learner engagement, case study examinations, practice exam questions and self-check/reflection to highlight self-identifying topics that require further preparation and study in advance of sitting for the ACHPN® examination. The ACHPN® Review Course provides a review of the content areas based upon the Hospice and Palliative Credentialing Center (HPCC) detailed test content outline. The educational content may also be used to increase the hospice and palliative advanced registered nurse's knowledge of palliative nursing. Our HPNA faculty are national subject matter experts with career experience in hospice/palliative care and certified by the Hospice and Palliative Credentialing Center in the specialty of Hospice and Palliative Care. ACHPN® Certification Review course participants require the following adjuvant 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/). The participants do not need to have access to these materials during the live review course.

CHPN® Certification Review: Registered Nurse (P08)

Cynthia Stafford, MSN GNP-BC ACHPN®, Carolinas Healthcare System, Concord, NC. Barbara Schmal, MS RN CHPN®, Hospice of the Valley, Phoenix, AZ.

Objectives

- Provide participants with a framework 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 purpose of this HPNA Endorsed CHPN® Review Course is to support nurses desiring to advance their professional development through specialty hospice and palliative nursing certification. This one-day provider-directed, provider-paced live intensive course is designed to assist with preparation for the hospice and palliative nurse certification exam through didactic course presentation with active learner engagement, case study examinations, practice exam questions and self-check/reflection to highlight self-identifying topics that require further preparation and study in advance of sitting for the CHPN®

specialty certification examination. This CHPN® Certification Review Course provides a review of the content areas based upon the Hospice and Palliative Credentialing Center (HPCC) detailed test content outline. The educational content may also be used to increase the hospice and palliative nurse's knowledge of palliative nursing. Our HPNA faculty are national subject matter experts with career experience in hospice/palliative care and certified by the Hospice and Palliative Credentialing Center in the specialty of Hospice and Palliative Care.

Attendees of this session will require the following adjuvant 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/). The participants do not need to have access to these materials during the live review course.

8–11:45 am

Getting to the Heart of the Matter—An Overview of Advances in Cardiac Palliative Care (P09)

Keith Swetz, MD MA FACP FAAHPM, University of Alabama at Birmingham, Birmingham, AL. Jatin Dave, MD MPH, Tufts Health Plan, Watertown, MA. Shannon Dunlay, MD MS, Mayo Clinic, Rochester, MN. Colleen McIlvennan, DNP ANP-BC, University of Colorado, Denver, CO. Sara Wordingham, MD, Mayo Clinic Arizona, Phoenix, AZ. Patricia Davidson, PhD MEd RN FAAN, Johns Hopkins University, Baltimore, MD. Beth Fahlberg, PhD RN AGPCNP-BC CHPN, University of Wisconsin–Madison, Madison, WI. Mohana Karlekar, MD, Vanderbilt University, Brentwood, TN.

Objectives

- Explain pathophysiology of heart failure and how it leads to the symptoms commonly associated with it.
- Recognize the role of palliative care in advanced cardiac diseases.
- Demonstrate skills in discussing goals of care and needs for transitions of care with patients who have advancing heart disease.

The options for treating advanced cardiac disease are diverse and ever-evolving, and palliative care providers are increasingly asked to be involved in the management of such patients. In this session, multidisciplinary experts in palliative care and cardiology—including heart failure, cardiac devices, symptom management, care transitions, and caregiver support—will explore how they approach the evaluation and management of patients with advanced cardiac disease. Each presenter will touch on how they interact with advanced cardiac disease providers at their own institutions, and will give basic to intermediate-level information about how palliative care engages patients with cardiac conditions. This session is recommended for providers with any level of experience in caring for patients with cardiac disease, and does not have a prerequisite of experience or knowledge. Presenters will assume that attendees may have had a broad range of previous experience in caring for patients with cardiovascular diseases, including some attendees that may have no or minimal experience to date.

Priming the System for Primary Palliative Care: More, Better, and Earlier Conversations with Seriously Ill Patients (P10)

Justin Sanders, MD MSC, Dana-Farber Cancer Institute and Harvard Medical School, Boston, MA. Joshua Lakin, MD, Harvard Medical School, Boston, MA. Rachelle Bernacki, MD MS FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Catherine Arnold, MSW LICSW, Brigham & Women's Hospital, Boston, MA. Joanna Paladino, MD, Ariadne Labs, Brookline, MA.

Objectives

- Identify the systems failures that result in absent, delayed, or inadequate serious illness communication.
- Describe a systems-based approach to quality improvement that results in more, earlier, and better conversations about patient values and goals.
- Competently utilize the Serious Illness Conversation Guide with their own patients.

Patients with serious illness routinely receive treatments that are not in alignment with their goals and often increase harm and suffering. The field of palliative care has shown that earlier clinical conversations about peoples' values and priorities for living with serious illness lead to more goal-concordant care, improved quality of life, and greater patient and family satisfaction. The Serious Illness Care Program has designed a systematic approach to train and support these clinicians in conducting more, earlier, and better conversations about goals of care with their seriously ill patients as part of routine clinical care.

Based on a three-day CME course developed by Ariadne Labs and the Harvard Medical School Center for Palliative Care, this workshop will provide a basic introduction to the principles, practice, and teaching of the Serious Illness Care Program's systematic approach to improving the care of patients with serious illness through a process that integrates more, better, and earlier conversations about goals and values into routine clinical processes. Elements of this approach include identification of appropriate patients; training and prompting of clinicians; facilitation of high quality discussions using a structured conversation guide; materials that support patients to more easily discuss these issues with their loved ones; and structured approaches to documentation in the medical record. Teaching methods include didactic presentations, large group interactive sessions and small group skills-based training and personalized feedback. Participants in this workshop will increase their personal effectiveness and comfort in conducting end-of-life discussions using a systematic approach, and will explore basic strategies to teach this approach to others.

Palliative Care and the Art of Poem Making: A Pathway to Deepen Dialogue with Ourselves, Our Patients, Our Colleagues (P11)

Judith Redwing Keyssar, RN BA, 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. John Fox California Institute of Integral Studies, Palo Alto, CA.

Objectives

- Identify two ways they might improve their communication with patients through the use of poetry/writing.
- Integrate poem-making/writing into their practice of self-care, self-understanding and self-acceptance and demonstrate the effectiveness of this experience in clinical settings.
- Create a plan of care for appropriate patients that includes using poetry as a healing modality.

"We may have lost faith in our ability to write poems, just as we have lost faith in our ability to heal. Recovering the poet strengthens the healer and sets free the unique song that is at the heart of every life." —Dr. Rachel Naomi Remen, from preface to *Poetic Medicine: The Healing Art of Poem-Making,* by John Fox

In our busy professional lives as palliative care clinicians, there are few sanctioned opportunities to examine our emotional and psychological experiences and our relationships with patients. Similarly, as patients, there are few opportunities offered by our healthcare system to allow expression of the deeper issues influencing the capacity to consider and accept a diagnosis or experience healing. For patients, and for clinicians working with people facing serious illness and/or the end of life, the use of poetry and creative self-expression can deepen the therapeutic potential of the work and transform the experience of the healing process. The practice of "poem making" can offer access to the body's deep wisdom and the means to express, through metaphor and image, something that helps us discover meaning in even our most intense suffering. This is true for clinician and patient alike. In this workshop, we will make use of poetry as a healing modality to enhance listening skills, and offer the possibility of deepening dialogue with our own hearts, minds and spirits, as well as with those we care for professionally. Through experiential exercises, dialogue, and contemplation, we will create a safe environment in which to explore the relationships between science and art, words and medicine, the personal and the universal.

Beyond Resilience: Cultivating Compassion and Gratitude (P12)

Ronald Epstein, MD FAAHPM, University of Rochester, Rochester, NY. Fred Marshall, MD, University of Rochester, Rochester, NY.

Objectives

- Understanding the nature of burnout and resilience and the role of positive and pro-social emotions
- Characterizing their own unhealthy reactions, survival strategies and healthy responses to stress
- Demonstrating ways they can foster resilience, fulfillment and well-being

Palliative care, which promotes compassionate care amid serious illnesses, depends on practitioners' ability to cultivate attentiveness, compassion, resilience and mindfulness in their interactions with patients, families and colleagues. The AAHPM prioritizes "identifying opportunities for enhanced self-care and resilience" as a key objective for its annual conference sessions. Yet, although it is known that people can enhance their capacity for resilience, addressing burnout and promoting resilience in health care settings has been elusive. Resilience is especially important in palliative care, where clinicians confront loss, grief, conflict and difficult decisions on a daily basis.

New evidence suggests that cultivating positive emotions (e.g. gratitude) and compassionate action reduce burnout and enhance resilience. This workshop will offer an experiential introduction to mindful practice with a focus on resilience, positive emotion (e.g., gratitude) and compassion, based on workshops for health professionals which have resulted in greater resilience, empathy and psychosocial orientation while reducing burnout (see RM Epstein, *JAMA* 1999, MS Krasner *JAMA* 2009, HB Beckman et al *Acad Med* 2012). Participants will practice bringing forth their capacity for gratitude and compassion through secular contemplative practices, paired dialogues using appreciative inquiry and insight dialogue techniques, and discussion of ways to experience greater resilience in work settings. We will review psychological and neurocognitive underpinnings of resilience; present evidence that resilience can be cultivated; and propose individual, team, and institutional efforts that promote resilience. No prior experience is necessary.

Now in 3D: Managing Geriatric Delirium, Dementia, and Dementia Related Behavioral Disturbances (P13)

AAHPM Leadership Forum: Ignite—Utilizing DISC Behavioral Styles to Increase Leadership and Team Effectiveness in Palliative Care and Hospice Settings (P14)

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

Objectives

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

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

1:15—5 pm

How to Create Actor-Based Simulations that Provide Deliberate Practice with Feedback (P15)

William Bond, MD MS, OSF Healthcare, Peoria, IL. Robert Sawicki, MD HMDC FAAFP FAAHPM, OSF Health Care, Peoria, IL. Linda Fehr, BSN RN CPHQ, OSF Healthcare System, Peoria, IL. Amy Funk, PhD, Illinois Wesleyan University, Bloomington, IL. Lynne Madori OSF Healthcare System, Peoria, IL.

Objectives

- Learn how to build actor-based simulation scenarios, including actor scripting.
- Write and use debriefing questions that emphasize appreciative inquiry methods.
- Learn to maximize the use of resources through observing learner engagement.

The session is a faculty development workshop designed to give learners insights and tools to build actor-based simulation at their institution and consider the resources required. Educational needs in palliative care are substantial, and there is often little or no opportunity for deliberate practice with feedback. Recent efforts to improve the education of Advanced Care Planning facilitators through the use of actor-based simulation will be demonstrated and shared. This will include: video vignette examples, templates for case development, actor scripting templates, debriefing scripting templates, methods and forms for observing learner engagement, and examples of assessments and evaluations. The workshop is hands-on with the goal of learners developing their own simulations that target their learners' educational needs. Simulations may be designed to meet the entire spectrum of learners in palliative care and may easily be built to include interprofessional learning objectives.

Oncologist in My Pocket: What the Hospice & Palliative Provider Needs to Know About Hematology/Oncology (P16)

Kristina Newport, MD FAAHPM, Hospice & Community Care, Lancaster, PA. Barton T. Bobb, MSN FNP-BC ACHPN, VCU Health Massey's Thomas Palliative Care Service, Richmond, VA. Thomas LeBlanc, MD MA, Duke University School of Medicine, Durham, NC. Shanthi Sivendran, MD, PENN Medicine at Lancaster General, Lancaster, PA.

Objectives

- Verbalize the need for increased knowledge of topics in Hematology/Oncology.
- Define and describe the language and assessment tools utilized by Hematologist/Oncologists.
- Describe available treatment and prognosis for advanced solid tumor malignancies including chemotherapy, immunotherapy and targeted treatments.

Hospice and palliative care (HPC) providers are increasingly called upon to care for patients receiving active treatment of hematologic or oncologic malignancies because of growing evidence that early palliative care improves survival, symptoms, mood, cost, and patient satisfaction. HPC providers may care for these patients on hospital consultation services, in outpatient clinics, and in home hospice or palliative care services. The need for upstream palliative care has resulted in the development of innovative models by private insurance companies and a demonstration project by the Center for Medicare and Medicaid Services. To ensure success of these models, and encourage upstream involvement, it is imperative that HPC providers can competently care for the patients in question. Current hospice & palliative training and certification does not necessarily ensure competency in all essential areas. In fact, providers may not have had any direct exposure to hematology/oncology care before entering the field while at the same time, care of patients with hematologic or oncologic malignancies is increasingly complex. Novel therapies emerge rapidly with mechanisms and side effects that are different from traditional chemotherapy and allow for treatment of patients with more limited performance status. This has resulted in attendees of the AAHPM annual meeting repeatedly requesting sessions to keep up-to-date on topics in hematology/oncology. This workshop will ensure providers are equipped with the essentials needed to approach the care of these patients, including: terminology, treatment options, unique aspects of targeted therapies, hematology/oncology emergencies, hospice coverage of cancer care, expected side effects of treatments and navigating relationships with hematologists/oncologists.

Upon completion of this workshop, hospice and palliative providers will have the necessary tools to develop an approach to the care of patients with hematologic or oncologic malignancies at any point along their cancer trajectory.

Opioid Pharmacology: The Good, the Bad, and the Ugly (P17)

Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA. Paul A. Sloan, MD, University of Kentucky, Lexington, KY.

Objectives

- Discuss the benefits of combining opioids, either bifunctional ligands or as opioid combinations.
- Discuss the evidence for opioid induced hyperalgesia and propose that early use of adjuvants such as gabapentinoids in minimizing opioid pronociception.

Commercially available opioids have side effect limitations and a narrow therapeutic index. Much of the practice of double opioid prescribing is by default without evidence. Opioid agonist interactions may modify receptor signaling biasing downstream signaling which favors analgesia and reduces side effects. The presence of receptor dimers means that multi-targeted opioid ligands which are linked, fused or merged can target mu homodimers, opioid heterodimers, or opioid receptor-non-opioid receptor heterodimers. Peptide bi-functional ligands have proven effective in animal models. Combinations of oxycodone with morphine, sequential use of fentanyl-morphine, combinations of morphine-methadone in animal models and in clinical studies have demonstrated improved pain responses at lower doses. Recent studies suggest that functional MRI studies can help in discovering and investigating opioid combinations. A recent study using nalbuphine found that the addition of low dose naloxone significantly potentiated analgesia in humans which correlated with alterations in functional connectivity between CNS centers.

On the other dark side is opioid induced hyperalgesia. Fourteen prospective human studies have a common finding which limits pain relief through analgesic tolerance or paradoxical pain. Quantitative sensory studies of prospectively treated patients have demonstrated increased cold pressor pain, increased temporal summation (wind-up), impaired conditioned pain modulation and clinically relevant increased procedure related pain in individuals who are opioid tolerant. Recent evidence suggests that all opioids cause neuroinflammation through Tool Like Receptors which leads to activation of glia and activation of NMDA receptors The common occurrence of opioid induced hyperalgesia suggests that early use of adjuvant analgesics such as (+) naloxone and (+) naltrexone which do not interact with opioid receptors gabapentin or tricyclic which limit hyperalgesia may facilitate analgesia. Future studies are needed to confirm this supposition.

"The Doctor Is In: Part 2": Challenging Topics at the Intersection of Pediatric Palliative Care and Psychiatry (P18)

Jennifer Hwang, MD MHS, Children's Hospital of Philadelphia, Philadelphia, PA. Vanessa Battista, MS RN CPNP-BC, Children's Hospital of Philadelphia, Philadelphia, PA. Natalie Jacobowski, MD, Massachusetts General Hospital, Boston, MA. Pamela Mosher, MD MDiv, Hospital for Sick Children, Toronto, ON. Anna Muriel, MD MPH, Dana-Farber Cancer Institute, Boston, MA. Carolyn Long, MSW, Children's Hospital of Philadelphia, Philadelphia, PA.

Objectives

- Give two examples of strategies your team can implement when providing palliative or hospice care for a child with a parent with major psychiatric illness.
- Describe a developmental approach to delirium assessment in young children.
- Create a medication and behavioral plan for a hospice patient with complex psychiatric symptoms including mania and psychosis.

Unaddressed psychiatric issues can prevent us from providing the best care to children and their families and not all pediatric palliative care teams and pediatric hospice teams have access to experts in Child and Adolescent Psychiatry who are comfortable managing children at the end of life. In this session, we will address three challenging topics: (1) providing palliative care to a child when a parent has a major psychiatric illness; (2) assessment and treatment of delirium in children (including those who are preverbal); (3) treatment of children with complex psychiatric symptoms and life limiting illnesses in the outpatient and home setting. In addition, we will have an “Ask the Experts” Q&A session in which participants are encouraged to submit cases and questions at the time of conference registration which will be used to guide the second half of the session. Topics for the second half of the session will likely include management of psychosis, anxiety, depression, aggression, mania and suicidal ideation as well as general strategies to employ in the face of pre-existing psychiatric illness but will be tailored to the requests of participants.

Unconscious Bias: Improving Palliative Care Practice, Team and Self (P19)

David Hunt, JD, Critical Measures, Minneapolis, MN. Tammie Quest, MD, Emory University, Atlanta, GA.

Objectives

- Describe the factors that trigger providers’ unconscious biases and how these biases contribute to disparities in patient outcomes, communication, safety and patient satisfaction.
- Describe the factors that trigger providers’ unconscious biases and how these biases contribute to disparities in patient outcomes, communication, safety and patient satisfaction and discover your own personal unconscious biases by taking the Implicit Association Test—the leading tool for measuring unconscious bias.
- Identify concrete strategies and best practices for overcoming unconscious biases—both for individual providers and for large healthcare organizations. In the past, human bias was regarded as conscious and intentional. Today, the new science of bias suggests that human biases are largely unconscious and unintentional.

This program will explore the scientific basis for this new understanding of human bias and the implications of unconscious bias theory for the health care system both in terms of workforce bias and in terms of threats to clinical objectivity. In particular, participants will be exposed to the Implicit Association Test, the world’s leading assessment instrument for measuring unconscious bias. Managers will understand the implications of unconscious bias research for hiring, promotions, performance evaluations and risk management. Research from the AHA’s Institute for Diversity in Health Management has consistently shown that people of color are far less satisfied with their workforce experiences and opportunities for advancement in the healthcare workforce than whites. Research documents the fact that providers’ unconscious biases contribute strongly to disparities in care to racial and ethnic minorities, language access patients and other historically disadvantaged groups. Unconscious biases strongly influence providers’ communication and treatment of patients and thus directly impact patient satisfaction. This webinar will explore what triggers providers’ unconscious biases and what individual providers and healthcare organizations can and must do to mitigate their negative impact on patients.

AAHPM Leadership Forum: Ignite—Using StrengthsFinder Leadership Strategies to Increase the Performance of You and Your Team in Palliative Care and Hospice Settings (P20)

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

Objectives

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

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

7:30—8:30 pm

Plenary Session

The Rhythm of Teamwork (101)

Strong teams communicate and engage in a rhythm of give and take. The Drum Café uses the power of rhythm and the universality of music to quickly engage and energize. Experience harmony and teamwork with this interactive drumming event. The Drum Café began in Johannesburg, South Africa, influenced by the experience of communal drumming and the passion to unite different groups of people in the country’s post-apartheid era. Don’t miss this exciting and unforgettable start to the Annual Assembly.

Thursday, February 23

7–8 am

Concurrent Sessions

How to Address Clinical and Regulatory Issues for Eligible Hospice Patients Living Past Their Expected Prognosis (TH300)

Todd Cote, MD HMDC FAAFP FAAHPM, Hospice of the Bluegrass, Lexington, KY. Salli Whisman, MD, Hospice of the Bluegrass, Lexington, KY. Robert Friedman, MD HMDC FAAFP FAAHPM, Hospice Austin, Austin, TX. Eugenia Smither, BS RN CHP CHE, Hospice of the Bluegrass, Lexington, KY. Jim Gaffney, MD MBA, Hosparus, Louisville, KY. Lori Earnshaw, MD, Hosparus, Louisville, KY.

Objectives

- Describe the similarities and differences between prognostication, hospice eligibility and eligibility for Claims Data on Hospice Patients.
- Utilize appropriate hospice team education, tools and process to ensure high quality appropriate care for eligible hospice patients living past their expected prognosis.
- Understand continued regulatory scrutiny of hospice care for long length of stay patients and the varied approaches Medicare Administrative Contractors (MACs) and other government audit contractors have toward the issue.

One of the most difficult challenges for a hospice, and the hospice medical director, is how to approach the hospice patient that lives past their expected prognosis. As we know, nationally 12%-15% of patients admitted to hospice service live past their "6 months of life or less" prognosis. The Center for Medicare and Medicaid Services (CMS) and government audit contractors continue to scrutinize hospice "long length of stay" patients. This coincides with continued difficulty in predicting a prognosis of "6 months or less" using current prognostication science. Traditionally, eligibility criteria have been used by Medicare Administrative Contractors (MAC) to analyze hospice claims for payment. The development of these types of criteria, often lacking scientific scrutiny, has not been well understood and continues to play a prominent role in hospice audits.

It is important for the hospice medical director to understand how utilizing developing prognostication science, along with proper, ongoing assessment of hospice patients, can assist the hospice team to care for appropriate, eligible hospice patients. Proactively developing a comprehensive process for eligibility/certification/recertification by using appropriate prognostication tools, regular clinical assessment, and clinical judgement documentation can support appropriate care for eligible hospice patients even if they live beyond a predetermined prognosis. Developing efficient strategy for discharging patients no longer eligible, or readmitting patients who again become eligible, is also an important process, particularly for patients living beyond their prognosis. Hopefully, determination of hospice eligibility stays within the hands of physicians and hospice medical directors working with other hospice interdisciplinary team experts. The current healthcare regulatory environment challenges this basic concept. It is critical for hospice medical directors to take a lead role in making sure all eligible patients receive timely hospice care, even if their time exceeds what was expected.

Evidence-Based Interventions for Treating Dyspnea in Advanced Disease and at the End of Life: A Report from the HPNA Dyspnea Task Force (TH301)

Margaret Campbell, PhD RN FPCN, Wayne State University, Detroit, MI. Lynn F. Reinke, PhD ARNP ANP-BC, VA Medical Center, Edmonds, WA. DorAnne Donesky, PhD ANP-BC ACHPN, University of California, Benicia, CA. Deborah Thorpe, PhD ANP-BC ACHPN, Rocky Mountain Hospice, Salt Lake City, UT. Beth Fahlberg, PhD RN AGPCNP-BC CHPN, University of Wisconsin—Madison, Madison, WI. Alison Walsh, RN, Pennsylvania State University, State College, PA.

Objectives

- Describe the process used to search and critique the evidence about dyspnea treatment.
- Describe levels of evidence.
- Describe dyspnea interventions ranked by level of evidence.

Dyspnea is one of the worst symptoms experienced by most patients with advanced illness and at the end of life. The evidence-base for dyspnea interventions lags behind what is known about treating pain. Yet, nurses and physicians face the challenge of treating this symptom every day. A Task Force (TF) of the Hospice and Palliative Nurses Association (HPNA) undertook a charge to search and critique the dyspnea intervention evidence base to create a summary report. In consultation with the ONS "Putting Evidence into Practice" project leaders this HPNA TF agreed to categorize the evidence into the following levels: 1) recommended for practice, 2) likely to be effective, 3) effectiveness not established, 4) benefit balanced with harm, and 5) not recommended for practice.

TF members undertook a systematic process with support from an academic librarian for dyspnea intervention studies from 1990 to present. Studies about adult samples with dyspnea as the primary or secondary dependent measure were identified. Manuscripts were excluded if they were case reports, opinion pieces, letters to the editor, expert consensus, or small pilot studies. Search terms included: dyspnea, breathless, advanced disease, COPD, heart failure, lung cancer, dementia, ALS, end of life, refractory, opioids, benzodiazepines, bronchodilators, anticholinergics, oxygen, medical air, bipap, cpap, fans, CAM, and positioning. The initial search identified 472 manuscripts. After a title search, using project inclusion criteria, we narrowed the evidence pool to 122 manuscripts. A face-to-face meeting at the 2016 annual assembly afforded reconciliation of disagreements to an evidence pool of 102 papers. Subsequently, the task force divided the papers for data extraction and evidence level categorization; each paper was reviewed by two task force members.

Conference calls followed and were used to reach agreement about levels of evidence and final report generation. The processes and final report will be presented in this concurrent session.

"Mr. Smith Killed Himself Last Night": The Scope of Suicidality in Hospice Care (TH302)

Martina Meier, MD, Providence TrinityCare Hospice, Los Angeles, CA. Eric Prommer, MD HMDC FAAHPM, Greater Los Angeles Healthcare, Los Angeles, CA. Scott Irwin, MD PhD, Cedars-Sinai Health System, Los Angeles, CA. Shannon Deslauriers, MSW, Providence TrinityCare Hospice, Los Angeles, CA. Richard Ortolano, MA, Theology MA Spiritual Psychology, Providence TrinityCare Hospice, Los Angeles, CA.

Objectives

- Identify risk factors for suicide in patients with advanced illness.
- Learn to assess and respond to the patient exhibiting suicidal ideation or other thoughts of wanting to die.
- Recognize the impact of suicide on the hospice team and families.

One of the most challenging aspects of hospice care is helping the patient with advanced illness physically, psychologically and spiritually through the dying process. Patients with advanced cancer, and other life-threatening medical illnesses, experience an enormous burden of both physical and psychological symptoms. When the limits of distress are reached, suicide may be contemplated as an option for those with advanced illness. Risk factors for suicide include advancing age, psychiatric comorbidity, male sex, AIDS diagnosis, a family history of suicide, and uncontrolled symptoms. Cancer patients have nearly twice the incidence of suicide relative to the general population. Depression, hopelessness, loss of control and fatigue increase a patient's vulnerability to suicidal thoughts. Assessment of suicide risk and appropriate intervention are critical. Early comprehensive psychiatric involvement with high-risk individuals can avert suicide. Despite all measures a patient may still take his or her own life. The impact of completed suicide on healthcare professionals often leads to feelings of anger, sadness, anxiety, guilt, embarrassment, helplessness, questioning, even symptoms of post-traumatic stress disorder. These responses have profound effects on clinicians' behavior including loss of self-confidence in professional judgment, preventive overutilization of hospitals, hypervigilance with respect to suicide and patient care, and preoccupation with medico-legal concerns. This multidisciplinary session consisting of palliative care specialists, psychiatrists, social work and chaplaincy will enable attendees to: 1.) Recognize risk factors for suicide in the hospice population; 2.) Learn to assess patients expressing suicidal ideation and when to make the call to the psychiatrist 3). Understand the differential diagnoses associated with expressing feelings of wanting to die, 4.) Recognize the impact of suicide on staff. 5). Learn methods of dealing with adverse reactions to loss. 6.) Recognize the impact of suicide on the families of patients with advanced illness 7.) Learn about implementation of suicide prevention programs in hospice.

Ventricular Assist Devices (VADs) in Children: Present and Future Considerations for Pediatric Heart Failure and Palliative Care Team Collaboration (TH303)

Shefali Parikh, MD, Children's Hospital of Philadelphia, Philadelphia, PA. Beth Kaufman, MD, Lucile Packard Children's Hospital, Palo Alto, CA. Gina Santucci, MSN FNP-BC APRN, Children's Hospital of Philadelphia, Philadelphia, PA.

Objectives

- Identify which groups of children with severe and/or intractable heart failure may be a candidate for a ventricular assist device (VAD).
- Review current guidelines for patients receiving VADs, specifically pediatric consideration including the need for an interdisciplinary and palliative approach.
- Examine how to best prepare the child, family and caregiver when a VAD is being initiated and/or deactivated.

Ventricular assist devices were initially used to support adults with heart failure as a 'bridge to transplant' and later as a ‘destination therapy’ (DT) in patients ineligible for heart transplant. Relatively recently, VADs have become an option for children with end-stage heart failure either as a bridge to transplant or recovery. The use of VADs as destination therapy for children is evolving, as new long term support devices appropriately sized for children are more readily available. Patients who may benefit from these devices include those with Duchenne muscular dystrophy, children with ongoing malignancy and chemotherapy-related toxicity or with congenital heart disease and multiple comorbidities.

VAD support is often effective to relieve symptoms of heart failure and therefore significantly improve quality of life, however chronic anticoagulation and dependence on mechanical support has risk for significant morbidities and caregiver burden. There are physical, social, and emotional strains on the child and family distinct from adults that are important to consider during decision-making related to VAD as DT in a child. Examples are re-integration into school and age-appropriate shared decision-making. In this session, we will discuss indications for VADs in children, types of devices, outcomes, current guidelines and future considerations including advance care planning and ethical implications.

The Dreaded Dialysis Discussion: What the Evidence Shows and How to Effectively Facilitate the Conversation (TH304)

Aziz Ansari, DO, Loyola University Medical Center, Maywood, IL. Stacie Levine, MD FAAHPM, University of Chicago, Chicago, IL. Laura Fosler, MS FNP-BC ACHPN, Rush University Medical Center, Chicago, IL.

Objectives

- Identify the impact of initiating dialysis in patients with late stage kidney disease (LKSD) with multiple co-morbidities.
- Review the effects on functional status after starting dialysis in the elderly.
- Discuss challenges regarding advance care planning in patients with LSKD.

There is growing interest in the role of palliative medicine (PM) support in the renal population. Many patients with late stage kidney disease (LSKD) experience symptom burdens and mortality rates similar to those with advanced malignancies. Although patients with LSKD often choose dialysis, it may not offer a survival advantage in the elderly, especially those with multiple comorbidities, functional impairment, and chronic malnutrition. Complications from falls, cognitive impairment, vascular access failure, and infections lead to further concern for worsening morbidity and psychosocial decline after initiating dialysis. In addition, prognostic uncertainty makes the choice of starting dialysis versus opting for conservative management very challenging. Several tradeoffs that impact quality of life need to be considered when making these important decisions. The timing and content of conversations regarding advance care planning in this population, particularly when the risks begin to outweigh the benefits, also poses significant challenges. Therefore, a comprehensive, interdisciplinary approach that incorporates PM into the facilitated discussion could benefit patients, caregivers, and medical teams.

This interactive session will utilize an audience response system to review the evidence regarding survival rates, symptom burden, and quality of life in elderly patients with LSKD who choose conservative management versus dialysis. We will discuss the challenges of advance care planning in this population, including timing and perceptions of hospice enrollment. Finally, we will present a series of clinical scenarios that incorporates the evidence into a shared decision-making model to assist PM clinicians in constructing a value-based discussion.

Building Payer-Provider Partnerships for Innovative Palliative Care Models (TH305)

Jatin Dave, MD MPH, Tufts Health Plan, Watertown, MA. Parag Bharadwaj, MD FAAHPM, Sentara Healthcare, Virginia Beach, VA. Tom Gualtieri-Reed, MBA BA, Spragens & Associates LLC Chapel Hill, NC. Dana Lustbader, MD, ProHEALTH, Great Neck, NY. Bruce Smith, MD, Regence BlueShield, Seattle, WA.

Objectives

- Describe the value of Palliative Care from payer and provider perspective to achieve quadruple aim.
- Describe actions payers are taking to integrate palliative care into payment models, care management programs, and benefits.
- Identify the critical steps necessary to build effective payer-provider partnerships to support those with serious illness.

Recent changes in the health care environment with shifting and shared risk have created unique opportunities for payers and palliative care providers to partner in the care of the most medically complex individuals. There is an increasing focus on the quadruple aim: better care, better health, lower costs and improving the work life of those who deliver care. Considering the added value of palliative care and challenges in adequate volume-based reimbursement for palliative care, such payer-provider partnerships are essential for creating sustainable models of palliative care across settings.

Through success stories, data, case examples, and group discussion, this session will focus on how palliative care can support the quadruple aim. By comparing provider and payer needs, the presenters will share strategies to align priorities to create innovative partnerships. The presenters will discuss how such partnerships can help support palliative care across the continuum: home, outpatient, inpatient, and post-acute care. Presenters will provide details of different types of models across the care continuum, including chronic care of the medically complex, palliative care and hospice models. Finally, the presenters will identify barriers in building effective payer-provider partnerships and practical strategies to overcome those barriers. The materials presented will be brainstormed in small and large group discussions facilitated by the session's faculty. Participants will have time to develop and work on plans for their own organizations.

Proactively Managing Our Own Transitions (TH306)

Timothy Quill, MD FACP FAAHPM, University of Rochester Medical Center, Rochester, NY. Charles Wellman, MD FAAHPM, Hospice of the Western Reserve, Cleveland, OH. Martha Twaddle, MD HMDC FACP FAAHPM, JourneyCare, Glenview, IL.

Objectives

- Discuss strategies for successful career transition anticipation and management, and to understand some of the warning signs when transition planning should be considered.
- Illustrate personal challenges and opportunities provided by transitions in our own professional and personal lives, and to commit to begin to address them.
- Large group reflection, comments and questions.

While palliative care clinicians pride themselves in their ability to help patients and families work though very daunting transitions, we are often less proficient at skillfully anticipating and negotiating our own transitions, especially in the professional realm. Much of this difficulty is characterological—we are more comfortable and more skilled at helping others to look inward to identify what is needed than we are at doing the same for ourselves (much less asking for help in the process). The net result of this avoidance may be an increasing likelihood of becoming burned out before making timely transitions that might be needed. Ironically, many clinicians came to palliative care after becoming burned out working in their original field, and risk continuing this pattern if they do not better understand and then proactively address the process.

In this session, participants will be introduced to a strategy for proactively identifying the need to make small or large transitions, hopefully before becoming burned out. Warning signs for needing to make changes on the job will be identified, as well as common personal as well as institutional barriers to initiating these changes. After a brief review of the literature around transition management and burnout, participants will explore potential transitions that are on their horizon in their personal and professional lives, and to consider both the barriers and opportunities that lay ahead. Participants will be asked to commit to two things they can do when they return home to proactively work on transitions that are in their horizons.

Measuring What Matters Forum: Making Your Quality Efforts Matter When You Don't Make the Rules! (TH308)

Joseph Rotella, MD MBA HMDC FAAHPM, American Academy of Hospice and Palliative Medicine, Chicago, IL. Lisa C. Lindley, PhD RN, University of Tennessee, Knoxville, TN. Arif Kamal, MD MHS, Duke Cancer Institute, Durham, NC.

Objectives

- Describe the work to date of the Measuring What Matters initiative and the key findings from a recent AAHPM and HPNA member survey on quality improvement needs.
- Describe the key quality reporting requirements under MACRA.
- Outline steps HPM clinicians can take to make their quality efforts matter under CMS quality reporting programs.

A panel of HPNA and AAHPM leaders engaged in Measuring What Matters will provide an update on the project, including results of a recent member survey on quality improvement needs. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) increases the linkage of quality reporting to payment. Most palliative medicine clinicians practicing in community settings will be subject to the Merit-Based Incentive Payment System (MIPS). Most of the measures included in MIPS have little or no relevance to palliative care. So how can palliative medicine clinicians meet the pay-for-reporting requirements and still engage in quality improvement that really matters for their patients? Speakers will provide clinicians with tips for making the required quality reporting work for them in spite of systems that weren't designed with palliative care in mind.

Paper Session

Prioritizing Outcomes for Advance Care Planning Research: Consensus from a Multidisciplinary, International Delphi Panel (TH307A)

Rebecca Sudore, MD, San Francisco VA Medical Center & University of California San Francisco, San

Francisco, CA. John You, MD MSc, McMaster University, Hamilton, ON. Ida Korfage, PhD, Erasmus University Medical Center, Rotterdam, Netherlands. Judith Rietjens, PhD, Erasmus University Medical Center, Rotterdam, Netherlands. Gem Le, PhD MHS, University of California San Francisco, San Francisco, CA. Daren Heyland, MD MSc FRCPC, Queen's University, Kingston, Ontario, Canada.

Objectives

- Describe an Organizing Framework developed by a large, multi-disciplinary Delphi panel regarding patient-centered ACP outcomes.
- Present patient-centered ACP outcomes ranked in order of importance by a large, multi-disciplinary Delphi panel.

Original Research Background. Without a shared understanding of standardized quality metrics that define successful advance care planning (ACP), it is difficult to compare interventions across systems and populations.

Research Objectives. To use a large, multi-disciplinary, Delphi panel of ACP experts to create an Organizing Framework, and identify and rank patient-centered ACP outcomes.

Methods. We first conducted literature reviews and solicited input from 5 international ACP conferences to collate ACP outcomes into an Organizing Framework. Next, we conducted 3 Delphi panel rounds with a 52-member panel of researchers, clinicians, legal experts, and policy makers. Panelists were asked to prioritize patient-centered outcomes, comment on the Organizing Framework, and rank outcomes on a 7-point "not-at-all" to "extremely important" scale. We used content analysis of panelists' comments to iteratively update the Framework and outcomes and present data back for Delphi panel review. We also calculated the mean rankings (± SD).

Results. Panelists were from USA, Canada, Netherlands, and Australia; 63% were women, and 71% were researchers. Outcome domains identified for the Organizing Framework included: moderators (i.e., demographics), process/mediators (i.e., attitudes), actions (i.e., discussions/documentation tasks), quality of care (i.e., satisfaction with care/communication), and healthcare (i.e., utilization). After 3 rounds, 138 ACP outcomes were identified. The top 5 outcomes included (1)care consistent with goals, mean 6.70 (±SD 0.31); (2)surrogate designation, 6.68 (0.44); (3)surrogate documentation, 6.48 (0.39); (4) discussions with surrogates, 6.44 (0.33); and (5)identifying values and goals 6.40 (0.62). Documentation of an advance directive was ranked 14th, 5.98 (0.59). The panel was unsure how to best measure care consistent with goals.

Conclusion. A large, international Delphi panel came to consensus about an Organizing Framework and important outcomes to define successful ACP.

Implications for research, policy or practice. This work will allow researchers, healthcare organizations, and policy makers to standardize outcomes that can be compared across sites. More research is needed to standardize the care consistent with goals measure.

A Patient-Facing Advance Care Planning (ACP) Website Called PREPARE Increases ACP Documentation and Engagement in a Randomized Trial of Diverse Older Primary Care Patients at a VA Medical Center (TH307B)

Rebecca Sudore, MD, San Francisco VA Medical Center & University of California San Francisco, San Francisco, CA. John Boscardin, PhD, University of California San Francisco, San Francisco, CA. Deborah Barnes, PhD MPH, University of California San Francisco, San Francisco, CA.

Objectives

- Describe the results of a randomized control trial comparing the ACP PREPARE website plus an easy-to-read advance directive to an easy-to-read advance directive alone.
- Discuss clinical implications of our trial findings.

Original Research Background. We created an interactive, patient-centered, video-based ACP website called PREPARE (www.prepareforyourcare.org) and an easy-to-use advance directive (http://www.iha4health.org/our-services/advance-directive/).

Research Objectives. To determine whether PREPARE, versus an advance directive (AD) alone, increases ACP among older primary care patients.

Methods. Participants were from the San Francisco VA, were ≥60 years old, had ≥two chronic/serious conditions, and had seen their primary provider ≥twice/year. Participants were randomized to review the AD (active control) or the directive plus PREPARE (intervention). There were no clinician/system-level interventions. The primary outcome was new ACP documentation of ADs/discussions at 6 months. Secondary outcomes included ACP engagement at 1 week, 3 months, and 6 months using validated surveys that assessed behavior change Process measures (i.e., 5-point knowledge, self-efficacy, readiness scales) and Action measures (e.g., surrogate designation, 0-25 scale). We used intention-to-treat mixed-effects logistic and linear regression, controlling for time, literacy, race/ethnicity, baseline ACP and clustered by physician.

Results. Mean age of 415 participants was 71 years (± 8), 9% were women, 17% had limited literacy, and

43% were non-white. No participant characteristics differed between arms (p>0.05). Follow-up at 6-months was 90%. New documentation was higher with PREPARE plus an AD versus an AD alone (adjusted 35% vs. 25%, OR 1.61 (CI: 1.03-2.51)). PREPARE also resulted in higher mean 5-point Process scores at each follow-up and overall from baseline (baseline 3.2 & 3.3: 1week 3.7 vs 3.5, 3 months 3.8 vs 3.5, 6 months 3.8 vs 3.6, p<.001) and higher 0-25 Action scores (baseline 11.7 & 12.5: 1week 14.7 vs 13.7, 3 months 15.3 vs 14.4, 6 months 15.0 vs 14.8, p<.001).

Conclusion. The purely patient-facing, ACP PREPARE website plus an easy-to-read advance directive compared to a directive alone increased ACP documentation and engagement among diverse older adults.

Implications for research, policy, or practice. Although integrated patient/clinician/system-level ACP interventions are needed, this study suggests that PREPARE is an effective strategy for increasing ACP.

Measuring Advance Care Planning: Optimizing the Advance Care Planning Engagement Survey (TH307C)

Rebecca Sudore, MD, San Francisco VA Medical Center & University of California San Francisco, San Francisco, CA. Daren Heyland, MD MSc FRCPC, Queen's University, Kingston, Ontario, Canada. Deborah Barnes, PhD MPH, University of California San Francisco, San Francisco, CA. Michelle Howard, PhD, McMaster University, Hamilton, Ontario, Canada. Konrad Fassbender, PhD, Covenant Health Palliative Institute, Edmonton, Alberta, Canada. Carole Robinson, PhD RN, University of British Columbia, Kelowna, British Columbia, Canada. John Boscardin, PhD, University of California San Francisco, San Francisco, CA. John You, MD, McMaster University, Hamilton, Ontario, Canada.

Objectives

- To describe a systematic process to reduce survey items on the validated Advance Care Planning Engagement Survey.
- To describe a systematic process to validate progressively shorter versions of the Advance Care Planning Engagement Survey.

Context. A validated 82-item Advance Care Planning (ACP) Engagement Survey measures a broad range of behaviors (i.e., discussions and documentation). However, concise surveys are needed.

Research Objectives. To validate progressively shorter versions of the ACP Engagement Survey.

Methods. The original Survey includes 57 Process Measures (i.e., knowledge, contemplation, self-efficacy, and readiness) and 25 Action Measures across 4 domains (surrogates, quality of life, flexibility, and asking questions). For item reduction (participants from 4 Canadian and 3 US sites), we systematically eliminated questions based on face validity, item non-response, redundancy, ceiling effects, and factor analysis. For construct validity (English- and Spanish-speaking participants from 3 ongoing US randomized ACP trials), we assessed internal consistency using Cronbach's alpha, cross-sectional correlations, and the ability of the progressively shorter surveys to detect change one week after exposure to an ACP intervention using Pearson's correlation coefficients.

Results. 501 participants were included in item reduction (age 69 years (±10), 41% non-white). Due to high correlations (mean 95% correlation, ±6) between readiness and action items, all action-items were removed. Due to high correlations and ceiling effects, 2 additional process-items were removed. Successive factor analysis then created 55, 34, 15, 9, and 4-item versions. 664 participants were included in the construct validity analysis (age 65 years (±8), 72% non-white, 34% Spanish-speaking). Cronbach's alpha was high for all versions (4-item, 0.84 to 55-item, 0.97). Compared to the original survey, cross-sectional Pearson's correlations were high (4-item, 0.85 to 55-item, 0.97) as were correlations detecting change (4-item, 0.68 to 55-item, 0.93). Correlations remained high for English and Spanish-speakers.

Conclusion. Shorter versions of the ACP Engagement Survey are valid, internally consistent, and able to detect change across a broad range of ACP behaviors for English and Spanish speakers.

Implications for research, policy or practice. Shorter ACP Surveys can efficiently and effectively measure broad ACP behaviors in research and clinical settings.

Using A Video-Based Advance Care Planning (ACP) Website to Facilitate Group Visits for Diverse Older Adults in Primary Care Is Feasible And Improves ACP Engagement (TH307D)

Carly Zapata, MPH MD, University of California San Francisco, San Francisco, CA. Emily Wistar, MD, University of California San Francisco, San Francisco, CA. Claire Horton, MD MPH, University of California San Francisco, San Francisco, CA. Hillary Lum, MD PhD, University of Colorado and Eastern Colorado GRECC, Aurora, CO. Rebecca Sudore, MD, San Francisco VA Medical Center & University of California San Francisco, San Francisco, CA.

Objectives

- To assess the feasibility of a video-based website to facilitate group visits for advance care planning.
- To engage a group of diverse older adults in a safety net primary care setting in advance care planning.

Original Research Background. Primary care providers in safety-net settings often do not have time to discuss advance care planning (ACP). However, ACP group visits (GV) may be an efficient way to provide ACP education.

Research Objectives. To assess the feasibility of a video-based website to facilitate ACP GVs and to engage diverse, older adults in ACP.

Methods. We conducted a feasibility pilot among patients from two primary care clinics in a Northern California safety net setting who were ≥ 55 years of age with ≥ 2 chronic/serious conditions. Participants attended two 90-minute GVs and viewed the 5-step videos of the PREPARE program (www.prepareforyourcare.org) concerning surrogates, values, and discussing wishes. Two clinician facilitators were available to answer questions and encourage participation. We assessed pre-to-post ACP knowledge (percent correct) and whether participants designated a surrogate or completed an advance directive using Fisher's exact tests. We assessed ease-of-use of the GV and PREPARE materials on a 10-point scale.

Results. We conducted two GVs with 22 participants, 9 and 13 respectively. Mean age was 64 years (± 7), 55% were women, 73% non-white, and 55% had limited literacy. Preliminary findings demonstrated improved knowledge about surrogate designation (46% correct pre to 85% post, p-value 0.01) and discussing decisions with others (59% vs 90%, p-value 0.01). Surrogate designation increased (48% vs. 85%, $p = 0.01$) and a trend toward advance directive completion (9% vs. 24%, $P = 0.21$). Participants rated the GV and PREPARE materials a mean of 8 (± 3.1) on a 10-point ease-of-use scale.

Conclusion. Using the PREPARE website to facilitate ACP GVs for older adults in safety-net, primary care settings is feasible and shows potential for increasing ACP engagement. PREPARE videos may be able to direct group learning in resource-poor environments or be used with other clinician-facilitated programs.

8:15—10 AM

Plenary Session

Only Connect: The Essential Commingling of Care and Story in Hospice and Palliative Care (102)

Theresa Brown, PhD BSN RN, Hospice Nurse, Writer, and Author, Pittsburgh, PA.

Objectives

- Importance of listening to caring for the whole patient.
- Value of clinicians better understanding our own work by telling our stories.

In this lecture, hospice nurse and best-selling author Theresa Brown will show the importance of narratives—stories—to the work we do in hospice and palliative care. Taking to heart novelist E.M. Forster's admonition to "only connect," Brown will discuss her own writing and how it has made her a better caregiver. She will then explore the value and importance of patients' stories, showing that illness tells a story, as does care. Hospice does not aim to cure, but care is central to the mission. How does that story of medical care without cure develop? To begin, we must first connect with the patient.

10:45—11:45 am

Concurrent Sessions

Building a Palliative Care Program in Primary Care for the Underserved: Challenges and Preliminary Outcomes (TH310)

Earl L. Smith, MD PhD FAAPMR, Columbia University Medical Center, New York, NY. Margaret R. Nolan, DNP GNP-BC ACHPN, New York Presbyterian Hospital, Bronx, NY. Cristina Ramirez-Urquiola, LCSW, New York Presbyterian Hospital, Bergenfield, NJ. Maria Becerra, BSN RN, New York Presbyterian Hospital, New York, NY. Felicia Blaise, MPH MA, New York Presbyterian Hospital, New York, NY. Craig D. Blinderman, MD MA, Columbia University and New York Presbyterian Hospital, New York, NY.

Objectives

- Describe the outpatient palliative care service for an underserved Medicaid urban population within the Delivery System Incentive Reform Payment (DSRIP) Program.
- Determine education interventions across a Patient Centered Medical Home of 90,000 lives across all disciplines.
- Practice multilingual communications strategies and culturally sensitive interchange.

Because the need of outpatient palliative care in predominantly underserved populations is so great, the federal government and the state of NY developed the DSRIP program to help medical homes address this in Medicaid patients. A bilingual medical team was embedded in the outpatient primary care clinics Patient Centered Medical Home to address the language, health literacy, and cultural barriers in this predominantly Spanish speaking population of 90,000 lives. The medical team developed training programs for the primary providers (MDs, SWs, RNs, medical residents) on how and when to perform culturally sensitive discussions on goals of care and advance directives, in addition to criteria for hospice referrals.

Evaluation tools were developed by translating the ESAS, health care proxy and MOLST forms to more culturally appropriate wording in Spanish. Criteria on hospital readmissions and ER visits were put in place to identify appropriate patients for a more advanced palliative care consultation, which includes complex symptom management, prognostication assistance and advanced post-acute care coordination. Through didactics, discussion, and use of case examples, the team created a process for forming positive alliances with primary care providers to assist the Medicaid population's palliative care needs. Initial outcomes and quality measures include number of ICU admissions, ICU deaths, patient and family satisfaction, provider satisfaction and primary team generalist palliative care skill set.

"They Can't Do That?" The Role of Court-Appointed Guardians in End-of-Life Decision-Making (TH311)

Diane Dietzen, MD FACP FAAHPM, Baystate Medical Center, Springfield, MA. Christine Bryson, DO, Baystate Medical Center, Springfield, MA. Peter DePergola, PhD MTS, Baystate Health, Springfield, MA. Barbara Stoll, JD MEd, Baystate Health, Springfield, MA.

Objectives

- Identify the population of patients you care for, who have court-appointed guardians as their decision-makers, and their special-needs in advanced care planning.
- Recognize limitations placed on court-appointed guardians for end-of-life decision-making in some states.
- Discuss methods to apply this information to patients in your practice.

In the state of Massachusetts, court-appointed guardians (CAGs) represent patients who are incapacitated and do not otherwise have healthcare proxies or medical decision-makers. Baystate Medical Center (BMC) frequently cares for such patients, who are either represented by clearly appointed guardians or find themselves in urgent need of them. These patients are frequently very sick, and the goal of providers in collaborating with guardians is to make appropriate decisions regarding goals of care and end-of-life plans. However, CAGs often feel uncomfortable and ill-equipped to make these decisions, despite the fact that it is an elemental part of caring for patients with complex health issues. Moreover, in many states, courts specify that guardians require special permission to make end-of-life decisions. These scenarios present concerns which become especially acute when the timing of critical health care or end-of-life decisions do not correspond with the court's granted authority to do so. Subsequently, a court hearing or presentation needs to be rapidly requested and performed, but this often comes at the cost of unsavory consequences to the patient, including threatened safety, possibly undesired health care, and comfort. We will discuss BMC's experience with CAGs who are charged to make end-of-life decisions, and reflect on the Massachusetts state law which undergirds and informs the process. To this end, we will utilize a case study, presented and discussed by representatives from palliative care, law, and ethics. We will also make a concerted effort to review this process in other states, juxtaposing it with our own, in the hope of informing others of the ability to negotiate this process within their institutions. We will then make an effort to describe methods to try to improve true advance care planning for this disadvantaged population.

Where Payers and Providers Overlap: Navigating the Edge (TH312)

Allison Silvers, MBA, Center to Advance Palliative Care, New York, NY. Torrie Fields, MPH BA BS, Cambia Health Solutions, San Francisco, CA. Anna Gosline, NA, Blue Cross Blue Shield of Massachusetts, Boston, MA. Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Define the best opportunities for palliative care providers to assume population management responsibilities for seriously ill patients.
- Evaluate two different approaches that payers are taking to ensure quality and cost-effectiveness for their members.
- Describe effective mechanisms to risk stratify patient populations and coordinate care across provider organizations to meet required outcomes, and consider the roles that either—or both—the payer and the provider can take in these areas.

As health care rapidly shifts to value-based payments, a strong opportunity is emerging for palliative care providers to capitalize on palliative care's role in providing quality care in a cost-effective manner. Palliative care provider organizations are striving to move from fee-for-service payment systems into alternative payment models. However, moving from a patient management approach to a population management approach requires providers to embrace several new skill sets and functions: using and developing risk stratification tools, working and sharing information across multiple provider organization, and focusing on care management of the population. How does a palliative care organization navigate this new territory? What is the best approach to working with payers? To begin, it is important for providers to understand the areas where payers are generally willing to delegate responsibility, the areas where payers take different approaches, and the areas where payers prefer to maintain responsibility—and why.

In this session, attendees will be introduced to this timely topic and will hear from two representatives from large payer entities with very different approaches to managing patient populations—one that encourages providers to manage their patient populations proactively and one that employs a more "hands-on" approach in working with their network providers to ensure the delivery of high-quality, cost-effective care for their members with serious illness. Specific opportunities to advance palliative care within alternative payment models will be discussed, along with descriptions of the challenges and successes from the field. Examples will be given to describe how the lines between the payer and provider are blurring, and how the responsibility varies by provider.

The challenges in coordinating care across providers will be highlighted, along with the strategies for building their own strong case management capabilities. The moderator will facilitate an interactive Q & A conversation with the audience, herself, and the panelists.

Emerging Triggers for Palliative Care Consultation in Surgery: Interdisciplinary Strategies to Identify and Meet Palliative Care Needs in the Elective and Inpatient Settings (TH313)

Ana Berlin, MD MPH FACS, Rutgers New Jersey Medical School, New York, NY. Jason Johanning, MD MS FACS, University of Nebraska Medical Center, Omaha, NE. Tammy Bockman, MSN MHA RN, VA Nebraska-Western Iowa Health Care System, Omaha, NE. Pierre Lavedan, MD, Baylor Family Medicine Residency, Garland, TX. Susanne Walther, MSN ACNP-BC ACHPN, University Hospital, Montclair, NJ. Christine Boardingham, MEd CCC-SLP, University Hospital, Nutley, NJ

Objectives

- Identify two emerging models for identifying the unmet palliative care needs of patients under consideration for surgical interventions.
- Describe how trigger-based approaches can be effective in changing the trajectory of care for patients undergoing evaluation for surgical treatment.
- Describe the limitations of current common models for incorporating palliative care into the surgical workflow.

Consideration of surgical intervention often represents a crucial clinical crossroads for patients. Systematic triggers for palliative care assessment and intervention in this context can help ensure that important opportunities are not missed. These include directing the trajectory of a patient's care in a goal-concordant manner (encompassing preoperative, intraoperative, postoperative, and nonoperative management decisions), as well as identifying and meeting unmet palliative care needs in the realms of prognostic determination, delivery of bad news, symptom management, and advance care planning. Unfortunately, common models for palliative care in surgical patients are limited by poor integration into the surgical workflow; the potential for undertreatment (e.g., denial of surgical treatment on the basis of risk, failure to rescue) and overtreatment (e.g., non-goal-concordant attempts at rescue); the perpetuation of palliative care as a reaction to a crisis at the end of life; and failure to provide earlier and better goal-setting and symptom management.

In this session, we discuss two emerging models for triggering palliative care earlier in the trajectory of care for patients with surgical problems: palliative care consultation in response to system-wide frailty screening for elective surgery patients, and an interdisciplinary referral model for palliative care assessment in patients being considered for feeding tube placement in the acute hospital setting. Both models incorporate a trigger for palliative care into the preoperative workflow. Patients for whom surgical intervention is deemed not to be concordant with goals can avoid a nonbeneficial intervention, and their underlying palliative care needs can be addressed earlier. Patients who elect surgical intervention can do so with confidence that their postoperative experience will be aligned with their preoperative expectations, and that their goals and preferences will be honored postoperatively. These systematic interventions facilitate the appropriate delivery of goal-concordant treatments, and allow for the optimal deployment of limited palliative care resources.

The Language of Illness: The Art of Telling, Listening, and Self-Care Through Narrative Medicine (TH314)

Melissa San Julian Mark, MD, Cincinnati Children's Hospital, Cincinnati, OH. Kristin Todd, MSW, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Daniel Todd, MA, Cincinnati State Technical and Community College, Cincinnati, OH.

Objectives

- Define narrative medicine and explain how it can be used to enhance patient care.
- Describe various methods for practicing narrative medicine both as a way to increase empathetic understanding as well as to process one's own experience as a caregiver.
- Demonstrate how the techniques of textual interpretation (or "close reading") can help one cultivate a broader and more nuanced perspective on the lives of patients.

Narrative has always been fundamental to the practice of medicine, dating back to Hippocrates. Formalized in academia in the 1980's through the work of Rita Charon, narrative medicine is medicine practiced with narrative competence, which is the ability to acknowledge, absorb, interpret, and act on the stories and plights of others. Narrative medicine has been used to cultivate greater empathetic understanding in the physician-patient relationship, as well as to help caregivers process their own experience.

Stories are fundamental to our nature. Not only are we embedded in the stories that comprise our lives, but patient care also unfolds in story form. Carefully interpreting the storied lives of patients is a critical component of humane and competent medical practice.

Our team has adopted narrative practice as a tool for self-care, particularly in response to secondary trauma. Our initial work has focused on trainees (residents and fellows) in Pediatric Hematology/Oncology who often have challenging experiences during their rotations secondary to the acuity, emotional intensity, and exposure to death and dying.

In this session, our interdisciplinary team will describe our current use of narrative medicine to facilitate opportunities for resident/fellow self-care and debriefing. We will introduce theory, methods, tools, and applications of narrative practice. In addition, we will share curricula, sample works, preliminary data and feedback about our current pilot program. We will also offer the opportunity for attendees to participate in a brief narrative exercise.

High Flow Oxygen for Palliation of Dyspnea: A State-of-the-Science Update (TH315)

David Hui, MD MS MSC, MD Anderson Cancer Center, Houston, TX. James (Eddy) Jackson, RRT, MD Anderson Cancer Center, Houston, TX.

Objectives

- Review the pathophysiology of dyspnea and mechanism of action of high flow oxygen.
- Provide an up-to-date the clinical evidence to support the use of high flow oxygen.
- Discuss the logistical and ethical considerations when administering high flow oxygen for palliation.

Dyspnea occurs in approximately 10%-70% of cancer patients and is one of the most feared symptoms. It is associated with decreased function, quality of life, and survival. Few therapeutic options are available for dyspnea, mainly because it is under-researched. Contemporary treatment with low-flow supplemental oxygen partially relieves the condition only in the minority of patients who are hypoxemic. In this presentation, we will discuss high flow oxygen's (HFOx) mechanism of action, evidence and practical applications for palliation of dyspnea in cancer patients. HFOx delivers up to 60 L per minute of heated humidified oxygen through a nasal cannula to maximize oxygenation. In addition to oxygenation, HFOx may improve ventilation by reducing nasopharyngeal dead space, augmenting end-distending pressure, reducing breathing effort by decreasing inspiratory resistance and increasing airway conductance, decreasing the metabolic cost of breathing, and stimulating the trigeminal and glossopharyngeal nerves through a high-flow mechanism and the delivery of humidified and heated gas. HFOx is currently used in the critical care, emergency room, post-operative, acute care, and to a certain extent, community care settings to improve patient outcomes. Specifically, HFOx has been found to improve survival compared to BiPAP and regular oxygen in patients with acute hypoxemic respiratory failure, enhance ventilation in patients with chronic hypercapenic respiratory failure, reduce the need for reintubation in the post-operative setting, and decrease apnea-hypopnea episodes among patients with sleep apnea. We will summarize several prospective clinical studies and randomized controlled trials that specifically examined the role of HFOx for the palliation of dyspnea. We will also discuss the practical aspects of delivering HFOx in the hospital and home settings, and some ethical considerations in using it at the end-of-life. We will end by discussing future research directions and how HFOx can be delivered in routine care. The last 15 minutes of this session will involve active discussion.

Clinical and Ethical Issues in Terminal Gastrointestinal Dysfunction in Children with Severe Neurological Impairment (TH316)

Jonathan Mullin, MD, Dana-Farber Cancer Institute and Boston Children's Hospital, Boston, MA. Robert Macauley, MD, University of Vermont, Burlington, VT.

Objectives

- Review the etiology, evaluation and treatment for feeding intolerance in children with neurological impairment.
- Formulate an approach to discussions surrounding withdrawal of artificial hydration and nutrition in children.
- Explore ethical, legal and religious considerations in withdrawing artificial nutrition and hydration in children.

Children with severe neurological impairment (SNI)—many of whom are dependent on artificial nutrition and hydration (ANH)—are often deemed to have "disease progression" when they experience refractory seizures, increased neurological disability, or worsening respiratory status. This prompts a reconsideration of the relative burdens and benefits of treatment and often leads to reevaluation of the overall goals of care.

However, when these children experience feeding intolerance that is refractory to symptomatic management or modifications in the feeding regimen, it is often not viewed in the same light. This is likely due to the emotional resonance attached to feeding a person (especially a child), the option of transitioning from enteral to parenteral nutrition and hydration (which has its own set of burdens and benefits), and the concern for pain and suffering caused by “starvation.”
This case-based session will explore this apparent inconsistency from clinical, ethical, religious, and legal perspectives. Empirical studies on the symptomatic and prognostic implications of withdrawing ANH will be examined. Ethical consensus statements on the role of ANH in serious and terminal illness will be reviewed, with specific attention to what—if anything—makes the pediatric context unique. The significance of feeding in specific religious traditions (including the Roman Catholic Ethical and Religious Directive #58) will be examined. The role and applicability of federal and state law—including the “Baby Doe” regulations—will be explored.
We will argue that persistently refractory feeding intolerance may represent “terminal gastrointestinal dysfunction” and can be considered an end-stage complication of SNI. As such, it should prompt a reconsideration of the benefits and burdens of potential treatments, as would disease progression in any other organ systems. Withdrawal of ANH may be clinically and ethically appropriate in such situations.

The Bridge Between Life and Death: Attempted Suicide at the End of Life (TH317)

Neha Darrah, MD, Cedars-Sinai Medical Center, Los Angeles, CA. Jaime Goldberg, LCSW, Cedars-Sinai Medical Center, Los Angeles, CA. Laura McVay, MSN GNP-BC, Cedars-Sinai Medical Center, Los Angeles, CA.

Objectives

- Identify medical and psychosocial risk factors for suicide in patients with life-limiting illness.
- Discuss core ethical principles informing medical decision making for patients after an attempted suicide.
- Review acute management of patients including initiation of artificial life support and establishing code status.

Suicide is the tenth leading cause of death in the United States and accounts for roughly 50,000 deaths per year. Less is known about suicide in patients with life-limiting illness, but advanced disease and age are known to be associated with increased suicide risk. Uncontrolled pain, cancer diagnosis, loss of independence, and sense of hopelessness are all associated with increased suicide risk.
The overwhelming majority of suicides in the general population stems from treatable psychiatric conditions. Because of this, patients who attempt suicide are assumed to lack capacity; overriding their autonomous wish for death by initiating invasive life-sustaining treatments and detaining them against their will is considered ethically acceptable.
Treating suicide attempts in patients with life-limiting illness poses an interesting ethical and clinical dilemma. Unlike most people who attempt suicide, these patients cannot be uniformly assumed to lack capacity. Rather, suicide at the end of life may be a rational approach to avoiding worsening functional status and having some control over impending death. In this framework, understanding how to compassionately care for patients with life-limiting illness who have attempted suicide or express suicidal ideation with intent and plan becomes more complicated and nuanced.
This presentation will help hospice and palliative care clinicians identify risk factors for suicide in patients with life-limiting illness, discuss core ethical principles informing medical decision making after a suicide attempt, and review both acute and long-term medical and psychosocial management of patients after a suicide attempt.

Deprescribing—the Who, What, When, Why, and How (TH318)

Jennifer Pruskowski, PharmD BCPS CGP CPE, University of Pittsburgh School of Pharmacy, Pittsburgh, PA. Mary Lynn McPherson, PharmD MA BCPS CPE, University of Maryland, Baltimore, MD. Holly Holmes, MD, UT Houston McGovern Medical School, Houston, TX.

Objectives

- Describe the current prevalence of potentially inappropriate medications, or polypharmacy, in patients with serious illness at the end of life.
- Identify the appropriate population for deprescribing.
- Criticize the current literature base for deprescribing.

There are numerous evidence-based guidelines for the initiation of drug therapy, however few to discontinue. This leaves an unbalanced equation for many patients with life-limiting illnesses. Deprescribing is the systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient’s care goals, current level of functioning, life expectancy, values, and preferences. It is critical for palliative care clinicians to understand this process, and the evidence based literature surrounding this topic. This concurrent session will focus on the current prevalence of polypharmacy in patients with life-limiting illnesses, the process of deprescribing, how to address barriers to deprescribing, model for implementation and the evidence regarding specific medication classes. We will highlight five commonly prescribed classes of medications that may be eligible for deprescribing: anti-hypertensives, anti-diabetics, anti-cholesterol medications, anticoagulants and ASA, and anti-dementia medications. This concurrent session will be focused for those clinicians practicing in the palliative care setting, to target patients prior to hospice.

"I Heard Something from Another Veteran": How to Use Group Visits to Engage Patients in Advance Care Planning (TH319)

Hillary Lum, MD PhD, University of Colorado and VA Eastern Colorado, Aurora, CO. Kimberly Garner, MD JD MPH FAAFP, Department of Veteran Affairs, Little Rock, AR. Charlie Antoni, LCSW ACHP-SW, Veterans Affairs, Orlando, FL.

Objectives

- Describe key components of advance care planning group visits.
- Obtain person-centered tools and communication skills to successfully facilitate advance care planning group visits.
- Discuss best practices for adapting and implementing advance care planning group visits.

Advance care planning (ACP) is a health behavior that requires person-centered education, support by trained professionals and motivational strategies to promote goal-setting and actions. Group visits in the healthcare setting can effectively increase an individual's knowledge, motivation and self-efficacy. This session presents best practices and lessons learned from implementation of group visits focused on ACP in three unique healthcare settings (Little Rock VA Medical Center [VAMC]; Orlando VAMC; University of Colorado Hospital). Over the past 5 years, we have collectively engaged more than 3,900 Veterans and 120 Medicare beneficiaries in ACP discussions, decision making, and documentation using group visits. To begin, we will provide an overview of the purpose, content, interdisciplinary team-based structure, patient population and recruitment strategies for group visit approaches, including strategies for adapting to particular healthcare settings. Next, we will describe the person-centered impact of participating in ACP groups, including increases in readiness and goal-setting related to ACP, discussions with loved ones, designation of surrogate decision makers, and documentation in the medical record. To maximize audience engagement, we will invite discussion of available evidence-based ACP patient resources and share specific group visit tools (i.e. patient booklets; SMART goals worksheet; check-in sheets and templates to facilitate documentation/billing). Finally, we will discuss the early experiences of "Planning for Future Medical Decisions via Group Visits" which was named a Gold Status Practice in the VHA Undersecretary Shulkin's Promising Practices Consortium and is being implemented at the Bedford Massachusetts VAMC. At the conclusion of the session, attendees will have practical guidance, techniques and tools for implementation of ACP discussions using group visits in integrated (VA) or fee-for-service (Medicare) outpatient settings.

Paper Sessions

A Provider-Based Quality Improvement Intervention Aimed at Increasing Appropriateness of Radiation Therapy Regimens for Patients with Advanced Cancer and Painful Bone Metastases (TH320A)

Anne Walling, MD PhD, University of California, Los Angeles, Los Angeles, CA. Phil Beron, MD, University of California, Los Angeles, Los Angeles, CA. Neil Wenger, MD, University of California, Los Angeles, Los Angeles, CA. Tania Kaprealian, MD, University of California, Los Angeles, Los Angeles, CA. Susie McCloskey, MD MSHS, University of California, Los Angeles, Los Angeles, CA. Christopher King, PhD MD, University of California, Los Angeles, Los Angeles, CA. Kris Murrell-Diedric, MD, University of California, Los Angeles, Los Angeles, CA.

Objectives

- Understand appropriate radiotherapy regimens for painful bone metastases in patients with advanced cancer.
- Understand an innovative approach aimed at increasing appropriateness of radiation therapy regimens for patients with advanced cancer and painful bone metastases.

Original Research Background. Although guidelines suggest that shorter course radiation treatments for patients with advanced cancer and painful bone metastases are most appropriate, treatment patterns in the United States are inconsistent with this approach.

Research Objectives. We implemented a provider-focused intervention at a university-based radiation oncology practice aimed at improving rates of shorter-course radiation treatments for patients with advanced cancer and painful bone metastases.

Methods. The intervention involved key leaders of the practice participating in a RAND/UCLA

Appropriateness Panel to review the latest guidelines and evidence and judge appropriateness of various treatment regimens as it pertained to their practice. These results were compared to current (7/2012-6/2013) practice patterns and presented to the faculty group. This exercise informed a template-based point of care intervention led by a clinical champion and leadership that focused on key aspects of clinical and patient-centered care including whether the bone metastases were complicated or uncomplicated, patient prognosis, extent of disease, and travel distance for the patient to the treatment site. We compared rates of lower burden treatment regimens (less than 10 fractions) for 81 pre-intervention patients with 107 metastases treated between 7/2012-6/2013 and 75 post-intervention patients with 94 metastases treated between 5/2015-1/2016.

Results. Overall, painful bone metastases were treated with less than 10 fractions more often in the post-intervention period (38% v. 63%, p<0.001). Uncomplicated bone metastases treated with conformal radiation were also more likely to be treated with less than 10 fractions in the post- intervention period (19% v. 52%, p<0.001). One quarter of metastases were treated with SBRT during both the pre and post intervention periods.

Conclusion. Leadership support, provider engagement in integrating guidelines into practice, and a note template with point of care clinical reminders can improve rates of appropriate, low-burden radiation oncology treatments for patients with advanced cancer.

Implications for research, policy or practice. This strategy can be used to improve appropriateness of radiation therapy.

The Impact of Social Work Encounters on Risk of ICU Admission, ICU Death, and CPR Among Hospitalized Patients with Cancer at End of Life (TH320B)

Ivan Chik, MPH, University of Hawaii at Manoa, John A. Burns School of Medicine, Honolulu, HI. Daniel Fischberg, MD PhD FAAHPM, John A Burns School of Medicine, Honolulu, HI. Ilan Bernstein, MD, University of Hawaii at Manoa, John A. Burns School of Medicine, Honolulu, HI.

Objectives

- Describe the role of a social worker in an end-of-life setting.
- Identify three areas of patient outcomes that can be improved with the presence of social work evaluations.

Original Research Background. As hospital based palliative care teams strive to expand their interdisciplinary services, they are often tasked with providing outcomes data to justify additional staff. Research highlighting improvement in patient outcomes can support the need for multiple disciplines within a palliative care team.

Research Objectives. The authors of this study aim to determine whether social workers impact the risk of ICU admission, ICU death, and cardiopulmonary resuscitation (CPR) events among hospital decedents followed by a Palliative Care practitioner.

Methods. A retrospective chart review was done using data collected between January 1, 2010 and February 29th, 2016 by the Pain and Palliative Care Department at the Queen's Medical Center. The study population included hospitalized patients with cancer who were followed by the Pain and Palliative Care service prior to any ICU transfer and ultimately died in the inpatient setting. Charts were evaluated for social work visits, ICU admissions, location of death, and CPR.

Results. Of the 256 patients who met the inclusion criteria, 196 patients were evaluated by social workers. 11 of 196 (6%) who were seen by a social worker were later admitted to the ICU. Alternatively, 17 of 60 (28%) patients who had not received a social work evaluation were admitted to the ICU. Social work exposure between ICU admits and non-ICU admits was statistically significant OR = .1504 (p<.0001). Similarly, risk of ICU death and presence of CPR was reduced among those who had social work intervention OR = .1538 (p<.0001) and OR = .2841 (p<.05), respectively.

Conclusion. Incorporating social workers in the care of patients followed by the Palliative Care team is associated with a significant reduction in risk of ICU admission, ICU death, and CPR.

Implications for research, policy or practice. Growth of interdisciplinary Palliative Care teams to include a higher staffing ratio of social workers may result in fewer ICU admissions at end of life.

Factors Predicting Red Blood Cell Transfusions at the End of Life in Cancer Patients (TH320C)

Jason Meadows, MD, Memorial Sloan-Kettering Cancer Center, New York, NY. Jessica Goldberg, MS MSN NP, Memorial Sloan Kettering Cancer Center, New York, NY. Raymond Baser, MS, Memorial Sloan Kettering Cancer Center, New York, NY.

Objectives

- Identify 3 factors that predict increased RBC transfusion at end of life in cancer patients.
- Identify 3 factors that do not predict RBC transfusion at end of life in cancer patients.

Original Research Background. In many situations, transfusions clearly improve longevity and/or quality of life (QOL). In terminal cancer patients the risk-benefit balance may sometimes be unclear.

Research Objectives. We undertook this retrospective study to understand which non-laboratory factors may predict red blood cell (RBC) transfusion in the last 7 days of life.

Methods. Between 10/1/2013 and 9/30/2015, 1248 in-patients with cancer died on medical oncology services at our institution. The primary endpoint was number of RBC units received within 7 days before death. Predictors included patient sex, age, race, religion, state/country of origin, cancer diagnosis, intensive care unit (ICU) death, length of stay (LOS), Do Not Resuscitate status, chaplaincy visits, and palliative medicine consultation. Associations between the predictors and number of RBC units received were evaluated using zero-hurdle negative binomial models to account for large numbers of patients who received zero RBC units.

Results. Patients were mostly Caucasian (73%), Christian (58%), local residents (92% from NY/NJ/CT), and male (52%). Just under half (49%) were seen by palliative medicine within 7 days before death. Thirty-eight percent received 1-6 RBC units and 3% received 7 or more units (range 7-23) within 7 days before death.

In the multivariable model, patients with leukemia, lymphoma, myeloma, and genitourinary cancers were significantly more likely to receive RBC transfusion. ICU death predicted both receipt of RBC transfusion (OR=4.7) and higher number of units received (RR=1.5). Female sex was associated with receiving transfusion (OR=1.6). In unadjusted analysis, patients who had a palliative medicine consultation were less to likely to receive a transfusion (OR=0.72) and tended to receive fewer units (RR=0.72), but this was not significant in multivariable analysis.

Conclusion. Sex, cancer type, and ICU death seem to influence end-of-life (EOL) transfusions whereas race, religion, and state/country of origin do not. Palliative consultation may reduce RBC transfusion at EOL for some patients but more research is needed to identify subgroups most impacted.

Implications for research, policy or practice. Research assessing transfusions and longevity/QOL at EOL are needed.

Depression and Health Care Utilization at End-of-Life Among Older Adults with Non-Small Cell Lung Cancer (TH320D)

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Objectives

- Describe the prevalence of pre-existing depression in this population.
- Characterize the relationship between pre-existing depression, hospice and EOL services in this population.

Original Research Background. Depression is common among cancer patients. While research has explored the association between psychological distress during and after cancer treatment and use of high intensity end-of-life (EOL) care, there are limited data available regarding depression existing prior to a lung cancer diagnosis and health care utilization at EOL.

Research Objectives. To evaluate the association between depression occurring in the year prior to a diagnosis of stage 3B/4 non-small cell lung cancer (NSCLC), hospice enrollment after diagnosis, and utilization of emergency room (ER) services, hospitalization, and chemotherapy in the last 30 days of life.

Methods. We used the Surveillance, Epidemiology, and End Results (SEER)-Medicare database with claims from 2007-2013. We identified subjects with depression using International Classification of Diseases, version 9 (ICD-9) codes and prescriptions for antidepressants from the Medicare Part D claims file.

Results. Subjects with pre-existing depression (n=2082, 14%) were more likely to be female, unmarried, white, Medicaid-eligible, and have higher comorbidity scores compared to 12,303 subjects (86%) without depression. Accounting for competing risk of death, depressed subjects were more likely to enroll in hospice care (subhazard ratio 1.19, 95% confidence interval (CI) 1.09-1.30) and less likely to die in hospital (adjusted odds ratio (AOR 0.79, 95% CI 0.65-0.97). We found no association between pre-existing depression and ER services (AOR 0.91, 95% CI 0.77-1.07), inpatient admission (AOR 1.06, 95% CI 0.90-1.25), or chemotherapy (AOR 0.84, 95% CI 0.68-1.05) in the last 30 days of life.

Conclusion. Older adults with depression prior to a diagnosis of advanced stage NSCLC were more likely to utilize hospice services compared to those without depression, were less likely to die in the hospital, and were no more likely to use high-intensity EOL care.

Implications for research, policy or practice. As depressed subjects were more likely to use hospice care, hospice providers may need additional support to meet mental health needs in this population.

Grieving or Getting Stuck: When LVAD Does Not Progress to Heart Transplantation (TH321A)

Megan Morrison, PhD ARNP ACHPN, University of Washington School of Nursing, Seattle, WA. Barbara B. McGrath, PhD RN, University of Washington School of Nursing, Seattle, WA. Megan L. Morrison, PhD RN ARNP ACHPN, University of Washington School of Nursing, Seattle, WA.

Objectives

- List the three LVAD device strategies and recognize the prevalence of clinical reclassification.
- Describe the grief and loss that was found in this study's participants.

Original Research Background. Left ventricular assist devices (LVADs) can be used as (a) bridge to heart transplant, (b) destination therapy, or (c) bridge to evaluation for transplant candidacy. Patients with LVADs are known to transition between these classifications and some unexpectedly find themselves with an LVAD for the remainder of their life when heart transplant becomes unequivocally not an option.

Research Objectives. This analysis came from unexpected findings in a qualitative study on the process of decision making in patients who have an LVAD for destination therapy. In the interview guide, there were no questions in regards to heart transplant, but the participants consistently and spontaneously discussed complicated thoughts and feelings about not being listed for transplant.

Methods. Semi-structured interviews conducted between June 2015 and December 2015 with 11 participants who had LVADs for DT. The average age of the participants was 67, with 10 males and one female. Median time from implantation of the LVAD to interview was 3.7 years (range: 1.17-7.25). Two participants resided in skilled nursing facilities.

Results. Grief and loss around not getting a heart transplant were core themes. Sub-themes including (a) taking in the news, (b) adjusting to this body, (c) no longer jumping through hoops, (d) mistrust, (e) the hypothetical transplant, and (f) hope.

Conclusion. Participants in this study described a lot of loss. On the one hand there is the defined loss of not progressing to a heart transplant, but the loss of transplant also yields a chronic loss for this group of not returning to a "normal" body and grieving an imagined post-transplant life.

Implications for research, policy or practice. Grief is a multidimensional experience that affects cognitive, spiritual and physical functioning. Clinical recognition, observance, and therapeutic presence in patient grief is ideal. For future research: validation of generalizable grief findings is needed and exploration of common and atypical grief's impact on decision-making is recommended.

What's in the "Black Box"? Describing the Focus of Early, Outpatient Palliative Care Consultation Evaluations and Treatment Recommendations for Individuals with Advanced Heart Failure (TH321B)

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Objectives

- Describe evaluation and treatment recommendations in a protocol driven outpatient palliative care consultation for patients with advanced heart failure.
- Consider implications of study results for future outpatient heart failure care.

Original Research Background. Little has been reported about the focus of outpatient palliative care consultation (OPCC) for persons with advanced heart failure (HF) enrolled in a trial of early palliative care (EPC).

Research Objectives. To describe evaluation practices, treatment recommendations, and regional variation of protocol-driven OPCCs for advanced HF EPC trial participants.

Methods. Qualitative content analysis of protocol-driven OPPC notes of NYHA Class III/IV patients performed during the ENABLE CHF-PC: Educate, Nurture, Advise, Before Life Ends; [4/1/14-8/31/

15]) EPC pilot trial conducted at two sites located in the North- and Southeast.

Results. Of 61 ENABLE CHF-PC participants, 39 (64%) had an OPCC (Northeast site, n=27; Southeast site, n=12), averaging 60 minutes in duration. Symptoms most frequently evaluated were mood (n=35, 90%), dyspnea (n=28, 72%), and chest pain (n=24, 62%). General care planning and social history areas most frequently assessed were history of close relationships (n=35, 90%), family support (n=33, 85%), advance directive/code status (n=33, 85%), and functional status (n=30, 77%). Treatment recommendations focused on care coordination (n=13, 33%) and specialty referrals (n=12, 31%). Between-site OPCC evaluation differences were assessing family support (Northeast vs. Southeast site: 100% vs. 50%, p=0.007), code status (96% vs. 58%, p=0.03), goals of care (89% vs. 41.7%, p=0.01), and prognosis understanding (85% vs. 33%, p=0.08). Treatment recommendation differences were most pronounced for care coordination (40.7% vs. 17%, p=0.11).

Conclusion. OPCCs for HF primarily focused on evaluating symptoms (mood, dyspnea, chest pain), relationship history, caregiver/family support, advance directive/code status, functional status, and on recommending care coordination and referrals. Considerable regional differences in OPCC practices may be attributable to site differences in OPCC documentation templates.

Implications for research, policy or practice. Use of uniform documentation templates based on National Consensus Guidelines, may ensure that OPCCs for HF patients are comprehensive and standardized.

We Work It Out Between Us: Identifying Opportunities to Enhance Heart Failure Self-Care in Community-Dwelling Patients and Informal Caregivers (TH321C)

Harleah Buck, PhD RN FPCN FAAN, Penn State Hershey Medical Center, University Park, PA.

Objectives

- Describe and differentiate the three HF self-care concepts — self-care maintenance, self-care management, self-care self-efficacy.
- Assess for life course patterns of self-care in older adults with HF.

Original Research Background. Understanding how patient and informal caregiver dyads mutually engage in heart failure (HF) self-care is imperative to the delivery of quality outpatient palliative care.

Research Objectives. To examine dyadic HF self-care.

Methods. In a cross-sectional mixed methods study, self-care was measured quantitatively in both partners with the Self-care of Heart Failure Index (SCHFI) comprised of maintenance (day to day care), management (symptom evaluation and response), and self-efficacy scales and a similar caregiver version. Scores were dichotomized- ≥70 adequate; ≤ 69 inadequate; joint qualitative interviews were conducted, transcribed verbatim and underwent content analysis. Data integration involved information matrices for within/across-case analyses.

Results. In 27 dyads (n=54), the average patient was 77 year old, male with a 64 year old caregiver (primarily spouse (n=15) or female adult child (n=9)). Mean scores on SCHFI maintenance, management, and self-efficacy scales were inadequate (range = 54-68) for both. Dyads engaged in self-care according to life course patterns ("*we do everything together because that's the way we are*"); and/or according to whether it was maintenance (*"I go through my routine. I weigh myself."*); or management (in response to symptoms, the previous person responded, "*We usually call right away*"); and/or by mobilizing the help of another (*"I called my sister."*). Dyads, where the patient or caregiver scored ≥ 70 on self-efficacy and/or management, kept their maintenance (day-to-day care) pattern despite the patient's increased symptoms. However, dyads scoring ≤ 69, were more likely to mobilize help.

Conclusions. We have identified an opportunity to enhance self-care by assessing for patients' and caregivers' dyadic patterns.

Implications for research and practice. Managing community-dwelling adults with HF needs to involve identifying life course patterns in self-care and supplementing inadequate self-care patterns as needed with outpatient palliative care services.

Primary Results from the Collaborative Care to Alleviate Symptoms and Adjust to Illness in Heart Failure (CASA) Randomized Clinical Trial (TH321D)

David Bekelman, MD MPH, University of Colorado Denver, Denver, CO. Larry Allen, MD MHS, University of Colorado School of Medicine, Aurora, CO. Brack Hattler, MD, Denver VA Medical Center, Denver, CO. Edward Havranek, MD, Denver Health Medical Center, Denver, CO. Diane Fairclough, DrPH, University of Colorado, Aurora, CO. Connor McBryde, MD, University of Colorado Denver, Denver, CO. Paula Meek, PhD RN, University of Colorado, Aurora, CO.

Objectives

- Describe the outcomes of a randomized clinical trial that tested the effect of a palliative and psychosocial care intervention in heart failure.

- Discuss the implications of the findings from the clinical trial, using data from the population enrolled, the outcome measures, and the intervention.

Background. Many people with heart failure (HF) suffer from poor health status (heavy symptom burden, reduced functional status and quality of life). Depression is strongly associated with health status in HF.

Objective. Determine whether a palliative and psychosocial care intervention improves health status in HF.

Methods. The CASA randomized clinical trial compared the CASA intervention to usual care. The CASA intervention included a nurse who managed symptoms (shortness of breath, fatigue, pain) and a social worker who provided psychosocial care. Patients were reviewed weekly with a primary care provider, cardiologist, and palliative care physician. Patients with HF and poor health status were enrolled from a VA, academic health system, and urban safety net hospital. The primary outcome was HF-specific health status, measured using the Kansas City Cardiomyopathy Questionnaire (range, 0-100), at 6 months. Secondary outcomes included depression (Patient Health Questionnaire-9), overall symptom distress (General Symptom Distress Scale), specific symptoms (PEG pain, PROMIS fatigue, shortness of breath) and mortality.

Results. 314 patients were randomized (157 intervention, 157 control). Participants were generally male (77%) and white (63%), and the mean age was 65.5 years. 57% had reduced ejection fraction. At 6 months, mean KCCQ score improved 5.5 points in the intervention arm and 2.9 points in the control arm (difference, 2.7; 95% CI -1.3, 6.6; p=0.19). Among secondary outcomes, depressive symptoms and fatigue improved at 6 months with CASA (effect sizes of -0.29 and -0.30, respectively, p=0.02 for both). There were no changes in overall symptom distress, pain, or shortness of breath. Mortality at 12 months was similar (CASA, 10/157; usual care, 13/157; p=0.52).

Conclusion. This multisite randomized trial of the CASA intervention did not demonstrate improved HF-specific health status. Depression and fatigue improved.

Implications. Alternate or more intensive interventions should be evaluated to improve health status in HF. This study raises questions about the link between depression and health status in HF.

1:30–2:30 pm

Concurrent Sessions

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

Anuja Damani, MD, Tata Memorial Hospital, Maharashtra, India. Rubayat Rahman, MD, Bangabandhu Sheikh Mujib Medical University, Bangladesh. 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.

A Rising Tide Lifts All Boats: the Palliative Care Research Cooperative (PCRC) as a Resource to Improve the Science of Palliative Care (TH331)

Jean S. Kutner, MD MSPH FAAHPM, University of Colorado School of Medicine, Aurora, CO. Krista Harrison, PhD, University of California San Francisco, San Francisco, CA. Christine Ritchie, MD FAAHPM, University of California San Francisco, San Francisco, CA. Betty Ferrell, PhD MA RN FAAN FPCN, City of Hope National Medical Center, Duarte, CA. Jon P. Furuno, PhD, Oregon State University, Portland, OR. Thomas LeBlanc, MD MA, Duke University School of Medicine, Durham, NC. Kathryn Pollak, PhD, Duke University, Durham, NC.

Objectives

- Summarize how the Palliative Care Research Cooperative Group (PCRC) can improve the

evidence base of palliative care and end-of-life clinical practice.
- Distinguish how the PCRC can facilitate the application and conduct of large multi-site trial testing the dissemination of a palliative care intervention.
- Assess how the PCRC supports investigator development, especially for those outside of traditional academic settings.

The Palliative Care Research Cooperative Group (PCRC) was established in 2010 with generous grant support from the National Institute of Nursing Research to improve the evidence base for palliative care practice. The PCRC is a first-of-its-kind group in the U.S., yet many palliative care clinicians and investigators are unaware of its remarkable resources and the opportunities it provides. Increasing overall awareness about the PCRC and its importance is critical for palliative care practice. The PCRC has created a community of palliative care clinicians and researchers who engage in research discovery via an infrastructure that supports investigators who seek to improve the quality and delivery of palliative and end-of-life care.

This multi-institutional, multi-disciplinary panel will illustrate how investigators are utilizing the PCRC's infrastructure to improve the quality of their methods and capabilities, as a roadmap for other current and future investigators to partner with the PCRC to improve the palliative care evidence base. Drs. Kutner and Ritchie, physician-researchers and co-leaders of the PCRC, will begin by outlining the need for the PCRC, its history, and the resources it provides to help investigators design, fund, and conduct their studies. Dr. Ferrell, a nurse-researcher, will use her funded study of a multi-site palliative care intervention to provide further examples of what resources are available to support high-quality clinically-relevant research. Dr. Pollak, PCRC co-lead, and Dr. Ritchie will then describe three ways that PCRC supports the development of investigator knowledge and skills in palliative care and end-of-life research, including a discussion of the PCRC "cores" and resources (for example, investigator development, caregiver research, etc.). Finally, Drs. Furuno, Harrison, and LeBlanc—respectively an epidemiologist, health services researcher, and physician-researcher—will discuss how findings and experience from PCRC-funded investigator development pilot studies are being leveraged into career development and independent research opportunities.

After the Conversation: Designing an Electronic Health Record for Dynamic Advance Care Planning (TH332)

Irene M. Yeh, MD MPH, Dana-Farber Cancer Institute, Boston, MA. Eliza Shulman, DO MPH, Atrius Health, Needham, MA. Jennifer Hester, DNP AOCNS-BC ACHPN, The Christ Hospital Health Network, Cincinnati, OH. Rachelle Bernacki, MD MS FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives
- List the current challenges of advance care planning (ACP) documentation within electronic health records (EHRs).
- Identify pearls and pitfalls of ongoing efforts to design EHR systems that support recommended practices, including entry, review and retrieval of ACP-related information.
- Describe key EHR design elements that promote the accessibility of advance directives in electronic health records.

The new Centers for Medicare and Medicaid Services (CMS) rule to reimburse for advance care planning (ACP) may result in more conversations in the clinic, at the bedside, and at home. The recent "Dying in America" report recommended that comprehensive care should "include coordinated, efficient, and interoperable information transfer across all providers and settings and be consistent with individuals' values, goals, and informed preferences." A recent survey of physicians found that only 60% said that their electronic medical record had a specific location for advance care plans and one third relayed that their EHR does not display content of the ACP conversations. Palliative care clinicians need to drive EHR modification to promote timely and accurate documentation, review and retrieval of ACP information across sites of care.

In this interactive interdisciplinary session, we will address standards and best practices necessary for advance care planning documentation in the EHR. First, we will review the challenges of ACP documentation within and across health care settings in an environment of competing EHR systems. We will then discuss the pearls and pitfalls of ongoing efforts to design EHR systems that support recommended ACP practices. Lastly, participants will be able to identify key design elements for the optimization of their own EHRs in advance care planning.

Designing a Staffing Model to Support Productivity and Flexibility Among Billable Providers (TH333)

Jessica S. Heintz, MD FAAHPM, Inova Health System, Fairfax, VA. Lynn H. Spragens, MBA BA, Spragens & Associates LLC, Durham, NC. Mary S. Wheeler, MSN FNPC RN ACHPN, Inova Fairfax Hospital, Fairfax, VA.

Objectives
- Discuss the mechanics of RVU derivation, and how to use the "conversion factor" to predict RVU generation based upon ranges of volume and use of billable staff.
- Utilize transparency in RVU data reporting to help manage interdisciplinary team performance

and effective use of IDT members to maximize flexibility in delivery of patient care.
- Build leadership credibility and improve support for palliative care staff by demonstrating competence in managing wRVU data.

One of the most challenging aspects of administrative leadership of palliative care teams is understanding and utilizing fiscal awareness and predictive modeling to staff appropriately for anticipated patient volume changes. While the larger movement in health care has been toward "value based health care" balancing safety, quality, and satisfaction with costs, pressures on the physician workforce continue to focus on volume driven productivity typically measured by RVU generation. While RVU production should not be the primary marker of value for providers, particularly in palliative care, a detailed understanding of the utility, mechanics and language surrounding RVUs is essential to leading, managing, and growing a palliative care team, in order to effectively negotiate with administrative leadership for programmatic needs.

Most palliative care team leaders do not have specific training in the financial aspects of provider billing, revenue prediction and management of staffing in the context of productivity pressures. Understanding how to reason through revenue offset of programmatic costs and implications for staff recruitment is essential for determining staffing optimization. In this concurrent session participants will learn from a palliative care team's journey through business planning, and staff increases based upon volume targets and successful revenue capture.

Through sample cases and guided discussion, this session will provide insight into developing effective coping strategies within an RVU focused world. Attendees will learn how to predict, adjust and adapt team models to meet growth needs, while balancing reality of productivity mandates. Participants will receive access to an RVU calculator and review income statements for a palliative care team.

When the Apple Falls Far from the Tree: A Systematic Approach to Providing Quality Care for Patients at High-Risk for Opioid-Dependence (TH334)

Nelia Jain, MD, Rush University Medical Center, Chicago, IL. Erin L. Bagwell, LCSW, Rush University Medical Center, Chicago, IL. Sean O'Mahony, MD MS, Rush University Medical Center, Chicago, IL.

Objectives
- Define a systematic approach to identify patients with recent or current substance abuse, opioid-dependence, and diversion.
- Propose a framework utilizing multi-disciplinary modalities to create action plans that address ongoing substance abuse issues while promoting opioid safety.
- Formulate conflict resolution model to promote comprehensive, longitudinal care between provider and patient; mitigate provider and patient distress; and develop advocacy strategies for this vulnerable patient population.

Caring for patients with recent or concurrent substance use, opioid dependence, and opioid diversion remains one of the most challenging sub-populations that Hospice and Palliative Medicine providers face. Meanwhile, on a national level, the number of deaths due to overdoses from drugs, including prescription medications, has quadrupled in recent years. This increase in drug-related deaths has led to increased scrutiny on the number of opioid prescriptions prescribed annually, sources of prescription opioids being used for non-medical purposes, and the role that physicians may have in inadvertently contributing to the epidemic. As a result, there has been a call for the provision of increased educational resources and prescriber guidelines to aid providers in making informed prescribing decisions and reduce the over-prescribing of opioids. However the institution of such guidelines, often with conflicting recommendations, is not sufficient to equip current Hospice and Palliative Medicine practitioners with realistic models by which to address issues of substance use, opioid dependence, and opioid diversion in patients who are actively experiencing symptomatic burden from their potentially life-limiting illnesses.

Utilizing summaries of recent evidence, case studies, and discussion, this concurrent session aims to present a practical framework for providers to build upon to address these complex issues within their own practice. Key areas of focus will include normalizing discussions about sensitive aspects of history-taking; standardizing intake information to improve identification of patients at high-risk for opioid dependence; and building communication strategies to enhance trust, promote patient engagement, and negotiate conflict within the clinical encounter. Finally, presenters will share their personal experience with developing timeframes to carry out action plans, efficacy of such action plans, and methods by which action plans have been re-evaluated, resulting in either continuation of care or identification of alternate route of care provision.

Courageous Conversations: Using Interactive Games to Discuss Goals of Care and Advance Care Planning with Adolescents and Their Families (TH335)

Tessie W. October, MD, Children's National Health Systems, Washington, DC. Lori Wiener, PhD, National

Cancer Institute and National Institute of Health, Bethesda, MD.

Objectives

- Briefly review state-of-the art, evidence-based interventions to support advance care planning for teens in order to promote patient-centered care.
- Introduce 3 interactive, play-based tools to facilitate adolescent patients' participation in goals of care and advance care planning discussions for end-of-life care.
- Practice beginning the advance care planning discussion using an advance care planning tool, Voicing My Choices.

Including adolescents in advance care planning has been identified by the Institute of Medicine as a standard designed to promote patient-centered care. Unfortunately, adolescents don't always get a seat at the table. This exclusion often occurs because providers are uncomfortable and unprepared to initiate these important discussions, adolescents frequently want to protect their parents and won't volunteer to be included, and parents are often afraid to talk about death with their child. We know from our research, and that of other scientists, that adolescents want to engage in these conversations and they can participate. Also, parents report less decisional regret and psychosocial long term outcomes when their child participated in advance care planning decisions.

In this workshop we aim to introduce 3 tools designed to engage adolescent patients in the discussion.

ShopTalk: a therapeutic game, created to help youth living with cancer talk about their illness in a non-threatening way with a health care provider.

Jenga: a game that uses stacked wooden blocks inscribed with thought-provoking questions that encourage discussion about goals of care and advance care planning.

My Gift of Grace: a conversation card game. 74% of people who played My Gift of Grace went on to perform an advance care planning activity following the game.

We will first introduce each of the tools then invite participants to practice in a small group, rotating through all 3 tools. After the small groups practice each tool, we will report our experiences to the large group as a whole. Finally, participants will be broken into triads (patient/family member/health care provider) to practice through role-play how to introduce advance care planning with patients and their families.

"I Understand There's A New Law...": Responding to Patient Inquiries About Physician-Assisted Dying (TH336)

Gregg VandeKieft, MD MA FAAHPM, Providence St. Peter Hospital, Olympia, WA. Eric Widera, MD FAAHPM, University of California San Francisco, San Francisco, CA. Vyjeyanthi Periyakoil, MD, Stanford University School of Medicine, Palo Alto, CA. Denise Hess, MDiv, Kaiser Permanente, Rancho Palos Verdes, CA.

Objectives

- Describe the history and regulatory framework of legalized PAD in the US.
- Identify the primary concerns expressed by patients who inquire about PAD.
- Identify individual provider and team biases (moral, ethical, affinity, confirmational), attitudes and assumptions about PAD and patients who request PAD.

Currently, one in six Americans live in a jurisdiction where physician-assisted dying (PAD) is legal. Most persons who inquire about PAD will ultimately not choose it. This session will present a brief overview of the current experiences with PAD in the US and highlight practical medico-legal points related to PAD. Next, using three interactive cases, we will elucidate the common challenges in communicating effectively with patients and families requesting PAD. The primary focus will be the clinician's response to any patient or family member who inquires, regardless of the clinician's personal political or ethical views regarding PAD or the patient's intent to actually follow through with it. The cases will help elicit a deeper understanding of the concerns or motivations prompting inquiries about PAD, with the goal of comprehensively addressing multi-dimensional suffering and fostering delivery of the best care possible for vulnerable individuals. We will use short interactive role play exercises to promote a deeper understanding of the common challenges in responding effectively to requests for PAD.

How Do We Chart a New Course for a System in Crisis? A Multi-Center, Regional Collaborative to Improve Supportive Oncology Care (TH337)

Catherine Deamant, MD, JourneyCare, Glenview, IL. Shelly Lo, MD, Cardinal Bernardin Cancer Center, Maywood, IL. Amy Scheu, MSH CHPCA, Advocate Healthcare, Chicago, IL. James Gerhart Rush University Medical Center, Chicago, IL. Dirk Labuschagne,

MDiv, Cook County Health and Hospitals System, Chicago, IL.

Objectives

- Define a structure to address gaps in supportive oncology care.
- Describe initiative work that addresses gaps and needs in supportive oncology care.
- Appraise the resources developed to impact supportive oncology quality.

This concurrent session will describe a regional collaboration to improve supportive oncology care across a large metropolitan area. Funded by the Coleman Foundation, the initiative focused on strategies to implement recommendations by Institute of Medicine (IOM) 2013 Report, *Delivering High Quality Cancer Care: Charting a New Course for a System in Crisis*. During the session we will provide an overview of a multicenter multi-disciplinary supportive oncology collaborative, which included academic, community and safety net healthcare organizations focused on identifying supportive oncology gaps and needs and identifying strategies for improving delivery of care. Three design teams focused on various aspects of supportive oncology, including distress; survivorship; and palliative care/hospice. We will present the supportive oncology screening tools (paper and electronic version) that will be available for public use, provide an overview of brief and practical reference documents that were developed to guide further evaluation or intervention resulting from the screening tool assessment, and development of National Comprehensive Cancer Network (NCCN) endorsed webinar training modules on key supportive oncology topics. A panel discussion representing multiple disciplines and stakeholders involved in the initiative will provide perspective and insight about the opportunities and challenges of this large, regional initiative and lessons learned.

Geriatric Palliative Care: From Bench to Bedside and Back in 2017 (TH338)

Barbara Messinger-Rapport, MD FACP, Hospice of the Western Reserve, Cleveland, OH. Mary Ersek, PhD RN FPCN, University of Pennsylvania, Philadelphia, PA. Kathleen Unroe, MD MHA, Indiana University, Indianapolis, IN.

Objectives

- Review high quality palliative care research from 2016 that focuses on older adults.
- Discuss the opportunities and challenges of applying this research to the care of older adults with life-limiting illness.
- Identify practical takeaways to implement change in clinical practice and system of care of older adults with palliative care needs.

This year in review focuses on patient- and systems-level research that impact the delivery of palliative care to older adults receiving long-term services and supports (LTSS), including institutional care. Functional and cognitive impairment are very common in older adults receiving LTSS. This patient population also has multiple chronic conditions, which are associated with high symptom burden. For example, among older adults with heart failure, 50% have 5 or more chronic conditions. High symptom burdens are associated with greater use of healthcare, higher risk of nursing home admission, and lower quality of life.

The purpose of this presentation is to identify and review recent research focusing on palliative care of older adults receiving LTSS, and guide the audience in applying the literature to their patients and to the systems of care in which they treat patients, using practical takeaways. The settings of interest are the entire continuum of care ranging from the community to assisted living to the nursing home, as well as acute and subacute care. The presenters utilize a modified Delphi method of screening and choosing publications that may impact the delivery of interdisciplinary palliative care over the coming year.

The three symposium presenters bring their diverse expertise to the presentation. Dr. Unroe is the project director of a CMS clinical demonstration project, OPTIMISTIC (Optimizing Patient Transfers, Improving Medical Quality, Impacting Symptoms: Transforming Institutional Care). Dr. Ersek has conducted several funded studies focused on older adults, particularly those living in nursing homes and those with dementia. Dr. Messinger-Rapport is a geriatric and palliative care physician and clinical educator with an emphasis on long-term care.

I Know It's Early but Can I Get a Refill on My Pain Medicines? How to Identify and Manage Chemical Coping in the Cancer Patient (TH339)

Eric Prommer, MD HMDC FAAHPM, Greater Los Angeles Healthcare, Los Angeles, CA. David Hui, MD MS MSC, MD Anderson Cancer Center, Houston, TX. Egidio Del Fabbro, MD, Virginia Commonwealth University, Richmond, VA. Rony Dev, DO, University of Texas and MD Anderson Cancer Center, Houston, TX.

Objectives

- Learn comprehensive assessment of decreased opioid efficacy in the cancer patient.
- Learn the concept of chemical coping and distinguish it from addiction.
- Learn how to screen for chemical coping.

The typical cancer patient experiences both a physical and emotional onslaught. Opioids have proven efficacy in the management of cancer pain. When patients require escalating doses of opioids without adequate pain relief, a differential diagnosis is generated. This list includes disease progression as well as examining issues in the psychological, social, and spiritual dimensions. The list of diagnostic considerations should now include delirium, somatization, depression, and chemical coping. Chemical coping is defined as "the use of opioids to cope with emotional distress, characterized by inappropriate and/or excessive opioid use". Patients exhibiting chemical coping often have a prior history of alcoholism or substance abuse, and may require higher doses of opioids like patients with addiction histories. It becomes important to recognize that a "chemical coper" may exhibit a broad spectrum of behavior that can range from harmless misuse of opioid to true addictive behavior. Where this patient truly exists on the spectrum may determine interventions needed. Accurate identification of the chemical coper may prevent extremes of opioid therapy such as unnecessary opioid dose escalation and opioid adverse effects or perhaps undertreating a patient requiring high-dose opioids for pain control. This session will focus on strategies to manage patients exhibiting chemical coping. By means of clinical case presentations and examination of the literature the session will: 1.) Review the causes of decreased opioid efficacy in the cancer patient; 2.) Identify characteristic features of the chemical coper and distinguish them from pseudo-addiction and addiction; 3.) Identify complications of chemical coping; 4.) Identify methods of screening for chemical coping; 5.) Identify and make recommendations with respect to risk mitigation strategies for chemical copers.

Paper Session

Outcomes of an Actor-Based Simulation Course for Advance Care Planning Facilitators (TH340A)

William Bond, MD MS, OSF HealthCare/University of Illinois COM, Jump Simulation, Peoria, IL. Linda Fehr, BSN RN CPHQ, OSF Healthcare System, Peoria, IL. Amy Funk, PhD RN-BC, Illinois Wesleyan University, Bloomington, IL. Robert Sawicki, MD HMDC FAAFP FAAHPM, OSF Health Care, Peoria, IL. Hanna Gonzalez, BS, University of Illinois College of Medicine, Peoria, IL. Jeremy McGarvey, MS, OSF Healthcare System, Peoria, IL. Jessica Svendsen, BA CCRC, OSF Healthcare, Peoria, IL.

Original Research Background. Advance care planning (ACP) facilitators require training and feedback to acquire confidence to perform this valuable service.

Research Objective. To improve the knowledge and confidence of novice ACP facilitators.

Methods. The course took place at a simulation center supporting a large healthcare system. All curricular items, surveys, and tests were pilot tested. The course included pre-course exposure to the discussion guide and a video demonstration, 2.5 hours of didactic content, and 4 simulations with actors playing patients. Knowledge was tested with 24-question pre-post multiple choice question (MCQ) test. A pre-post-delayed (30 to 90 days) survey of learner confidence across 6 content areas was analyzed with a linear mixed effects model.

Results. 69/83 individuals consented to participate during 7 courses over 13 months ending May 2016, including 43 nurses, 16 social workers, and 10 others. Pre-Post MCQ scores improved from 83%±10 to 92%±8 (p < 0.001). Paired surveys of self-confidence were available for 65, 65, and 40 learners respectively with combined scores of 5.4±2.8 pre, 7.6±1.9 post, and 8.1±1.8 delayed on a 10 point scale. (Pre-Post, p< 0.001) (Pre-Delayed, p < 0.001). Self-perceived competence with advance directives improved with 48% pre, 86% post, and 92% delayed choosing "minimal supervision" or "independent" on a 4 category scale (rank-sum chi^2 (2df) =37.90, p < 0.001). Delayed surveys indicated 20/40 conducted ACP. Of consented individuals with logging data 28/58 went on to conduct 806 ACPs (mean 2.2/month/facilitator, median 0.0/month/facilitator), with a skewed distribution due to several individuals given ACP as a core job role.

Conclusion. Knowledge and self-perceived confidence and competence improved with training, with half of learners going on to conduct ACP in practice.

Implications for research, policy or practice. Future research will focus on success measured by patient centered outcomes. Health systems need to consider training resources and job support to promote ACP.

Palliative Care Knowledge and Attitudes of Multidisciplinary Health Profession Trainees (TH340B)

Nathan Boucher, DPH MPA MS PA, Durham VA Medical Center GRECC/Duke University, Durham, NC. Jessica Sautter, PhD, University of the Sciences, Philadelphia, PA. Anita Franzione, DrPH, Rutgers University, New Brunswick, NJ.

Objectives

- Describe the reported KNOWLEDGE of palliative care and end-of-life care of a multidisciplinary health professions sample.
- Describe the reported ATTITUDES towards palliative care and end-of-life care of a multidisciplinary health professions sample.

Original Research Background. A strong interprofessional palliative care workforce is needed to care for the growing older American population, in particular. The Institute of Medicine (2014) critically noted the inadequately staffed palliative care workforce and recommended increasing training and exposure in primary palliative care for all health professionals.

Research Objectives. We wanted to examine multiple health professions' knowledge, attitudes, and intentions towards palliative care.

Methods. During May-April 2016, we conducted an IRB-approved online survey of 360 students in their final years of training in pharmacy, medicine, nursing, physician assistant, occupational therapy, physical therapy, and public health programs at five universities. We queried their knowledge and attitudes regarding palliative care and care delivered near the end of life.

Results. Sufficient knowledge of palliative care was reported by 25% of the sample while sufficient knowledge of advance care planning was reported by 17%. Respondents (96%) thought it was important to discuss end-of-life issues in their training curricula; 92% believed their profession could play an important role in patients' end-of-life care. Managing pain was reported as the best example of palliative care by 93.6% over removing life sustaining equipment (2.5%) and performing surgery to cure illness (2.5%). Designating a health care proxy was reported as the best example of advance care planning by 55.8%. We will discuss these and other findings related to each professional subsets' perceptions of their didactic preparation in palliative care, knowledge of palliative care access/function, attitudes about death/dying, and intentions to care for seriously ill patients in their future practice.

Conclusion. There is interest in palliative care, including end-of-life care, and knowledge of its function among students from multiple health professions.

Implications for Research, Policy, or Practice. These findings can provide guidance for how we train health professionals from multiple disciplines to care for the people they will serve in their future professional practice.

Critical Conversations in Gynecologic Oncology: Communication Skills Training for Fellows and Advanced Practice Providers in a Primarily Surgical Specialty (TH340C)

Lisa Podgurski, MD MS, University of Pittsburgh Medical Center, Pittsburgh, PA. Kerri Bevis, MD MSPH, University of Alabama at Birmingham, Birmingham, AL. Elise Carey, MD FAAHPM, Mayo Clinic, Rochester, MN. Carolyn Lefkowits, MD MPH MS, University of Colorado Denver, Denver, CO.

Objectives

- Describe the background evidence for communication skills training (CST) in improving health care providers' skills.
- Describe the content of the CST we developed for gynecologic oncology providers.
- Describe the impact of the CST on the GO providers, as evaluated by pre- and post-intervention surveys.

Original Research Background. Good communication is crucial to good patient care, particularly in the setting of serious illnesses like cancer. Communication skills training (CST) has been shown to improve skill acquisition in providers of multiple specialties, but it has not been described in providers from gynecologic oncology (GO) or any surgical oncologic specialty.

Research Objectives. 1.To demonstrate feasibility and acceptability of a communication skills training workshop for GO providers

2.To evaluate the impact of the training on perceived preparedness to address communication challenges and anticipated impact on clinical practice

Methods. We conducted a two-day CST workshop in the VitalTalk model with 4 faculty members (2 gynecologic oncologists and 2 palliative care physicians) and 10 gynecologic oncology provider participants (5 fellows and 5 advanced practice providers). Acceptability, perceived impact on preparedness to address challenging communication scenarios, and anticipated impact on practice patterns were assessed by self-report pre- and immediately-post-workshop. We compared pre-workshop and post-workshop prevalence of score of 4 or 5 on a 5-point Likert scale for perceived preparedness to handle 14 challenging communication scenarios.

Results. Participants showed statistically-significant increase in perceived preparedness for 13 out of 14 challenging communication scenarios described in our pre-post questionnaire. Among those 13 topics, magnitude of improvement in proportion rating preparedness 4 or 5 out of 5 ranged from 0.4 to 1 (all $p<0.05$). All participants recommend the course to others and all strongly agreed that this training should be required of all GO clinicians.

Conclusion. Participants felt strongly that the workshop provided high quality education relevant to their practice. As a result of the workshop, participants reported statistically significantly increased perceived preparedness to handle challenging communication scenarios. CST is feasible and has high perceived effectiveness for clinicians in the primarily surgical oncologic specialty of gynecologic oncology.

Implications for research, policy or practice. Communication skills training can be successfully applied in a surgical oncology setting.

POLST: House Staff Knowledge and Attitudes (TH340D)

Zankhana Mehta, MD, Geisinger Health System, Danville, PA. Kelly Downey, MD, Geisinger Medical Center, Danville, PA. Sharon Larson, PhD, Geisinger Health System, Danville, PA. Mellar Davis, MD FAAHPM FCCP, Geisinger Medical Center, Danville, PA.

Objectives

- Demonstrate need for POLST training for house staff.
- Discuss differences between advance directives and POLST.

Background. Documenting patients' preferences for life-sustaining treatment across various sites of care presents a challenge for the seriously ill. There is a paucity of data regarding trainees understanding of the Physicians Orders for Life Sustaining Treatment (POLST) tool application for advance care planning.

Methods. We utilized a survey tool to establish a baseline for house staff knowledge and attitudes related to POLST. We developed an on-line survey consisting of 21 questions in the form of Likert scale, True or False, and multiple choice questions. Surveys were completed electronically by trainees using Survey Monkey. Out of 47 trainees who responded, 20 were from Internal medicine, 9 were Med-Peds and 18 were from general surgery, neurology, emergency, critical care, pulmonary and critical care, nephrology, and cardiology. 22 of respondents had two or fewer years of post-graduate training and 25 had more than two years of training.

Results. 79% of respondents had reviewed and completed POLST during their training. 67% felt comfortable discussing and completing POLST forms with patients. However 20% did not know which patients were appropriate for POLST discussions. 77% identified that health care professionals must sign POLST form but 72% answered incorrectly or did not know which sections to complete. 49% answered incorrectly or did not know that POLST is not based on existing advance directive. 51% of respondents preferred to call Palliative Medicine for questions related to POLST. 91% agreed to have additional POLST training.

Conclusions. Our survey demonstrates a lack of understanding of POLST which needs to be improved by education before implementation. Many trainees are not clear on differences between advance directives and POLST regardless of the years of training or number of completed POLST forms.

Expanding Access to Community-Based Palliative Care: A Palliative Care in Home Health (PCHH) Model (TH341A)

Marilyn Bookbinder, RN MJHS, New York, NY. Mary Wagner, MEd RN MJHS, New York, NY. Kathleen Dier, MSN RN MJHS, Home Care, Brooklyn, NY. Lorette Shea, MPS BSN RN, MJHS Institute For Innovation In Palliative Care, New York, NY. Russell Portenoy, MD, MJHS Hospice and Palliative Care, New York, NY. Lenard Parisi, MA RN CPHQ FNAHQ MJHS, New York, NY.

Objectives

- Describe an innovative model for delivery of community-based palliative care in home health (PCHH).
- Describe methods and results for evaluating feasibility of the new PHHC.

Original Research Background. In July 2016, The Joint Commission issued its first certification for community-based palliative care in home health to MJHS Home Care, New York. Designed to expand access to generalist-level palliative care, particularly in transitional care, the Palliative Care in Home Health (PCHH) program has the potential to become a national model.

Research Objectives. To describe the PCHH model and evaluate its feasibility.

Methods. The PCHH program identifies patients based on diagnosis and illness burden. The program includes comprehensive assessment by a home health nurse within an interdisciplinary team (IDT); regular evaluation using the ESAS-r; front-loading of nurse visits; protocolized interventions for pain, dyspnea, anxiety, and depression; assistance with advance care planning; medication reconciliation and assistance in acquiring concrete services; hospice eligibility review and education; and ongoing discussion with the primary physician. Implementation involved modification of the electronic medical record, training of both nurses and social workers, and establishment of the IDT.

Results. To date, 8 patients have been managed by the PCCH program; 8 were identified on hospital discharge. All had advanced illness (CHF, cancer, or COPD). Adherence to the protocols was 96%, including repeated visits within 48 hours. Care planning discussed at a weekly IDT meeting led to: hospice referrals (3), changes in management for pain (4), dyspnea (4), anxiety (4), depression (2) and clarification of advance directives (8). One patient died during the care episode after emergency transfer to the hospital.

Conclusion. PCHH appears to be a feasible model to expand access to generalist-level palliative care in the home care environment and may be particularly important to improve transitional care between the hospital and home.

Implications for research, policy or practice. Larger studies over a longer periods are needed to evaluate the clinical and economic outcomes of this model in varied populations.

Screening Patients for Early Palliative Care: Can Serious Illness Diagnoses Identify Patients Likely to Benefit from Palliative Care? (TH341B)

Kara Bischoff, MD, University of California San Francisco, San Francisco, CA. Joanne Yim, PhD, University of California San Francisco, San Francisco, CA. Teri Rose University of California San Francisco, San Francisco, CA. Christine Ritchie, MD FAAHPM, University of California San Francisco, San Francisco, CA. Steven Pantilat, MD FAAHPM, University of California San Francisco, San Francisco, CA.

Objectives

- Understand how a list of serious illness diagnoses, derived through expert consensus for the purpose of quality measurement, can be used to predict patients' eventual referral to palliative care and death.
- Consider the strengths and limitations of this list of serious illness diagnoses for the purposes of screening patients into early palliative care.

Original Research Background. Early PC is associated with better outcomes and lower costs. Proactive screening can identify patients in need of PC earlier than usual referral mechanisms. An expert panel developed a list of serious illness diagnoses (SID) - including metastatic cancer, end-stage heart failure and advanced dementia - for the purposes of quality measurement.

Research Objectives. We examined whether these SID could be used to screen patients for early PC.

Methods. We examined data from encounters at University of California, San Francisco Medical Center from 07/01/2012 to 06/30/2015 to determine associations between SID and referral to PC or death.

Results. For hospitalized patients, the presence of a SID is associated with referral to PC (OR 2.6) and death within 12 months (OR 3.3). Hospitalized patients with a SID carry that diagnosis for an average of 16.4 months prior to death. However, 41.2% of patients referred to inpatient PC do not have a SID. For ambulatory cancer patients, presence of a SID is associated with referral to PC (OR 2.7) and death within 12 months (OR 18.9). Ambulatory cancer patients with a SID carry that diagnosis for an average of 16.1 months. However, 42.6% of patients referred to outpatient PC do not have a SID.

For primary care patients, presence of a SID is strongly associated with death within 12 months (OR 30). Primary care patients with a SID carry that diagnosis for an average of 25.8 months.

Among patients with a SID, a minority has an advance directive (hospital=24.5%, cancer center=16.4%, primary care=31.2%). A smaller minority has a Physician Orders for Life-Sustaining Treatment form (hospital=4.7%, cancer center=2.0%, primary care=9.1%).

Conclusion. Serious illness diagnoses derived by expert consensus can identify many, but not all, patients who are likely to benefit from PC.

Implications for research, policy or practice. Efforts are underway to design a robust screen to identify patients in need of PC early.

Palliative Care Office Hours: An Innovative Model for Care Delivery and Education (TH341C)

Anessa Foxwell, MSN ACHPN CRNP, Hospital of the University of Pennsylvania, Philadelphia, PA. Mary Moyer, BSN RN, Hospital of the University of Pennsylvania, Philadelphia, PA. Nina O'Connor, MD, University of Pennsylvania, Philadelphia, PA.

Objectives

- List three patient populations for which palliative care office hours would be effective.
- Describe implementation of palliative care office hours.
- Describe the impact of palliative care office hours on palliative care consult volume, composition, and outcomes.

Original Research Background. Many palliative care programs are experiencing rapid growth, with demand for consults surpassing staffing. Innovative models are needed to efficiently deliver palliative care and to equip non-palliative care providers to manage basic palliative care issues.

Research Objectives. To describe a novel program of palliative care office hours for oncology advanced practice providers, and to evaluate the impact of the office hours program on palliative care consult volume and composition.

Methods. A palliative care nurse practitioner or pharmacist was available daily to the hematologic oncology advanced practice providers to answer questions about pain, non-pain symptoms, and psychosocial distress. Data were collected on office hour utilization and palliative care consults from the hematologic oncology services.

Results. Palliative care office hours were efficient (mean duration of 16 minutes per day, range 5 to 55) and well-utilized (mean of 11 patients discussed per week, range 4 to 20). Pain, nausea, and anxiety were the issues most frequently raised during office hours. Of the 299 patients discussed during office hours in the first six months, only 61 (20.4%) required a full palliative care consult. After implementation of office hours, full palliative care consults were less likely to be for pain (26.2% versus 56.3%, p = 0.002) and more likely to be for goals of care (11.4% versus 1.1%, p = 0.007). Overall, palliative care consults from the hematologic oncology services decreased by 30% with no impact on hospice referrals.

Conclusion. Office hours are an efficient model when demand for palliative care consults exceeds capacity.

Implications for research, policy or practice. Office hours are likely to be effective for other patient populations with frequent palliative care needs. Office hours also serve an important educational function, enabling primary teams to manage basic palliative care issues so that palliative care specialists can focus on complex symptom management and goals of care.

Evaluation of Emergency Department Management of Opioid-Tolerant Cancer Patients with Acute Pain (TH341D)

Pina Patel, MD, The Ohio State University Wexner Medical Center, Columbus, OH. Lauren Goodman, MD MSC, Ohio State University, Columbus, OH. Sheri Knepel, MD, Zusman Hospice, New Albany, OH. Charles Miller, MD, The Ohio State University Wexner Medical Center, Columbus, OH. Asma Azimi, MD, Alta Bates Summit Hospital, Columbus, OH. Jillian Gustin, MD, The Ohio State University Wexner Medical Center, Columbus, OH. Amber Hartman, PharmD, The Ohio State University Wexner Medical Center, Columbus, OH.

Objectives

- Recognize that opioid-tolerant cancer patients are at risk of being undertreated with opiate dosing during ED encounters.
- Quantify degree to which patients may have mathematically inadequate opiate dosing based on home OME use.
- Compare adequate vs. inadequate dosing based on years of training.

Original Research Background. There are no previously published studies examining opioid doses administered to opioid-tolerant cancer patients during Emergency Department (ED) encounters.

Research Objectives. We performed a retrospective review of ED management of pain in opioid-tolerant cancer patients in our academic tertiary care cancer center over a 2-year period. The objective was to determine if opioid-tolerant cancer patients presenting with acute pain exacerbations receive adequate initial doses of PRN opioids during ED encounters based on home Oral Morphine Equivalents (OME) use.

Methods. The percentage of patients that received an adequate initial dose of PRN opioid (defined as ≥10% of total 24-hour ambulatory OME) was evaluated. Logistic regression was used to establish the relationship between 24-hour ambulatory OME and initial ED OME to assess whether higher home usage was associated with higher likelihood of being undertreated.

Results. Of 216 patients, 61.1% of patients received an adequate initial PRN dose of opioid in the ED. Of patients taking <200 OME per day at home, 77.4% received an adequate initial dose; however, only 3.2% of patients taking >400 OME per day at home received an adequate dose. Patients with ambulatory 24-hour OME >400 had 99% lower odds of receiving an adequate initial dose of PRN opioid in the ED compared to patients with ambulatory 24-hour OME less than 100 (OR <0.01, CI 0.00-0.02, p <0.001).

Conclusion. Patients with daily home use less than 200 OME generally received adequate initial PRN opioid doses during their ED visit. However, patients with higher home opioid usage were at increased likelihood of being undertreated.

Implications for research, policy or practice. Further investigation regarding the impact of pain management education for ED providers and availability of Palliative consultation services is vital for the emergency care of cancer patients with pain.

Extremis: An Insider's Glimpse into the ICU (TH342)

Jessica Zitter, MD MPH, Highland Hospital, Oakland, CA.

Objectives

- Identify typical obstacles to breaking bad news in the ICU environment, including communication challenges, medical uncertainty, and navigating conflict.

- Recognize the importance of early, frequent, and clear communication about prognosis in the ICU, including potential changes in medical decision making.

Join us for an exclusive screening of *Extremis,* a verité documentary exploring the harrowing decisions facing patients, families and physicians in urgent end-of-life cases. We will explore the complex topics raised by the film—including communication challenges, medical uncertainty, and navigating conflict—that are major components of the care of critically-ill patients.

Directed by Emmy and Academy Award-nominated filmmaker Dan Krauss, *Extremis* follows Dr. Jessica Zitter and her team in the intensive care unit of a public hospital in Oakland, California. The extraordinary access granted in this 24-minute film offers a uniquely intimate look at the intersection of science, faith, and humanity.

The film provides an opportunity to evaluate and discuss the approach to patients at the end of life in the ICU. It contains examples of both productive and problematic communication, and raises critical questions about how healthcare providers can best support their patients through these challenging times.

Extremis premiered at the Tribeca Film Festival in April 2016 and won the award for Best Documentary Short. It was also awarded first prize for Bay Area Short at the San Francisco International Film Festival and will screen at the Sheffield Doc/Fest and AFI DOCS Film Festival in June 2016.

Netflix will premiere the film, its first original short documentary, in September 2016, and will translate the work into 20 languages.

3—4 pm

Public Policy Forum: Advancing Palliative Care in Alternative Payment Models: Surviving and Thriving Under MACRA (TH350)

Phillip E. Rodgers, MD FAAHPM; and Harold D. Miller.

Diversity & Inclusion Forum: Conversations that Matter: Creating a Culture of Inclusivity and Candor (TH352)

Jessica Pettitt, MEd BA, Good Enough Now, Eureka, CA.

Objectives

- Understand what to do with positive and negative bias.
- Communicate across difference.
- Listen across difference.

Health care access, serving clients, and working within our community is incredibly important work. To best do this work, we need to know who we are, what we bring to the table, and what we don't know. Join in for a lively conversation to uncover what we don't know, and how step 1 is asking the right questions of ourselves and listening to others. Once you know who and how you are, you can reclaim responsibility for these behavior response patterns and leave room for others to do the same. Before you know it, you are having better conversations and fuller relationships with those around you. I promise—it is that easy.

- Feel welcomed to a conversation about the unknown.
- Understand the difference between social justice and diversity.
- Review real life stories, share and reflect on our own experiences.
- Learn how to listen and leave some wiggle room in difficult conversation with others.
- Learn a 3 part framework or model for taking responsibility of how they show up.

Book Club Discussion

"When Breath Becomes Air" By Paul Kalanithi (TH353)

Nurses Leading Change and Transforming Care (TH354)

Inaugural Nessa Coyle Palliative Nursing Leadership Lecture

Betty Ferrell, PhD MA FAAN FPCN.

Objectives

- Describe the career of Nessa Coyle, PhD FAAN, a pioneer and leader in palliative care.
- Apply the lessons from this career to future leadership needs to advance palliative care.

The field of palliative care has revolved over the past 30 years with contributions by pioneers in the field who have defined and implemented palliative care. This presentation launches the Nessa Coyle Lectureship honoring Dr. Coyle's significant contributions which have advanced compassionate care for patients and families around the world. Lessons from her career will be summarized and applied to the future needs for leadership development.

4:30–5:30 pm

Concurrent Sessions

Adding Your Voice: Vetting the Curricular Milestones for HPM Physicians in Training (TH360)

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

Objectives

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

With ACGME's move to the Next Accreditation System (NAS), 3 new tools were introduced for medical training. These include: 1. Reporting Milestones—essentially a report card that training programs submit twice a year to ACGME to document each resident or fellow's progress; 2. Entrustable Professional Activities (EPAs)—key activities of the job that as fellows' gain competence can be "entrusted" to them to perform without supervision; and 3. Curricular Milestones—more detailed elements of a training program that help offer structure and curricular guidance to educators. The AAHPM HPM Curricular Milestones/EPAs Workgroup completed the development and distribution of HPM EPAs. The workgroup is now focused on the development of HPM curricular milestones. The goal is to produce a curricular milestone set that is helpful and practical for HPM fellowship programs in defining and standardizing HPM curricula across training programs. At the 2017 Assembly the workgroup will educate on these important concepts, provide an update on workgroup progress, share a drafted set of curricular milestones, and elicit member feedback on the proposed curricular milestones.

Palliative Care and Population Health Management: Key Steps on the Path to Integration (TH361)

Jean Kutner, MD MSPH FAAHPM, University of Colorado School of Medicine, Aurora, CO. Christine Ritchie, MD FAAHPM, University of California San Francisco, San Francisco, CA. Margaret Reidy, MD, and Margaret E. Reidy, M.D, PLLC, Pittsburgh, PA. Jean Haynes, MBA RN, UCHealth, Aurora, CO.

Objectives

- Describe the current status, and predicted future, of population health in the setting of the Affordable Care Act.
- Identify post-acute care strategies that effectively meet the needs of patients with serious advanced illness.
- Describe approaches for enhancing care for people with complex care needs and measuring the effectiveness of these approaches.

Population health management seeks to harness the efforts of health care delivery systems, public health agencies, community-based organizations, and many other entities to improve health outcomes in the communities they serve. The Affordable Care Act served as a catalyst to population health management by promoting the implementation of accountable care organizations (ACOs) to incentivize providers to take responsibility for population health outcomes. Palliative care improves value in ACOs and other integrated care delivery networks by increasing high-quality care and decreasing costs for the sickest patients. Through a combination of presentations, discussion, and individual reflective work, session attendees will develop an action plan for enhancing integration of palliative care into population health initiatives in their local settings. Session faculty will address the following topics:

Population health overview:

- What does population health management look like under the Affordable Care Act?
- Commercial payers, Medicare ACOs, Medicare Advantage and bundled payments: how do these populations differ and what are the implications for program design?
- Why should palliative care be engaged with population health management?

Post-acute care strategy:

- Key components of an effective post-acute care strategy
- The role for palliative care in comprehensive post-acute care strategies

Complex care, panel management and measurement:
- Innovative approaches for addressing the needs of patients with complex care needs
- Palliative care's role in facilitating panel management
- Selecting relevant process and outcome measures

Effecting change:
- Identifying key partnerships
- Shaping the message

Time will be alloted for a structured exercise in which participants will create action plans, identifying key stakeholders in their environment and shaping a message relevant to their local situation. These action plans, with timelines, will be shared among participants for feedback from session faculty and peers.

Is This Patient GIP Eligible? Improving Your Hospice's Compliance and Documentation for General Inpatient and Continuous Care (TH362)

Martina Meier, MD, Providence TrinityCare Hospice, Los Angeles, CA. Eric Prommer, MD HMDC FAAHPM, Greater Los Angeles Healthcare, Los Angeles, CA. Shaida Talebreza, MD HMDC FAAHPM, University of Utah, Salt Lake City, UT.

Objectives
- Gain profound knowledge of CMS regulations and qualification criteria for GIP level of care.
- Be able to document a patient's eligibility for GIP or continuous care.
- Be aware of the OIG's report and recommendations made to CMS regarding oversight of GIP claims and know red flags that should trigger concern over appropriateness of GIP admission.

The Office of Inspector General's 2016 report on Hospice General Inpatient Care (GIP) indicated a high rate of misuse of GIP services; the report states that 31% of all GIP stays were billed inappropriately in 2012. Typically, there was insufficient evidence of unmanaged symptoms warranting GIP level of care. Inappropriate GIP billing occurred more commonly in For-Profit-Hospices and for GIP care provided in Skilled Nursing Facilities. The OIG recommends that CMS increase its oversight of GIP claims and follow up on inappropriate GIP stays. This session will improve the participant's understanding of both the conditions that make patients eligible for GIP, and adequate documentation of GIP eligibility. For example, how bad does a patient's shortness of breath or pain need to be in order to justify GIP? When is wound care complex enough to warrant GIP admission? To what levels do treatments need to be changed and titrated in order to justify GIP level of care? When should a patient be discharged from GIP? Is there a difference between GIP and continuous care (CC) in terms of eligibility or documentation requirements? How do you respond to hospital pressure to admit patients to GIP who are actively dying but otherwise asymptomatic? Do hospices who own their own "hospice houses" have a greater misuse of GIP? We will use multiple case examples of patients who do and do not qualify for GIP and CC. The documentation necessary to justify admission and examples of adequate and inadequate documentation will be provided and discussed. Attendees will come away from this session with a strong understanding of the criteria for GIP and Continuous Care and how to ensure accurate documentation.

Seizing the Opportunity: Overcoming Barriers to the Use of Transmucosal Midazolam in Hospice Patients (TH363)

Sam Perna, DO, University of Alabama at Birmingham, Birmingham, AL. James Rhinewalt, MD, University of Alabama at Birmingham, Birmingham, AL. Erin Currie, PhD RN, University of Alabama at Birmingham, Birmingham, AL.

Objectives
- Describe the current use of transmucosal midazolam to treat seizures in non-hospitalized, adult and pediatric, hospice patients.
- Identify barriers to the use of transmucosal midazolam for non-hospitalized patients in the US.
- Describe implications for practice related to the use of transmucosal midazolam for non-hospitalized, adult and pediatric, hospice patients.

Background. Seizures in hospice patients are distressing events for caregivers. Rectal diazepam is the only abortive therapy approved by the United States FDA for seizures occurring out of hospital. However, transmucosal (buccal and intranasal) midazolam hydrochloride is less expensive and likely more acceptable for patient comfort/modesty. This treatment has been studied, approved, and included in clinical guidelines in many other countries. The purpose of this presentation is to discuss the current use of transmucosal midazolam to treat out of hospital seizures and implications for practice in outpatient hospice settings.

Methods. A review of the literature and clinical practice guidelines were used to investigate barriers and explore the feasibility of transmucosal midazolam use in US outpatient hospice settings. Communications with national and state agencies, as well as interviews with epileptologists, pharmacists, and a national hospice pharmaceutical supplier were completed to investigate barriers and explore the feasibility of transmucosal midazolam use. An electronic survey was utilized to explore transmucosal midazolam use among hospice physicians, nurses, and administrators in the state of Alabama.

Results. Transmucosal midazolam has been documented throughout the literature and has been reported by expert clinicians as an efficacious, safe, and appropriate pharmaceutical intervention for the abortive treatment of seizures in non-hospitalized patients. Barriers reported from the survey (N=27) included unfamiliarity with transmucosal route and lack of provider orders. None of the respondents reported transmucosal midazolam use in the outpatient hospice setting.

Conclusion. Transmucosal midazolam hydrochloride is an effective, safe, cost-saving, and readily available treatment for acute seizures in pediatric and adult hospice patients as an alternative to rectal diazepam. Further research is necessary to understand barriers to transmucosal midazolam in a larger, more representative sample. Provider and patient education is needed to address a knowledge deficit on the use of transmucosal midazolam in non-hospitalized hospice patients.

Interprofessional Education in Palliative Care: A Report from the Trenches (TH364)

Barbara Head, PhD RN, CHPN FPCN, University of Louisville, Louisville, KY. Susan Breakwell, DNP APHN-BC, Marquette University, Milwaukee, WI. Dor-Anne Donesky, PhD ANP-BC ACHPN, University of California San Francisco, San Francisco, CA.

Objectives

- Describe three strategies for overcoming common challenges when developing interprofessional educational opportunities in palliative care.
- Develop an evaluation plan for IPE.
- List educational strategies and resources available for IPE.

The recent IOM reports, *Dying in America* and *Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes,* challenge educational institutions to prepare clinicians who are competent in communication and collaboration across disciplines, particularly in palliative care. Such training mandates interprofessional education (IPE) experiences, yet many efforts are thwarted by the multiple obstacles and lack of resources for developing and implementing IPE. It is unusual for university-based palliative care IPE curriculum to be developed from the ground up by multiple disciplines with equal representation. In this session, faculty from three universities with successful IPE programs will share lessons learned as they (1) successfully developed and integrated interprofessional curriculum and activities into their programs; (2) built curriculum with equal interdisciplinary representation; (3) aligned the curriculum with the core competencies established by the Interprofessional Education Collaborative (values & ethics, roles & responsibilities, communication, and teamwork and team-based care) and (4) leveled and involved learners from different disciplines and academic levels. This session will address both opportunities and challenges that were encountered, including: assessing institutional readiness, early planning for IPE, creating and maintaining an interprofessional faculty team, educational strategies and resources for curricular development, logistical solutions, recruitment of appropriate learners from palliative care disciplines, and evaluation methods and tools. Attendees will be linked to online resources and organizations which provide materials and support IPE initiatives. Presenters will share examples of successful efforts through lecture, video and experiential activities.

There's No Place Like Home: Creating a Successful Model for Community Based Pediatric Palliative and Hospice Care (TH365)

Lily Gillmor, BSN RN CHPPN CHPN, Transitions Lifecare, Raleigh, NC. Laura Patel, MD, Transitions Life-Care, Raleigh, NC. Christopher Thompson, MD, Transitions LifeCare, Raleigh, NC.

Objectives

- Identify both the need for and barriers to providing community based pediatric palliative care.
- Recognize the necessity of successful collaboration between inpatient and home based pediatric palliative care programs.
- Identify the role Concurrent Care plays in pediatric palliative and hospice care and the variability between states.

Over the past 30 years there has been significant advancement in palliative care, however there continues to be a gap in pediatric services in both inpatient and community based settings. There are numerous reasons for this gap including funding support, complexity of Concurrent Care, the definition of and eligibility for palliative care services, and the difficulty separating out palliative from hospice care. While there is not nearly the volume of research in pediatric palliative care as there is in adult palliative care, the research that has been done strongly supports the use of pediatric palliative care, demonstrating its benefit in both the active care of patients as well as during the bereavement process for parents whose child dies. Despite this strong evidence, pediatric palliative care continues to be significantly underutilized.

This session will focus specifically on pediatric palliative care in the home. We will present an interdisciplinary model of community-based palliative and hospice care featuring four pathways of support. The rationale for each pathway will be discussed as well as the successes and challenges, necessity of collaboration with outside hospitals, and feasibility of replication. Funding support will also be reviewed, including a look at the Concurrent Care Waiver and its implications on both a local and national level. The session will end with case examples of the care provided in the different pathways, with time for a brief question and answer session.

The Birds and Bees Do It, So Why Can't We Talk About It? Intimacy and Sexuality in Serious Illness and at the End of Life (TH366)

Heather Shaw, GNP, Stanford University, Stanford, CA. Joshua Fronk, DO, Stanford University School of Medicine, Palo Alto, CA. Felicia Hui, MD, Stanford University, Palo Alto, CA. Karl Lorenz, MD MS MSHS, Stanford University, Palo Alto, CA. Karla Schroeder, DNP MHA ANP-BC, Stanford Health Care, Palo Alto, CA. Ruth Kenemuth, MSW ASW, Stanford Health Care, Palo Alto, CA. Sharon Bober, PhD, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Compare and contrast assessment tools that can be used to assess sexual and intimate relationships in patients with serious illness.
- Analyze ways in which assessing sexuality and intimacy will improve the quality of care for patients and families.
- Identify barriers to and strategies for communication about sexuality/intimacy with patients and families. Apply and perform communication skills that providers can use when assessing patient sexuality and intimacy.

Sexuality and intimacy are vital parts of the human experience and are ever present even with serious illness or at the end of life. They are not synonymous and have vastly different meanings for different patients. Furthermore, the perception and expectations of intimate and sexual relationships may change with disease progression, impacting any of the four corners of wellness—physical, social, psychological or spiritual. Partnering with patients and families to address issues affecting intimate relationships can promote well-being in addition to decreasing grief and existential suffering. However, there is currently a lack of a universal standard for assessment and management of sexuality and intimacy within hospice and palliative care. As crucial as intimate relationships are to our sense of well-being, providers may feel embarrassed or uncomfortable eliciting information about intimacy or sexual wellness. Similarly, they may lack the resources to adequately guide patients and families. We will review assessment tools and techniques from the literature that can be used to elicit important information about patient's sexual and intimate relationships, as well as resources and responses that providers in the interdisciplinary team can use to support the well-being of their patients' intimate relationships. Learners will have the opportunity to engage in practical communication to decrease fear or anxiety when addressing these topics.

EOL Clinician at Work, EOL Caregiver at Home—HELP Is on the Way! The Dual-Role Caregiver Vulnerability Paradigm (TH367)

April Mazzarino-Willett, MSN ANP-BC ACHPN, Baystate Medical Center, Springfield, MA. Alice Leveston, MSW LICSW BCD, Baystate Medical Center, Springfield, MA.

Objectives

- Identify two pitfalls to the role of being both an EOL Clinician while simultaneously being a family caregiver for a terminally ill loved one [Dual-role Caregiver].
- Describe two techniques to help the EOL Clinician adapt to their role, as a Dual-role Caregiver when caring for a terminally ill loved one.
- List two concurrent stressors faced by EOL Clinicians when they are asked to consult on cases of nuclear or extended family members.

One of the most challenging events in the lives of family caregivers is tending to a terminally ill loved one. But what happens when a family caregiver tending to a terminally ill loved one is also a practicing End of Life (EOL) Clinician? What is an algorithm of care, specific burdens, coping vulnerabilities and grieving complexities of this Dual-role Caregiver (both an EOL clinician while simultaneously being a family caregiver)? More importantly, how do we, the Interdisciplinary Team of EOL Clinicians, meet the specific needs of this population?

Grounded theorist, Ireen M. Proot et al, 2003, notes family caregiving at end of life is a continuous balance between care burden and capacity to cope, even in the setting of courage and strength. Thankfully, EOL clinicians are well versed in the specific burdens and coping vulnerabilities of family caregivers caring for a terminally ill loved one and the core benefits of an Interdisciplinary Team approach to care.

A review of the literature yielded neither journal articles nor research studies with respect to this complicated clinician predicament. We therefore created a paradigm to explain and support the EOL Clinician caring for either a nuclear or an extended terminally ill family member utilizing Qualitative research method, Grounded Theory, the Stress-Vulnerability Model, and our combined thirty personal experiences caring for both our nuclear and extended family members. Through paradigm presentation, discussion, and case examples, we will examine the specific burdens, coping vulnerabilities, delayed grief and an algorithm for caring for our own at end of life.

Reaching Out to Those Who Can't Reach Us: A Pilot Project Incorporating Palliative Telemedicine in Home Health Practice (TH368)

Matthew Peachey, MD, Vanderbilt Medical Center, Nashville, TN. Julia Triplett, MSN MBA NE-BC, Vanderbilt Home Care Services, Inc., Nashville, TN. Mohana Karlekar, MD, Vanderbilt University, Nashville, TN.

Objectives

- Review the challenges and needs of homebound patients unable to reach appropriate palliative care resources.
- Discuss the common needs home health practitioners have when dealing with serious illness and end-of-life situations.
- Share the development of a "smart-device-driven" pilot program to connect homebound patients with palliative care resources.

One of the greatest challenges palliative medicine faces is reaching patients whose health has deteriorated to a point they can no longer leave the home. Early palliative care can help patients receive the resources they need to honor their wishes to remain at home, but a majority of palliative medicine is still provided in an inpatient setting, often coming too late for patients and families who wish to avoid further admissions. In rural communities, this issue is compounded by the distance that must be traveled to reach appropriate support. Many of these patients receive care at home through home health, but far too often palliative care is not available through these agencies. As technology has incorporated into medical practice it has opened the possibilities of communication between patients and providers. We will discuss the institution of a pilot project reaching out to those most vulnerable patients who have the greatest potential to benefit from palliative care. Our palliative medicine team has partnered with our home health service to identify those patients most at risk for increased healthcare utilization and unmet healthcare needs. By using a HIPAA-compliant video conferencing tool, we offer homebound patients an opportunity to speak with palliative medicine specialists working on advance planning, goals of care discussions, and optimizing symptoms in conjunction with their primary providers. This not only provides patients an opportunity to maximize their quality time at home, but can also provide our home health partners the resources they desperately need as they address end-of-life issues and limit unwanted hospitalizations and utilization. This workshop will share the common issues home health professionals may face and how palliative medicine practitioners can improve patient care in the home setting. We also review "lessons learned" of overcoming challenges in communicating through technology and finding the opportunities for improved care.

Community Based Participatory Research: How to Use This Proven Method in Reducing Health Disparities in Palliative Care (TH369)

Ronit Elk, PhD, University of South Carolina, Columbia, SC. Marie Bakitas, DNSc NP-C FAAN, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Increase awareness and understanding of CBPR as an important evidence-based tool to reduce health disparities in Palliative Care.
- Discuss key principles and elements of CBPR.
- Explore which principles and tools participants would use if they were to use CBPR.

Community-Based Participatory Research (CBPR) is a public health method that over the last 20 years has demonstrated effectiveness in reducing health care disparities across a variety of health care settings and illnesses. Using this method, researchers partner with community members and together design programs that meet the needs of the community or help to find solutions to problems that affect the community. Unlike most programs that are developed by experts, by using CBPR the community members play a key and prominent role in determining the elements of the program. A Community Advisory Board guides all aspects of the study or program development, from beginning to end. Because of this deep level of community participation, involvement and input, the program or solution to the problem reflects the wishes of the community, and there is strong community ownership of the program or solution once it has been implemented. This can result in increased community participation in palliative care programs, an increased level of trust in the providers and healthcare organizations, and in teaching others in the community about the benefits of palliative care. CBPR has only recently begun to be used in palliative care research or program development; there remains a large opportunity in palliative care to use this evidence-based method to reduce demonstrated health care disparities in palliative care. Although primarily used as a research method, the principles of CBPR have strong relevance to clinical practice. For example, in designing a program to provide information to local community members about palliative care. In this session participants will gain an understanding of this exciting method and how it has been proven effective, and will understand how they too can use it so that the voices of the community they serve are heard and their ideas implemented.

Paper Sessions

Interactions Between Hospice Clinicians and Adolescents with a Parent Enrolled In Hospice Care (TH370A)

M. Mayo, ACHPN CHPN, Ursuline College, Cleveland, OH. Denice Sheehan, PhD RN, Kent State University, Kent, OH. Pam Stephenson, PhD RN AOCNS, Kent State University, Kent, OH. Kim Heim, MSN RN APRN AOCNP, Cleveland Clinic/Akron General, Tallmadge, OH. Ghada Shahrour, MSN, Kent State University, Kent, OH. Claire Draucker, PhD RN FAAN, Indiana University, Indianapolis, IN. Dana Hansen, PhD APRN ACHPN, Kent State University College of Nursing, Kent, OH.

Objectives

- Identify four ways adolescents describe their interactions with hospice clinicians.
- Cite one implication for practice.

Original Research Background. Many adolescents in the United States experience not only the death of a parent but also the stress of living in a household with a parent who is dying. Little research is published from the teens' perspective on their needs and the role of the hospice clinicians with the adolescents.

Research Objectives. To describe the ways in which adolescents and hospice clinicians interact during the time a parent is near the end of life.

Methods. Descriptive qualitative methods were used. Data were drawn from and 30 individual pre-death interviews and 9 post-death interviews with the adolescents; all were part of a larger grounded theory study on strategies to help adolescents with a parent in hospice. The transcripts were coded and analyzed using conventional content analysis techniques by an interdisciplinary research team.

Results. Drawing from 25 families, 18 daughters and 12 sons described their interactions with hospice clinicians in a variety of ways. Four categories were identified: No Interactions (n = 12), In-passing Interactions (n =6), Engaged, Interactions (n =6), and Formal Interactions (n =6).

Conclusion. The majority of adolescents did not describe a meaningful interaction with hospice clinicians. While some adolescents denied needs, many teens did not even perceive that hospice clinicians were there to support them as well as their ill parent.

Implications for research, policy or practice. In order to bridge this gap, clinicians may need to schedule visits outside the traditional work hours when teens are more likely to be at home. In addition, functional decline in the ill parent may provide clinicians an opportunity to connect with adolescents and offer support.

Weighing Distress and Benefit: Understanding the Research Participation Experiences of Bereaved Parents of Children with Medical Complexity (TH370B)

Danielle Decourcey, MD MPH, Boston Children's Hospital, Boston, MA. Melanie Silverman, MPH, Boston Children's Hospital, Boston, MA. Joanne Wolfe, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Understand the experiences of bereaved parent participating in survey based research.
- Describe factors associated with distress or benefit from the research participation experience of bereaved parents of children with medical complexity.

Original Research Background. Improving end of life (EOL) care for children with medical complexity (CMC) requires a better understanding of parent perspectives, yet tension exists around vulnerability of bereaved parent participation in research. Human subject protection committees (HSPCs) must weigh the emotional impact of research participation with potential benefits, however, studies assessing the risks and benefits of such participation for bereaved parents are lacking.

Research Objectives. To examine bereaved parent experiences during participation in a study of communication around advance care planning (ACP) and EOL care and to identify factors associated with distress or benefit from the research experience.

Methods. We surveyed 108 bereaved parents of CMC (65% response rate), who received care at Boston Children's Hospital from 2008-2015. The survey focused on communication around prognosis, ACP, and EOL care. At the end, parents were asked about their comfort, distress and benefit from survey completion.

Results. A majority of parents (78%) felt comfortable completing the survey and reported benefit associated with participation (87%). Only 4% of parents reported that participation caused "a great deal" of distress and of those reporting "a great deal of distress," 86% still found it beneficial ($p=0.05$). Gender was associated with differences in perceived benefit with 24% of males vs 4% of females ($p=0.04$) deriving "no benefit at all" from participation. Parent age, gender, religiousness, spirituality or time since child's death had no influence on distress. Parents more often reported distress when they endorsed decisional regret about their child's EOL care (OR 3.21, $p = 0.015$).

Conclusion. A majority of participating parents were able to respond to questions about their child's EOL care without significant distress, and when present, distress was often accompanied by a perception that participation was beneficial.

Implications for Research, Policy, or Practice. Parent perspectives are crucial to advance pediatric palliative care and HSPCs should be reassured that parents are willing participants and benefit from the experience.

Difficult Conversations: Telling Adolescents About a Parent's Life Limiting Illness and Death (TH370C)

Denice Sheehan, PhD RN, Kent State University, Kent, OH. M. Mayo, ACHPN CHPN, Ursuline College, Cleveland, OH. Dana Hansen, PhD ACHPN, Kent State University, Kent, OH. Pam Stephenson, PhD RN AOCNS, Kent State University, Kent, OH.

Objectives

- Describe four ways parents tell their adolescent children that a parent has a life threatening illness.
- Identify one implication for research.

Original Research Background. When a parent is diagnosed with a life limiting illness, one of the most difficult tasks facing the parents is informing their children. This study describes four ways in which parents disclose information about a parent's life limiting illness and death to their adolescent children.

Research Objectives. To explicate ways in which parents tell their adolescents about a parent's life limiting illness and death.

Methods. Descriptive qualitative methods were used. Data were drawn from and 56 individual pre-death and 15 post death interviews with hospice patients, spouses and their adolescent children; all were part of a larger grounded theory study on strategies to help adolescents with a parent in hospice. The interviews were digitally recorded and transcribed verbatim. The transcripts were coded and analyzed using conventional content analysis techniques.

Results. Parents informed adolescents about a parent's life limiting illness and imminent death in ways that were intended to ease the adolescents' distress. The parents engaged in the process of disclosure in one of four ways: measured telling; skirted telling; matter-of-fact telling; inconsistent telling.

Conclusion. The findings support a framework that describes the processes of disclosure of a parent's illness, imminent death and death to their adolescent children. Pre death findings about the ways the adolescents were informed were consistent with the post death findings.

Implications for research, policy or practice. These results can be used to inform the development of interventions in which health care professionals assist families with disclosure pre and post death by tailoring strategies according to the family's communication style.

The Benefits and Burdens of Cancer: A Prospective, Longitudinal Cohort Study of Adolescents and Young Adults (TH370D)

Joelle Straehla, MD, Boston Children's Hospital/ Dana-Farber Cancer Cent, Boston, MA. Krysta Barton, PhD MPH, Seattle Children's Research Institute, Seattle, WA. Joyce Yi-Frazier, PhD, Seattle Children's Research Institute, Seattle, WA. Scott Baker, MD MS, Fred Hutchinson Cancer Research Center, Seattle, WA. Kira Bona, MD MPH, Dana-Farber Cancer Institute, Boston, MA. Joanne Wolfe, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Abby

Rosenberg, MD MS, Seattle Children's Hospital, Seattle, WA.

Objectives

- Become familiar with the unique perspectives of coping with cancer according to adolescents and young adults (AYAs).
- Describe content of AYA patient-reported benefits and burdens of cancer, including physical distress, existential growth, and meaning-making.

Original Research Background. Adolescents and Young Adults (AYAs) with cancer are at high risk for poor health and psychosocial outcomes. Positive psychological responses such as benefit-finding may buffer the negative impacts of cancer, but they are poorly understood in this population.

Research Objectives. We aimed to prospectively describe the content and trajectory of benefit- and burden-finding among AYAs in order to develop potential targets for future intervention.

Methods. One-on-one, semi-structured interviews were conducted with English-speaking AYA patients (aged 14-25 years) within 60 days of diagnosis of a non-Central Nervous System malignancy requiring chemotherapy, 6-12, and 12-18 months later. Interviews were coded using directed content analyses with *a priori* schema defined by existing theoretical frameworks including changed sense of self, relationships, philosophy of life, and physical well-being. We compared the content, raw counts, and ratios of benefit-to-burden by patient and by time-point.

Results. Seventeen participants (mean age 17.1 years, SD=2.7) with sarcoma (n=8), acute leukemia (n=6), and lymphoma (n=3) completed 44 interviews with >100 hours of transcript-data. Twelve participated in interviews at all three time-points. Average benefit counts were higher than average burden counts at each time-point; 68% of interviews had a benefit-to-burden ratio >1. Positive changed sense of self was the most common benefit across all time-points (44% of all reported benefits); reports of physical distress were the most common burden (32%). Longitudinal analyses suggested an evolution of perceptions; over time, participants tended to focus less on physical manifestations of cancer and more on personal strengths and life purpose.

Conclusion. AYAs with cancer identify more benefits than burdens throughout their cancer treatment and demonstrate rapid maturation of perspectives.

Implications for research, policy or practice. These findings not only inform communication practices with AYAs, but also suggest opportunities for interventions to encourage additional benefit-finding and potentially improve outcomes.

Medication Changes on Discharge from Acute Care to Hospice (TH371A)

Jon Furuno, PhD, Oregon State University/Oregon Health & Science University College of Pharmacy, Portland, OR. Brie Noble, BS, Oregon State University College of Pharmacy, Portland, OR. Seiko Izumi, PhD RN, Oregon Health & Science University, Portland, OR. Kirsten Kadoyama, BA, Oregon State University College of Pharmacy, Portland, OR. Mary Lynn McPherson, PharmD BCPS CPE, University of Maryland Baltimore, Baltimore, MD. Jennifer Tjia, MD MSCE, University of Massachusetts Medical School, Worcester, MA. Carey Candrian, PhD, University of Colorado School of Medicine, Aurora, CO. Erik Fromme, MD MSCRFAAHPM, Oregon Health & Science University, Portland, OR

Objectives

- Describe the burden of medications prescribed on discharge from acute care to hospice care.
- Describe the trend in medication prescribing behavior over time for patients discharged from acute care to hospice care.
- Describe the frequency of medication changes on discharge to hospice care.

Original Research Background. The transition from acute care to hospice often requires patients, caregivers, and providers to make difficult decisions regarding continuation, discontinuation, and initiation of medications.

Research Objectives. We quantified the frequency and documentation of medication orders for patients discharged from acute care to hospice care.

Methods. This was a retrospective cohort study of adult (≥ 18 years) patients discharged directly from Oregon Health & Science University Hospital to hospice between 1/1/2010 and 3/31/2016. Data were collected from an electronic repository of medical record data. In addition, we manually reviewed a consecutive sample of 100 patient discharge summaries to quantify the frequency and documentation of medication changes. Medication changes were defined as 1) continuation of medications but changes in dose, route, or frequency, 2) discontinuation of medications, or 3) newly started medications.

Results. Among 1,499 discharges to hospice, the mean (standard deviation) number of medications patients were receiving was 7.2 (4.8) and this number increased by 0.34 mediations/year over the study period, $P < 0.001$. Review of 96 discharge summaries

(4 were excluded because of missing data) identified 1,466 medication decisions (mean=15.3 decisions per discharge summary) of which 441 (30%) were to continue medications without changes, 103 (7%) were to continue medications but with changes, 458 (31%) were to start new medications, and 464 (32%) were to discontinue existing medications. Among medications that were initiated or changed, morphine was the most frequent new medication (7%) and aspirin was the most frequently discontinued medication (5%). Only 38% of medication changes had a documented rationale for the change.

Conclusion. Medication changes are common on discharge to hospice and frequently lack documentation of the rationale for these changes.

Implications for research, policy or practice. While hospitals are under increasing pressure to discharge patients before they die, more research is needed to better understand the effect of medication changes and to ensure a smooth transition to hospice.

Characteristics of Patients Who Elect Full Resuscitation Status During Enrollment in the Medicare Hospice Benefit in Two Large Nonprofit Hospices: A Retrospective Review (TH371B)

Claire Ankuda, MPH MD, University of Michigan, Ann Arbor, MI. Evan Fonger, MD, Wayne State University, Detroit, MI. Thomas O'Neil, MD, University of Michigan, Ann Arbor, MI.

Objectives

- Describe the characteristics of individuals on hospice without DNR orders in place.
- Identify the relevance of this work to a hospice director.

Original Research Background. Some patients elect the hospice benefit and yet still do not feel comfortable signing do not resuscitate (DNR) orders.

Research Objectives. We aim to assess the characteristics of this population and as well as the association of DNR orders with hospice live discharge rates.

Methods. This was a retrospective cross-sectional analysis of medical records from two of Michigan's largest nonprofit hospices. The cohort was comprised of patients enrolled in hospice from 2009-2014. Dependent variable was the absence of DNR orders on admission. Other variables include demographics (race, sex, age), primary diagnosis, place of residence before admission, hospice length of stay and live discharge status. The demographic characteristics of hospice patients not electing DNR status were described. Multivariable logistic regression was then used to determine the association between DNR orders and live discharge status adjusting for demographic and illness characteristics.

Results. We captured 17,824 individuals admitted to hospice and completing advance directive forms. Of these, 2,862 (16.1%) did not elect DNR status. Individuals not electing DNR status compared to those who did were significantly younger (mean age 72.1, SD 17.0 vs. 79.6, SD 14.2), more likely to be male (49.7% vs. 42.3%), more likely to be African American (15.0% vs. 5.8%), more likely to have cancer (50.6% vs. 33.8%), and less likely to have dementia or frailty (19.6% vs. 25.9%).

After adjusting for all demographic and illness characteristics, individuals not electing DNR at admission to hospice had double the odds (Odds Ratio 2.01, 95% CI 1.56-2.59) of live discharge from hospice. This is equivalent to an adjusted live discharge rate of 6.1% for those with DNR orders vs 11.2% for those without.

Conclusion. Lack of DNR orders on hospice admission is highly predictive of hospice live discharge.

Implications for research, policy or practice. This presents an opportunity to prospectively identify and support this high risk population.

Hospice Visit Intensity by Physicians and Nurse Practitioners on the General Inpatient Level of Care (TH371C)

Thomas Christian, PhD, Abt Associates, Cambridge, MA. Joan Teno, MD MS, University of Washington, Seattle, WA. Pedro Gozalo, PhD, Brown University School of Public Health, Providence, RI. Michael Plotzke, PhD, Abt Associates, Cambridge, MA.

Objectives

- Describe the rate of physician or nurse practitioner services during GIP service.
- Describe episode characteristics associated with the rate of physician or nurse practitioner services during GIP service.

Original Research Background. The Medicare Hospice Benefit's General Inpatient (GIP) level of care is intended to provide for pain and symptom management in an inpatient facility that could not be managed in the patient's home.

Research Objectives. Examine how beneficiaries utilize physician and nurse practitioner services while receiving GIP care.

Methods. Retrospective cohort analysis of Medicare hospice beneficiaries utilizing GIP during Federal Fiscal Year 2014 (FY2014). Using 100% Medicare hospice and Part B claims from FY2014 we examined physician and nurse practitioner service visit intensity during GIP.

Results. We found that among the 1.5 million GIP days serviced in FY2014, the majority of days (52.4%) were not associated with any recorded physician or nurse practitioner services. Rates of the absence of these services were particularly high among hospice GIP days provided in (Acute) Inpatient Facilities (69.1% of days missing physician/ nurse practitioner services), Long-Term Care Hospitals (84.3% missing services), and Skilled Nursing Facilities (85.3% missing services). Moreover, one in five hospice episodes that have at least three days of sequential GIP care did not have any physician or nurse practitioner services recorded from either the hospice or Part B claims; this was true for more than half of such episodes beginning in long-term care hospitals or skilled nursing facilities. We found that over two-thirds of all GIP days are serviced in hospice inpatient units and that cancer was the most common primary hospice diagnosis at admission among GIP days.

Conclusion. GIP is an important component of the hospice benefit and these findings underscore a recent Office of Inspector General report finding variation in the utilization of GIP.

Implications for research, policy or practice. Further research and monitoring is needed to ensure that hospice beneficiaries are receiving adequate care regardless of their setting of care.

Discharge Patterns in Medicare Advantage vs. Fee for Service Hospice Patients (TH371D)

Joan Teno, MD MS, University of Washington, Seattle, WA. Thomas Christian, PhD, Abt Associates, Cambridge, MA. Michael Plotzke, PhD, Abt Associates, Cambridge, MA. Pedro Gozalo, PhD, Brown University School of Public Health, Providence RI.

Objectives

- Understand the current policy regarding Medicare Advantage and Hospice.
- Examine the results of analysis of 2014 Medicare data regarding discharge patterns of MA vs. FFS.

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

Research Objectives. Characterize hospice discharge patterns among MA plan members vs. fee-for-service (FFS) Medicare beneficiaries and examine whether patterns differed by the MA concentration in the Hospital Referral Region (HRR).

Methods. The patterns of live discharges (early discharges in the first 7 days, late discharges post 210 days, and burdensome transitions defined as hospice live discharge, hospital admission, then hospice readmission) between FFS and MA enrollees were examined as well as hospice length of stay among decedents in FY2014. A multivariate random effects effect model examined whether MA vs. FFS hospice patients had differential patterns of discharge.

Results. In FY2014, there were 1,212,537 hospice discharges with 335,243 MA patients having a higher unadjusted live discharge rate (15.7%) compared to 877,294 FFS hospice discharges (15.4%), though the rate did not differ after controlling for patient characteristics (AOR 1.01, 95% CI 0.99 – 1.02). MA hospice patients had lower rates of early live discharges (9.1% vs. 9.7% AOR 0.87, 95% CI 0.84-0.91) and burdensome transitions (5.0% vs. 7.7% AOR 0.61, 95% CI 0.58-0.64) but did not differ in late live discharge (AOR 0.98, 95% CI 0.96-1.01). Among decedent discharges, MA hospice patients were less likely to have a 3 day length of stay (AOR 0.95, 95% CI 0.94-0.96) or hospice stay exceeding 180 days (AOR 0.97, 95% CI 0.96-0.99). The concentration of MA patients within the HRR did not impact these results.

Conclusion. MA enrollees compared to those in FFS experience lower rates of early live discharges, early decedent discharges, and burdensome transitions. The concentration of MA hospice patients did not impact these findings.

Implications for research, policy or practice: MA patients' discharge patterns were slightly less concerning than FFS hospice patients.

Friday, February 24

7–8 am

Concurrent Sessions

Walking Across the Bridge to Nowhere: The Role of Palliative Care in the Support of Patients on ECMO (FR400)

Rachel Klinedinst, MSN CCRN CRNP, Hospital of the University of Pennsylvania, Philadelphia, PA. Nina O'Connor, MD, Hospital of the University of Pennsylvania, Philadelphia, PA. Jill Farabelli, MSW LCSW, University of Pennsylvania, Philadelphia, PA.

Objectives

- Describe the clinical indications for veno-venous (VV) and veno-arterial (VA) ECMO, as well as basic prognostication during ECMO support.
- List three common themes that emerge from the psychosocial struggles faced by families of ECMO patients.
- Explain three strategies for facilitating effective goals of care conversations with families of ECMO patients.

Extracorporeal membrane oxygenation (ECMO) is an advanced form of mechanical circulatory support for patients with severe respiratory or cardiac failure. Previously used only in the pediatric population, ECMO has evolved over the past two decades into an increasingly widespread intervention for patients of all ages. ECMO provides total cardio-pulmonary support for a period of days to weeks, with the goal of transitioning to either recovery or other advanced therapies such as VAD or transplant. Its use carries a substantial risk of serious complications, and a significant proportion of patients die after withdrawal of ECMO support.

Palliative care providers face unique challenges and opportunities in the care of ECMO patients. Because ECMO is a bridge therapy, families often experience momentous distress in the face of uncertain outcomes. This session will highlight the key role of interdisciplinary palliative care teams in providing intensive psychosocial and emotional support to families. We will discuss strategies for early palliative care involvement at initiation of ECMO, presence throughout the process of eligibility determination for advanced therapies, and support after the decision for continued medical interventions or withdrawal of life support. This session will also offer strategies for facilitating effective goals of care conversations about ECMO.

Decision-making related to ECMO often invokes ethical dilemmas. Some patients are placed emergently on ECMO during prolonged cardiac arrests, delaying the dying process and shifting the burden of decision making to family. Additionally, staff experience moral distress when ECMO is continued as a "bridge to nowhere" for patients who are not candidates for any other therapies. To close this session, we will discuss the critical role of the palliative care team in offering support for the front line clinicians who care for ECMO patients.

Advance Care Planning Billing Codes: Benefits and Barriers for Palliative Care Teams (FR401)

Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI.

Objectives

- Describe the recently established Continuing Procedural Terminology (CPT) codes for Advance Care Planning services (ACP) in the context of changing fee-for-service Medicare reimbursement.
- Summarize key benefits, barriers and considerations related to reporting advance care planning services separately through the new CPT codes.
- Develop a strategy for your providers and team to maximize the value of ACP code reporting.

Starting in January 2016, the Centers for Medicare and Medicaid Services (CMS) began making separate payment for Advance Care Planning (ACP) services delivered in the Medicare program. This decision has been widely regarded as a significant step forward to improve care for Medicare beneficiaries, and supported by the vast majority of health professional societies, patient organizations, and advocacy groups for older adults.

While this policy change is intended to encourage all health professionals to engage in advance care planning with their patients, it is particularly important to palliative care providers and teams, for whom ACP is a fundamental and very frequently delivered service. However, as palliative care teams have begun to implement strategies for reporting ACP codes, several questions have arisen, including: What are the specific requirements to report the codes? How can the codes be reported along with other evaluation and management (E/M) services? Can the codes be used to capture ACP services delivered by the entire interdisciplinary team (including those who are not usually able to bill for E/M services)? How does reimbursement through reported ACP codes compare with that via other mechanisms (i.e. time-base E/M codes and/or prolonged services codes)?

This session will focus on the key issues, benefits and considerations for palliative care professionals and teams who are reporting ACP codes. We will review the structure and purpose of the codes, the context of their reimbursement within broader payment change in the Medicare program, specifics of documentation and reporting requirements, comparative reimbursement, and mechanisms for integration into existing electronic health record platforms.

Participants will then be invited to share their own experiences with implementing ACP code reporting strategies and mechanisms. The presenter will respond, and stimulate discussion about best practices, and overcoming barriers to success.

Novel Palliative Care Delivery Mechanisms in an Increasingly Electronic World (FR402)

Bethany Rose Daubman, MD, Massachusetts General Hospital, North Billerica, MA. Leah Rosenberg, MD, Massachusetts General Hospital, Cambridge, MA. Mihir Kamdar, MD, Massachusetts General Hospital, Boston, MA.

Objectives

- Review the benefits and drawbacks of traditional vs. electronic palliative care delivery systems within the constraints of our current medical system.
- Discuss the need for unique electronic palliative care delivery systems within three major domains: peer-to-peer coaching, subspecialist-to-generalist education, and patient-to-clinician communication.
- Explore three electronic palliative care delivery systems to address each domain: electronic palliative care consultations, teleconferences, and symptom management mobile phone apps.

As the demand for palliative care exceeds the available supply of palliative care specialists, innovative delivery mechanisms are rapidly becoming a necessity. In this presentation we will discuss a variety of mechanisms that utilize technology to meet the expanding palliative care needs in our healthcare system.

Given the limited number palliative care specialists, the concept of primary palliative care is gaining traction. One delivery mechanism that could significantly augment primary palliative care education is electronic consultations. In this modality a primary care provider submits a clinical question to an expert palliative care clinician, who reviews the clinical scenario and provides written recommendations electronically. This model not only provides increased access for patients who may be unable to see a palliative care specialist due to geographical or staffing constraints, but also effects change through the broader goal of augmenting the primary palliative care skills of referring providers.

For patients in countries where palliative care education is limited, utilizing technology for teleconferences is crucial. These modalities can have far-reaching impact both for direct patient care and by providing primary palliative care education in areas where palliative care resources may be scarce.

A third type of electronic palliative care delivery consists of increased clinician-patient communication through smartphone app technology. Such technology is helpful for gathering patient-reported metrics, but also for real-time intervention to improve patient care and reduce healthcare utilization. Similar models have been used in other disease states such as congestive heart failure, and hence there could be a similar benefit in palliative care.

For each domain, we will review the relevant clinical literature, explore case studies, and discuss pilot data from our institution's experience with electronic delivery models. In doing so, our hope is that audience members will leave feeling empowered to consider development of electronic palliative care pathways at their home institutions.

Policy Opportunity: Putting Palliative Care on the Agendas of the New Administration and Congress (FR403)

Marian Grant, DNP CRNP ACHPN, The Coalition to Transform Advanced Care, Reisterstown, MD. Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Discuss the likely healthcare priorities of the new administration and how palliative care could contribute to those priorities.
- Describe the new Congress and the extent to which palliative care could become more of a priority there.
- Discuss the latest evidence on existing efforts to promote palliative and hospice care through new demonstration, delivery, and payment models.

Although it's hard to know what the results of the 2016 election will be, one thing is clear: whoever becomes President will have a new administration including new heads of agencies like Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), the National Institute of Health (NIH), etc. At the same time, there could be changes in who gets elected/re-elected to Congress. In both cases, there will be the opportunities to educate new leaders and their staff on the benefits and need for palliative care for those with serious illness.

This presentation will provide an overview of the legislative and regulatory opportunities for palliative care for 2017 going forward. Attendees will get perspective on the new administration's healthcare priorities along with suggestions on how palliative care could be positioned to help deliver those priorities. In addition, the new Congress will be analyzed and opportunities for current key palliative care legislation, e.g. the Palliative Care and Hospice Education and Training Act (PCHETA), will be reviewed.

The presentation will then include an update on the continuing work on new delivery and payment models at CMS and any potential opportunities for palliative care there. Results from the first wave of CMS demonstration models will begin to be available later in 2016 and so these will be reviewed as well. New and alternate payment systems coming out of the Medicare and CHIP Access Reauthorization Act (MACRA) will be also discussed since these will impact how future healthcare quality will be measured and paid for.

Participants will gain a better understanding of what the federal policy priorities regarding palliative care are and also how they and their professional associations and coalitions can participate in making them realities.

When Fragility Translates to Empowerment: Integrating/Embedding Palliative Care in the Neonatal Intensive Care Unit (FR404)

Pamela Rowland, MSN CRNP, Children's of Alabama, Birmingham, AL. Lynn Vaughn, MSN RN, Children's of Alabama, Birmingham, AL. Samuel Perna, DO, Children's of Alabama, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Describe integration/embedding process of Palliative Care in the Neonatal Intensive Care Unit.
- Utilize triggers based on disease/prognosis that direct consult classification.
- Describe the use of an electronic program to notify Palliative Team of patient return for outpatient visits and/or readmissions.

A family preparing for the birth of a baby often ponders a new beginning; there are thoughts of hope, wonder, and dreams of possibilities. When plans for a healthy newborn are disrupted by critical illness, a considerable amount of emotional and psychological burden is placed on parents and families in a short time frame. They are forced to reconcile their previous joyous plans to their new reality; their baby's future is now uncertain. There has been much advancement for treatments and technology in neonatal intensive care over the past several years. Parents, most who have no medical background, are now faced with the daunting task of navigating and trying to understand this strange new world of words that are difficult to pronounce, life-saving machinery, medications, and procedures. If there is ever a case for Palliative Care consult this would be that case. Often, consults are missed due to clinician misunderstandings, rotation, and time constraints.

How can Palliative Care clinicians partner with NICU teams to identify patients and families who would benefit from Palliative Care intervention? In this concurrent session, members of the Palliative Care Team will present the development and integration/embedding of Palliative Care in a high risk NICU, with plans for long term follow up and identification of neonatal palliative research endeavors.

"Be Prepared"—Clinical Applications and Practical Guidance in Developing Culturally Appropriate Advance Care Planning Tools for American Indian and Alaska Native People (FR405)

Christopher Piromalli, DO MPH, Alaska Native Tribal Health Consortium, Anchorage, AK. Lisa Marr, MD, University of New Mexico, Albuquerque, NM. Rona Johnson, BSN RN OCN, Alaska Native Medical Center, Anchorage, AK. Stacy Kelley, MPH, Alaska Native Tribal Health Consortium, Anchorage, AK.

Objectives

- Discuss the concepts of cultural humility and its applications in advance care planning with American Indian and Alaska Native People.
- Describe the use of innovative clinical tools to educate American Indian and Alaska Native patients and families on advance care planning. These tools include the use of advance care planning conversation maps, group visits and conversation guides.
- Develop a framework to educate and equip health care providers with advance care planning tools and resources for culturally diverse and underserved populations in urban and rural regions.

Alaska Native and American Indian People (AN/AI people) have diverse and rich cultural perspectives on advance care planning. There is very limited information and studies on advance care planning with AN/AI people and the approaches on how to engage in these conversations. The Alaska Native Tribal Health Consortium Palliative Care Program has developed innovative clinical tools for advance care planning that integrate concepts of cultural humility to respect the diverse traditions and cultures of AN/AI people. By incorporating the traditions of storytelling and pictures, the concepts of advance care planning are explored through the innovative use of conversation maps, group visits and conversation guides. With the integration of motivational interviewing techniques, these tools for advance care planning help to provide a culturally sensitive way to engage in these important conversations with patients and families of diverse cultural backgrounds. In addition, the Alaska Native Tribal Health Consortium Palliative Care Program has helped to integrate these advance care planning tools throughout the Alaska Tribal Health System in both rural and urban settings. Through these efforts, tools and resources have been provided to educate and equip health care providers and ancillary staff to have advance care planning conversations in a variety of settings.

8:15–10 am

Plenary Session

Redesigning the End-of-Life Experience (103)

Paul Bennett, CCO, IDEO, New York, NY. B.J. Miller, MD, Zen Hospice Project, University of San Francisco, San Francisco, CA.

Objectives

- Educate the audience about the methods and applications of Design Thinking in the Palliative Care and Patient journey.
- Engage the audience in a collaborative dialogue about new solutions in the Palliative Care Industries.
- Facilitate a conversation about ways for individuals and organizations to engage in Design Thinking.

Using the format of a moderated conversation, Dr. Miller and Mr. Bennett will cover 2 topic areas:

1. A general introduction to the practices and outcomes of Design Thinking. IDEO, where Mr. Bennett is the CCO, is the world leader in the application of Design Thinking; showcasing examples through multiple industries will hopefully enlighten the audience.
2. Dr. Miller will talk about his own experiences in the world of Palliative Care and highlight where he feels there are opportunities for the world of Design Thinking to intersect with this critical conversation.

By facilitating a conversation between the audience and the speakers, we hope to have an enlightened discussion to include everyone's ideas and we will create together a framework of tangible possibilities.

10:45–11:45 am

Concurrent Sessions

PC-FACS: Year in Review (FR410)

Donna Zhukovsky, MD FACP FAAHPM, MD Anderson Cancer Center, Houston, TX. Mellar P. Davis, MD FCCP FAAHPM, Geisinger Health System, Danville, PA.

Objectives

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

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

It's Not Alzheimers...Now What Do We Do? A Discussion on the Course and Prognosis of Non-Alzheimer's Dementias (FR411)

Priya Pinto, MBBS, Montefiore Medical Center, Bronx, NY. Allison Stark, MD MBA, Montefiore Medical Center, Bronx, NY. Mirnova Ceide, MD, Montefiore Medical Center, Bronx, NY.

Objectives

- Identify and recognize differences in dementias other than Alzheimer's.
- Prognosticate and treat symptoms of dementias other than Alzheimer's.

Dementia is not a specific disease. It's an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities. Alzheimer's accounts for 60 to 80 percent of cases. There are well over 100 causes of dementia, but the big four that make up 94 to 98 percent are Alzheimer's disease, Lewy Body Dementia (LBD), Frontotemporal dementia (FTD), and Vascular Dementia.

No treatment specifically for LBD, FTD or Parkinsons dementia exists. However, many of the newer medications are beginning to show some impact on the behavioral and motor aspects of these processes. Symptomatic treatments are available with medications developed for other disorders, such as psychiatric medications for behavioral problems or mood disorders. However, even among symptomatic treatments each diagnosis has a different risk and benefit ratio. There are no treatments for language problems. The identification of non-Alzheimer's dementias impact the advance care planning process. Some, such as LBD and FTD, progress much faster and care needs change more rapidly. Traditional hospice admission criteria do not always account for some of the differences in prognostication and progression. A multi-disciplinary approach that includes physical therapy and behavioral therapy could be beneficial to patients and their families. As dementia progresses patients require more oversight and families require more guidance and assistance. There is room for education and training of primary care providers, geriatricians and palliative care doctors to identify and better prognosticate so we can achieve better outcomes for these patients and families.

At the end of this session, through a series of case studies, providers will be better equipped to identify and manage the complex behavioral and psycho-social aspects involved in caring for these patients.

Why is No One Talking About This? Addressing Intimacy and Sexual Concerns in Patients with Serious Illness (FR412)

Renee Holder, PharmD BCPS CPE, MedStar Washington Hospital Center, Washington, DC. Anne Kelemen, ACHP-SW LICSW, MedStar Washington Hospital Center, Washington, DC. Farshid Sadeghi, MD, Arizona Urology Specialists, Scottsdale, AZ.

Objectives

- Describe the existing evidence base on intimacy and sexual symptom assessment and treatment in the palliative care population.
- Perform an intimacy and sexual symptom screening and assessment.
- Identify medical, psychological, and social issues leading to intimacy and sexual symptom concerns in patients with serious illness.

Intimacy and sexual symptoms are a common concern in patients with advanced illness. There are medical, psychological, and social causes of these concerns. The National Quality Forum (NQF) preferred practices guidelines for palliative and hospice care note, "a social assessment plan should address sexuality/intimacy." Presently, palliative care providers do not routinely address intimacy and sexual symptom concerns, leading to a dissonance between guideline recommendations and practice. Additionally intimacy and sexual symptom concerns may be underreported and undertreated. Attendees of this session will leave with an enhanced understanding of the literature regarding intimacy and sexual symptoms in the palliative care patient population. Attendees will also be able to perform a brief screening with their patients to identify intimacy and sexual symptom concerns. Furthermore, a review of sexual symptom pathophysiology and intimacy will be provided, as well as a case series to help attendees apply newly gained knowledge on screening, communication, and treatment to patient scenarios.

Hospices as Providers of Community-Based Palliative Care: Exploring the Ins and Outs (FR413)

Jeanne Twohig, ACHP-SW ACHPN ACNS AGSF ANP AOCN AOCNP C, Center to Advance Palliative Care, New York, NY. Martha Twaddle, MD HMDC FACP FAAHPM, JourneyCare, Glenview, IL. Turner West, MPH MTS, Hospice of the Bluegrass, Lexington, KY. Richelle Nugent Hooper, MSN MBA FNP-BC ACHPN, Four Seasons, Flat Rock, NC.

Objectives

- Describe why and how hospice organizations provide natural administrative homes for providing quality, cost-effective community-based palliative care services.
- Identify two viable administrative structures that hospice organizations use to differentiate the delivery of hospice services from community-based palliative care services offered by hospice organizations.
- Describe how a hospice organization offering community-based palliative care services addresses the program's operational features.

Hospice organizations across the country are expanding their services to offer palliative care programs as new business lines distinct from their hospice services. What essential aspects of planning and service delivery should hospices consider as they launch community-based palliative care programs? This session will feature representatives from three hospices who have successfully designed and are operating community-based palliative care programs: JourneyCare, a hospice in Illinois that offers home-based palliative care; Four Seasons, a large hospice in western North Carolina with divisions offering home-based, office-based, and inpatient palliative care programs; and Hospice of the Bluegrass, a hospice serving 32 counties in central, southeast, and northern Kentucky that provides consultative palliative care services to several hospitals. Borrowing from the format of a town hall meeting, the three panelists will respond to questions from a moderator and session participants to describe their organizations' models. Attendees will learn the practical ins and outs of administrative structures, staffing patterns, service differentiation, patient identification and transition, and reimbursement strategies. Guided by the structured questions of the moderator, along with the interactive dynamics of the town hall format, session participants will explore with these leaders the benefits, opportunities, and challenges their hospices experience while offering community-based palliative care as part of a hospice organization. Finally, the moderator will summarize take-home messages from the discussion for the audience.

Integration of Fur, Paws, Whiskers and Hooves into your Agency-Enhancing Patients' Lives through Pet Therapy (FR414)

Ann Roseman, MS CCLS, Hospice of the Valley, Phoenix, AZ.

Objectives

- Describe the benefits of and process to develop a pet therapy program.
- Compare and contrast Animal Assisted Activity versus Animal Assisted Therapy and therapy versus service animals.

Pet therapy is a positive opportunity to diversify the psychosocial programs that hospice and palliative care agencies offer. There is wide agreement on the benefits of pet therapy, including but not limited to:

- positive sensory stimulation
- distraction from pain, distress and agitation
- lightened mood
- facilitation of communication and movement
- lowered blood pressure
- …and more

Patients, families and staff talk about pet therapy nationally…from the research findings, to firsthand accounts, to sharing amazing stories posted on social media.

This session will discuss how to offer pet therapy as an additional integrative therapy for hospice/palliative care clients. Participants will learn how to create and maintain a pet therapy program.

People assume the first step to pet therapy is acquiring the pets. As important as this is, the many other intermediary steps such as the following will be elaborated upon in the session:

- Weigh pros and cons and decide on providing Animal Assisted Visits and/or Animal Assisted Therapy.
- Obtain budget, support, and resources from administration, volunteer services, quality/risk, infection control, employee health and other related departments.
- Write and approve policies.
- Create referral process; educate and disseminate to appropriate staff.
- Obtain or identify Volunteer Coordinator(s) to recruit, interview, orient, assign and supervise pet therapy volunteers including assurance of pet therapy specific compliance issues.
- Become informed and clear on the differences between therapy and service animals.

In lieu of creating an internal agency program, alternative community options will be discussed.

Participants will leave the session with the tools necessary to build a successful pet therapy program.

Poetry for Patients: Learning to Read Poetry with Your Colleagues, Patients and Families: A Collaborative Workshop with the Poetry Foundation (FR415)

Nora Segar, MD, Northwestern University, Chicago, IL. Joshua Hauser, MD, Northwestern and Jesse Brown VA, Chicago, IL. Katherine Litwin, MLIS, Poetry Foundation, Chicago, IL. Whitney You, MD MPH, Northwestern University, Chicago, IL.

Objectives

- Describe the 'Poetry for Patients' Project at Northwestern: Audience will be able to explain the Poetry for Patients Project as it has been implemented at our institution.
- Engage in close reading of key selected poems: Learner will demonstrate close reading of a poem in one of three main categories: City, Nature, or Health and Illness as selected and guided by staff at the Poetry Foundation. Learner will be able to discuss application of this exercise to their work with patients.
- Develop strategies for how to read and analyze poems with patients and families: Learner will be able to explain rationale for reading poetry with patients and identify how they might apply concepts presented in the workshop in their own patient care environment.

Background. While there is growing evidence that close reading of literature and reflective writing can improve providers' appreciation of the patient experience, foster physician development and combat burnout, there has been less work on the experience of reading literature with patients facing serious or life-threatening illness. Longer form reading may be unsuitable for some portions of the palliative care population, given high burden of fatigue and possible contribution of delirium. Time pressure may also preclude discussion by a practitioner working in a busy clinical context. In contrast, we feel the condensed medium of poetry presents a natural opportunity to engage patients with the medical humanities, helping them to articulate difficult or joyful experiences, and/or serving as necessary diversion when facing serious illness.

Project description. Poetry for Patients—a project developed through collaboration between Northwestern Memorial Hospital and the Poetry Foundation in Chicago, an independent literary organization committed to a vigorous presence for poetry in our culture—has developed three short collections of poems, and an accompanying discussion guide for use specifically with patients and families.

Objectives. In this workshop, we will describe our experience of reading poems with patients and families, engage in close reading of selected poems, and identify an approach to reading poems with patients in a variety of clinical settings.

Methodology. In addition to describing our experience, we will use interactive, mixed method didactics to engage participants. We will provide selected poems to participants and use a portion of the workshop space for guided close reading. We will also provide participants with discussion guides to use with patients at their own institutions and copies of the poetry collections.

Outcomes. Participants will leave the workshop with an appreciation for the therapeutic power of reading poetry and gain the skills and knowledge necessary to read poetry with their own patients.

The Who, What, Where, When, Why and How of Medical Marijuana in Pediatric Palliative Care (FR416)

Billie Winegard, MD MPH, University of Illinois at Peoria, Peoria, IL. Elissa Miller, MD, Nemours/AI DuPont Hospital for Children, Wilmington, DE. Tressia Shaw, MD, Phoenix Children's Hospital, Phoenix, AZ. Matthew Troester, DO, Barrow Neurological Institute at Phoenix Children's Hospital, Phoenix, AZ.

Objectives

- Describe the pharmacology of medical marijuana and the forms available for pediatric patients, including a discussion of key drug/drug interactions.
- Describe state laws regarding the use of medical marijuana for pediatric patients and discuss hospital policy differences at children's hospitals from different regions of the country.
- Identify the symptoms and diseases that a pediatric palliative care patient may benefit from medical marijuana use and discussed most recent evidence to support its use.

Background. Since ancient times, marijuana has been used medicinally. It became illegal in the United States in the late 1930s with the federal passage of the Marihuana Tax Act of 1937, was removed from the US Dispensatory and stripped of therapeutic legitimacy in 1942, and later was made a Schedule I drug by the Controlled Substance Act (CSA) in the 1970s. Beginning with California in 1996, many states from around the country have begun to decriminalize medical marijuana possession, and the US Department of Justice announced that medical marijuana users who had complied with state laws would not be prosecuted. An increasing number of states allow medical marijuana for pediatric patients, as well.

Discussion. There is a growing body of literature which shows benefits for palliative care patients with the use of medical marijuana. This session will provide a review of the current evidence regarding medical marijuana with a focus on its use in pediatric palliative care (PPC). Presenters will discuss eligible patients (who), forms of medical marijuana available for pediatric patients (what), an overview and comparison of state regulations and hospital policies (where), a discussion of appropriate use and timing of use (when), best evidence regarding drug/drug interactions and the risks/benefits (why) and instructions for parents on obtaining and administering medical marijuana to their minor child (how). Cases from 3 children's hospitals located in states where medical marijuana has been legalized from different regions of the United States (East coast, Midwest, and Southwest) will be used to illustrate the above.

Conclusion. As an increasing number of states legalize medical marijuana for pediatric patients, it is important that PPC providers understand its use, including the risks and benefits, so we are able to guide and counsel families appropriately.

The Professional Working Group—How to Create and Use a Process Group to Build Community, Prevent Burnout, and Make Work-Life Sustainable (FR417)

Bonnie Chen, MD, Kaiser Permanente, Oakland, CA. Juliet Jacobsen, MD, Massachusetts General Hospital, Boston, MA. Joshua Jones, MD MA, University of Pennsylvania Health System, Philadelphia, PA. Warren Lewin, MD, The Mount Sinai Hospital, New York City, NY. Jane DeLima Thomas, MD FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Erica Tuggey, MS ANP-BC, Mount Sinai Medical Center, New York, NY.

Objectives

- Recognize the domains of burnout and describe a model that predicts burnout using the gold standard Maslach Burnout Inventory scale.

- Understand how a Balint group could be adapted to the palliative care fellowship training setting to promote sustainability and prevent burnout.

Discuss models for group support and peer mentoring that can be used beyond fellowship training to (1) help participants identify work-related issues leading to burnout, (2) provide a support base to strategize ways to prevent burnout and increase engagement and sustainability.

Burnout is a psychological syndrome occurring in response to chronic interpersonal stressors affecting up to 50% of the clinician workforce, and 62% of the palliative care workforce. Left unattended, burnout leads to job dissatisfaction, workplace turnover, and increased clinician error. In order to prevent burnout, palliative care fellowship must include training related to self-care and resilience. Based on our fellowship experience, we present a resiliency-building model for fellowship training and beyond that aims to prevent burnout, foster community, and make work-life sustainable.

In this session, we will discuss the domains of burnout and describe a model that predicts risk of burnout using the Maslach Burnout Inventory scale. We will then outline palliative care fellowship core competencies related to burnout and resilience and explore how these competencies can be translated into a yearlong curriculum that promotes resilience through self-reflection and community building. In particular, we will discuss the use of a Balint group and explore how this model for physician support can be modified for palliative care clinicians in training.

Finally, we will explore the use of group process and peer-mentoring after fellowship across geographic settings to help faculty prevent burnout and increase engagement and sustainability. In our case, an interdisciplinary group of four engage in an online professional group, meeting monthly to maintain our supportive relationships, discuss complex clinical issues we are struggling with, and celebrate our professional and personal successes. We are tracking our own burnout scores to see if there is a correlation between participation in such a group and degree of stress and burnout.

The Unintended Consequences of Quality Metrics (FR418)

Christine Toevs, MD, Terre Haute Regional Hospital, Terre Haute, IN. Robert M. Taylor, MD FAAHPM, The Ohio State University, Columbus, OH. Francis L. Mueller, MD FAAFP FAAHPM, Sutter Santa Rosa Regional Medical Center, Santa Rosa, CA. Arif Kamal, MD MHS MBA FAAHPM, Duke Cancer Institute, Durham, NC.

Objectives

- Evaluate the consequences of quality metrics and the goals of Palliative Medicine.
- Examine the role of the 30-day surgical mortality metric and potential conflict with patient goals.
- Critique the role of DNR status and self-fulfilling prophecies.

Quality Metrics have been applied in many different fields and are exponentially growing in medicine and Palliative Medicine in particular. Although the intention is admirable in the desire to quantify and measure good patient care, sometimes these metrics have unintended consequences. Several areas of concern to be discussed in this session:

30-day mortality rule and surgery. Surgeons are graded on their 30-day mortality rates. Patients and families may not want to wait 30 days to withdraw life-sustaining treatment, when they perceive the burden of that treatment is too great. Surgeons are sometimes unwilling to respect family wishes, given the consequences to their careers. As a corollary, surgeons may be unwilling to operate on patients who may benefit, due to the risk of mortality.

DNR and self-fulfilling prophecies. Although DNR is designed to not attempt resuscitation once the heart stops, it is often applied as “do not treat.” Neurology and trauma have specifically documented higher mortality rates and worse patient outcomes related to the patient having a DNR order. Although the goal is to respect the patient’s and family’s wishes regarding end-of-life, there is a perception that DNR may hasten death. Furthermore, because hospitals use DNR as a way of documenting expected deaths, DNR can sometimes be used to hide poor quality care.

Metrics in Palliative Medicine. Currently there are over 300 quality metrics within the field of Palliative Medicine. However, these metrics are not prioritized and there are few guidelines for logistics of what needs to be measured, frequency, reporting, and how to measure. Specifically the quality metric of weight loss especially in nursing homes, creates conflict and a push for placement of feeding tubes at the end of life.

Paper Sessions

Characterization of Deaths Within a Free-Standing Children’s Hospital: Where Can Palliative Care Focus Their Efforts? (FR419B)

Amy Trowbridge, MD, Seattle Children’s Hospital, Seattle, WA. Jennifer Walter, MD MS PhD, University of Pennsylvania, Philadelphia, PA. Eric McConathey, BS, Children’s Hospital of Philadelphia, Philadelphia, PA. Chris Feudtner, MD MPH PhD, The Children’s Hospital of Philadelphia, Philadelphia, PA.

Objectives

- Gain a deeper understanding of current practices at the end of life in children’s hospitals.

- List several factors that may influence the characteristics of patients' end of life, and present a hypothesis on why.
- Compare data presented to their personal experience, and apply newly gained information to future research, teaching, and clinical practice.

Original Research Background. Our knowledge about the circumstances of overall in-hospital pediatric deaths is incomplete. Most published studies are either focused on neonatal or pediatric intensive care units, or rely on billing data that does not provide sufficient detail.

Research Objectives. 1.Determine frequencies of types of deaths at a free-standing children's hospital. 2.Describe patient- and hospital- level factors associated with circumstances of death.

Methods. Retrospective chart review recording demographics, diagnoses, lengths of stay, location of death, and palliative care involvement for all deceased patients at CHOP between July 2011 and June 2014. Based on review of patient charts, each patient was assigned to one of five "types" of death: failed resuscitation, withdrawal of life-sustaining therapy (WLST), non-escalation, code event followed by withdrawal, or brain death. These categories were determined using an iterative process by experts on the research team. Descriptive statistics were calculated.

Results. Sample included 579 deceased patients. Sixty percent were under one-year of age, and 49% were female. The most common locations of death were the Pediatric ICU (30%) and Neonatal ICU (32%). Withdrawal of life-sustaining therapy (WLST) was the most common type of death (40%), followed by non-escalation (25%). Failed resuscitation was most common among black patients (45%) while WLST was most common among white patents (42%). Of patients with palliative care involved (32%), they were most likely to have non-escalation (57%) and least likely to have a code event followed by withdrawal (3%).

Conclusion. In a major children's hospital most deaths occur in ICUs. Race and whether palliative care were involved may affect the manner of a child death.

Implications for research, policy or practice. Although improvements have been made regarding pediatric in-hospital end of life care, further opportunities for improvement clearly exist and should be pursued.

Pediatric Cardiologist Attitudes About Palliative Care (FR419C)

Emily Balkin, MD, University of California San Francisco, San Francisco, CA. Joanne Wolfe, MD MPH FAAHPM, Dana-Farber Cancer Institute, Boston, MA. James Kirkpatrick, MD, University of Washington, Seattle, WA. Keith Swetz, MD MA FACP FAAHPM, University of Alabama at Birmingham, Birmingham, AL. Elizabeth Blume, MD, Boston Children's Hospital, Boston, MA. Beth Kaufman, MD, Lucile Packard Children's Hospital Stanford, Palo Alto, CA.

Objectives

- Describe the current attitudes of pediatric cardiologists and cardiac surgeons towards palliative care for children with heart disease.
- Identify perceived barriers to palliative care consultation for children with heart disease.

Original Research Background. As availability of palliative care (PC) consultation for children with advanced heart disease (AHD) increases, little is known about pediatric cardiologist attitudes towards PC.

Research Objectives. To describe perspectives of cardiologists regarding PC for children with AHD.

Methods. Cross-sectional email-based survey of pediatric cardiologists from 18 pediatric medical centers in June 2016.

Results. 122 physicians completed the survey (27% response rate). Respondents had a median of 19 years of experience since medical school graduation (range 7-49) and most practiced at academic medical centers (89%). Thirty-two percent reported having received formal didactic training in PC and 20% reported having received didactic training in caring for children with AHD at end-of-life. Fifty-nine percent of respondents felt that PC consultations occur "too late;" yet, a large majority (89%) "strongly agreed" or "agreed" that PC consultations are helpful. Barriers to requesting PC consultation were "few" to "somewhat" common (72%) frequently described as, "referring to PC services too early will undermine the parents' hope" (46%) and "concern that parents will think I am giving up on their child" (58%). Only 33% of cardiologists reported feeling "very" competent in caring for a child with AHD at end-of-life, while 34% felt "moderately," 21% "somewhat," and 13% "a little" or "not at all" prepared.

Conclusion. Pediatric cardiologists report that PC consultations for their patients are helpful but tend to occur too late. Perceived barriers to PC consultation include concern that PC services will undermine parental hope and suggest that physicians are giving up. Perceived competency in caring for patients at end-of-life varies.

Implications for research, policy or practice. Research is needed to define ways to facilitate earlier PC consultation for children with AHD and overcome the perception that PC is incongruent with life-sustaining care. Understanding the attitudes of cardiologists and perceived barriers to PC involvement will help inform future research and educational efforts.

Lasting Legacy: Maternal Perspectives on Perinatal Palliative Care (FR419D)

Heidi Kamrath, DO FAAP, University of Minnesota, Minneapolis, MN. Susan O'Conner-Von, PhD RN-BC CHPPN, University of Minnesota, Minneapolis, MN. Jennifer Needle, MD MPH, University of Minnesota, Minneapolis, MN. Erin Osterholm, MD, University of Minnesota, Minneapolis, MN. Thomas George, MD, University of Minnesota, Minneapolis, MN. Rachael Stover-Haney, MSW LICSW, University of Minnesota Masonic Children's Hospital, Minneapolis, MN.

Objectives

- Identify themes important to women offered perinatal palliative care during pregnancy.
- Identify practice change opportunities based on the themes identified.

Original Research Background. Many life-limiting conditions can be diagnosed prenatally which allows for perinatal palliative care planning as an option. This study is one of the first to explore the maternal experience of receiving a life-limiting diagnosis during pregnancy.

Research Objectives. The aim of this project is to explore the maternal perspective after being offered perinatal palliative care following the prenatal diagnosis of a life-limiting diagnosis for their fetus.

Methods. In a prior retrospective chart review, our group identified 27 mothers who were offered perinatal palliative care, 18 chose perinatal palliative care and 9 did not. In this mixed methods study, these women were invited to take part in focus groups or interviews as well as complete a survey on prenatal and infant end of life care and the validated Complicated Grief Assessment. Focus group and interview text analysis were simultaneous and continuous. In addition to investigator analysis, ALTAS-TI software was utilized.

Results. Of the 27 participants invited, 5 participated in a focus group and 2 completed phone interviews. Focus group and interview text analysis identified several main themes including the importance of comprehensive care, normalization of experience and legacy formation.

Conclusion and Implications for Practice. This novel study identifies common themes among mothers who contemplated perinatal palliative care during pregnancy from which important implications for practice are described. The theme of care incorporates participant appreciation for expert care and empathy as well as the strong recommendation from study participants that medical professionals provide accurate resources as early as possible and stop using the terminology "incompatible with life". Additionally, the health care team can promote a positive experience by identifying opportunities for normalization of prenatal and newborn care. Finally, the importance of legacy formation was a strong theme which was unique in expression between study participants including but not limited to rituals, research participation and value of the child's life beyond time.

The Discussion to Ensure the Patient-Centered, Health-Focused, Prognosis-Appropriate, and Rational Medication Regimen (DE-PHARM) Quality Improvement Project—Rational Deprescribing in Residents with Life-Limiting Illness (FR420A)

Jennifer Pruskowski, PharmD, University of Pittsburgh School of Pharmacy, Pittsburgh, PA. Steven Handler, MD PhD, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Discuss the current dilemma of potentially inappropriate medications for patients with life-limiting illnesses.
- Introduce one model for the implementation of de-prescribing.

Background. There are many evidence-based guidelines for the initiations of medications, however few to discontinue. This unbalanced equation leaves many potentially inappropriate medications, or polypharmacy, in patients with life-limiting illnesses. The Discussion to Ensure the Patient-centered, Health-focused, prognosis-Appropriate, and Rational Medication regimen (DE-PHARM) quality improvement project is the first palliative care clinical pharmacist driven de-prescribing model for long-term care residents.

Objective. The objective of this study was to de-prescribe medications via accepted recommendations from clinicians.

Methods. This is a UPMC Quality Assurance/Performance Improvement (QAPI) board approved project. Phase I of this project occurred between October 2015 and March 2016. To be eligible for this project, residents had to be residing in the UPMC Heritage Place Senior Community, receiving long-term (custodial care), and had previously noted a comfort-focused treatment plan (defined as a POLST designation of DNR/DNI and either CMO or LAI). The palliative care clinical pharmacist then completed an extensive chart review, incorporating the Holmes' model for rational prescribing, and extrapolation of current evidence-based literature, to target medications for de-prescribing. Recommendations were sent to clinicians via email with a desired 120 day response time.

Results. There were 47 residents that met inclusion criteria. Most were female (N=43, 88%), were a mean age of 87.5 years. Seventy-two (72%) of residents were diagnosed with dementia. On averages residents has a total of 9.63 scheduled medications, and 5.38 as needed medications. Thirty-nine recommendations were given by the palliative care clinical pharmacist (range of 0-5/patient). Ten (26%) of recommendations were accepted, while 19 (38%) were not responded to and 3 (7%) recommendations were rejected.

Conclusion. The DE-PHARM may be a feasible, palliative care clinical pharmacist driven, de-prescribing model for patients with life-limiting illnesses.

Implications for Practice, Policy and Research. There is a need to develop formal de-prescribing models to reduce potentially inappropriate medications to improve a patient's quality of life and care.

Ten Year Review of Intravenous Ketamine in the Treatment of Cancer-Related Pain (FR420B)

Jessica Goldberg, MSN MS NP, Memorial Sloan Kettering Cancer Center, New York, NY. Jason Meadows, MD, Memorial Sloan-Kettering Cancer Center, New York, NY. Lauren Koranteng, PharmD, Memorial Sloan-Kettering Cancer Center, New York, NY. Natalie Moryl, MD, Memorial Sloan Kettering Cancer Center, New York, NY.

Objectives

- Articulate the role of Ketamine in the management of cancer-related pain in an opioid-tolerant patient.
- Evaluate the effectiveness and safety of Ketamine as a co-analgesic in treating cancer-related pain.

Original Research Background. Ketamine can be used as an analgesic for severe cancer pain when opioid side effects preclude dose escalation and other analgesics are not effective or are contraindicated. The effectiveness and tolerability of Ketamine in cancer patients has not been consistently demonstrated in the literature.

Research Objectives. Therefore, we conducted a retrospective review of the use of Ketamine infusions at our institution over the past ten years to identify its effects on opioid requirements, pain control, and reported side effects.

Methods. From 2004 to 2014, Ketamine was used in the inpatient population in 201 cases. Of these, a total of 157 patients had admissions where they received intravenous (IV) Ketamine infusions at sub-anesthetic doses as an adjunct to opioid pain management for acute and chronic cancer-related pain. Demographic information, clinical variables, and patient outcomes were abstracted from the records.

Results. The median starting dose of Ketamine was 2mg/hr (range 1-4mg/hr) and the median ending dose was 12mg/hr (range 2-24mg/hr). Patients were treated with ketamine for a median of seven days (range 1-18 days). The median opioid dose prior to initiating Ketamine was 532mg Morphine equivalent (IVME) (range 45-9420mg IVME) and after completion was 288mg IVME (range 10-3699mg IVME). The median numeric pain scores before and after Ketamine infusion were not significantly different (7 vs 6). Ketamine was largely well tolerated, and the most commonly reported side effect was hallucinations.

Conclusion. Patients who received Ketamine in our cancer center had severe pain despite receiving high dose opioids (22 mg IVME/h). In this population of patients with intractable cancer pain, the addition of Ketamine was associated with 46% opioid dose reduction with some improvement in analgesia.

Implications for research, policy or practice. Further research into the appropriate use of Ketamine in this population is warranted.

Pilot Study of Minocycline for the Prevention of Paclitaxel-Associated Neuropathy: ACCRU RU221408I (FR420C)

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Objectives

- Understand the results of this pilot study of minocycline for the prevention of P-APS and CIPN.
- Gain knowledge of the potential effect of minocycline for prevention of fatigue in patients treated with paclitaxel.

Original Research Background. Paclitaxel is associated with both an acute pain syndrome (P-APS) and chronic chemotherapy-induced peripheral neuropathy (CIPN). Preliminary animal data suggest that minocycline may be effective for the prevention of chemotherapy-induced neurotoxicity.

Research Objectives. The primary goal of this study was to obtain pilot data regarding the possible effect of minocycline on the prevention of paclitaxel-induced CIPN and P-APS, to determine if conducting a larger phase III placebo-controlled trial was indicated.

Methods. Patients with breast cancer were enrolled prior to initiating neoadjuvant or adjuvant weekly paclitaxel for 12 weeks. They were randomized to receive minocycline 200mg on day 1 followed by 100mg twice daily or a placebo, with the same dosing schedule. Patients completed 1) an acute pain syndrome questionnaire daily during chemotherapy, and 2) the EORTC QLQ-CIPN20 questionnaire at baseline, prior to each dose of paclitaxel, and monthly for 6 months post treatment. Scores obtained from patient questionnaires were converted to a 0-100 scale, where higher scores = better quality of life.

Results. Forty-seven patients were randomized, 45 of which were evaluable, with a mean age of 55. There were no remarkable differences noted between the two groups for the overall sensory score of the EORTC-CIPN 20 or its individual sub-questions, which evaluated tingling, numbness, or shooting burning pain in hands and feet. However, there was a significant difference in the daily average AUC pain score attributed to P-APS, favoring minocycline (median 96.0 vs 84.3; p=0.02). Correspondingly, patients receiving minocycline used less opioid pain medications for control of P-APS (0% vs 23%, P=0.05). Not only were no increased toxicities reported with minocycline, but there was an apparent improvement in fatigue (median AUC 76.7 vs 59.0; P= 0.02).

Conclusion. Based on the results of this pilot study, minocycline did not appear to be beneficial for the prevention of CIPN, but did look promising for reducing P-APS. Further study of this effect maybe warranted.

Evaluation of QTc Interval Prolongation Among Cancer Patients Using Oral Methadone (FR420D)

Amanda Lovell Optum Hospice Pharmacy Services, Dublin, OH. Bridget McCrate Protus, PharmD CGP CDP, Optum Hospice Pharmacy Services, Dublin, OH. Amber Hartman, PharmD, The Ohio State University Wexner Medical Center, Columbus, OH. Maureen Saphire, PharmD, Optum Hospice Pharmacy Services, Dublin, OH.

Objectives

- Describe the incidence of QTc prolongation in cancer patients taking oral methadone.
- Discuss the effect of increasing methadone doses on QTc prolongation in cancer patients.

Original Research Background. Methadone's effect on QTc in cancer pain patients is not well known. The lone published study may not represent all palliative prescribing patterns.

Research Objectives. The objective of this study is to describe and characterize the effect of low-, moderate-, and high-dose methadone on QTc in cancer patients.

Methods. This retrospective cohort study was exempt from IRB. Cancer patients with an order for enteral methadone over a 27-month period were included. Participants were divided into three methadone daily dose groups: <30mg (low-dose), 30 to 59mg (moderate-dose), >60mg (high-dose). Primary outcome was the incidence of QTc prolongation in each group. Secondary outcomes included change in QTc from baseline to study electrocardiogram (ECG), incidence of clinically significant QTc prolongation (> 500ms), and prevalence of adverse cardiac outcomes including Torsades de Pointes.

Results. A total of 203 of 430 met the inclusion criteria for the study; low-dose: 91 patients (45%), moderate-dose: 52 (26%), and high-dose: 60 (29%). Incidence of QTc prolongation for low-, moderate-, and high-dose groups was 50 (55%), 37 (71%), and 43 (72%), respectively (p=0.039). Incidence of clinically significant QTc prolongation was 10 (11%), 4 (8%), and 7 (12%) for low-, moderate-, and high-dose groups. Median change in QTc interval from baseline to study ECG for low-, moderate-, and high-dose groups was 6ms, 18ms, 14.5ms, respectively (p=0.068). Sixty-two percent of patients in the moderate-dose group and 67% of patients in the high-dose group without QTc prolongation at baseline had QTc prolongation at study ECG.

Conclusion. Our data suggest there may be a higher incidence of QTc prolongation in patients using oral methadone in the cancer population than previously defined in the literature.

Implications for research, policy or practice: Further studies are needed to determine risk of adverse cardiac effects in the cancer population and determine appropriate use and monitoring of methadone for pain management.

1:30–2:30 pm

Concurrent Sessions

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

Cornelius Huwa, MBBS Mphill PallMed PGDip PallMed HIVFe, Palliative Care Support Trust, Malawi, Africa. Seema Mishra, MD, AIIMS, New Deli, India. Mohammad Shahinur Kabir, MBBS MPH Dip

PallMed, Hospice Bangladesh Limited, Mohammadpur, Bangladesh. Ahmad Mustafa Mehran, MD, Wazir Mohammad Akbar Khan Hospital, Kabul, Afghanistan.

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 the POLST Paradigm to Honor Patient Wishes Across the Care Continuum: Presenting a Comprehensive Toolkit Designed to Help Health Care Professionals and Facilities Implement the POLST Paradigm (FR431)

Amy Vandenbroucke, JD, National POLST Paradigm, Portland, OR. Patricia Bomba, MD BA FACP, Lifetime HealthCare Companies, Rochester, NY. Kathryn Borgenicht, MD HMDC, Bozeman Health Hospital, Bozeman, MT.

Objectives

- Review advance care planning and define the differences between advance directives and the POLST Paradigm.
- Identify challenges to POLST Paradigm implementation in nursing home, hospice, primary care offices and hospitals.
- Illustrate appropriate clinician training, public education, policies and procedures in nursing homes, hospice and primary care offices to ensure patient POLST Paradigm orders are elicited, known and honored.

A key recommendation from the Institute of Medicine's (IOM) Report *Dying in America* is to "encourage states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements." The National POLST Paradigm sets those core requirements and works to ensure that individuals with serious advanced illness or frailty not only have access to POLST Paradigm forms but to professionals who understand the value of POLST and are trained to have meaningful goals of care conversations to elicit and document patient treatment wishes properly on a POLST Paradigm form, as well as professionals who will honor them.

Since its inception in 1994, the POLST Paradigm has grown exponentially and now exists, at some level, in 49 states, creating an intense need for education and resources to help facilities and professionals appropriately use POLST Paradigm Forms. Used appropriately, these actionable medical order forms potentially avoid unwanted hospitalizations and emergency department visits and achieves the triple aim. Patients have peace of mind that their wishes are known and will be honored during a medical emergency.

In this concurrent session, a toolkit created in partnership with the Pew Charitable Trusts will be presented. Using POLST to Honor Patient Wishes Across the Care Continuum will help facilities implement the Paradigm by addressing the needs of specific patient populations and professionals in primary care offices, hospitals, nursing homes and hospice facilities. In addition to educating about the benefits and value of the POLST Paradigm (including how it differs and complements advance directives as well as how it fits within advance care planning), the toolkit provides setting-specific resources for POLST Paradigm implementation to address the specific needs of implementing POLST in different types of care facilities.

Joining Forces with Geriatrics: Palliative Care Initiatives in the HRSA Geriatric Workforce Enhancement Program, Collaborating to Lead Change (FR432)

Maura J. Brennan, MD HMDC FAAHPM, Baystate Health, Springfield, MA. Ana Tuya Fulton Care New England Health Systems, Providence, RI. Shaida Talebreza, MD HMDC FAAHPM, University of Utah, Salt Lake City, UT. Delores Thomas-Rodriguez, RN CHPN, BVNAH, Springfield, MA.

Objectives

- Select one or more of the geriatrics-palliative collaborative models of care discussed in the session to adapt and try following return home within 6 months.
- Choose one or more educational programs/tools to adapt and apply within 6 months after return home from the annual meeting.

Palliative Care and Geriatrics share a holistic, patient-centered approach; both care for vulnerable patients/families, work in interprofessional teams and struggle in a "fee for service" world. Most palliative care patients are older; geriatric patients are often in their last years of life and frequently frail and suffering. Geriatricians will fail without excellent palliative care skills; palliative care clinicians will be unable to fully support their older patients without a solid grasp of geriatrics. Clearly, the two specialties need to collaborate closely educationally, clinically and in leading system's change.

In June 2015, HRSA awarded $37.5 million over 3 years to 44 new Geriatrics Education Centers across the nation. The overarching goal is to improve the care of elders by better incorporating geriatrics practices into primary care while simultaneously developing the interprofessional work force. Securing community engagement and meeting the needs of disadvantaged patients and those with dementia are key themes. Over 1/3 of successful GWEP applicants have incorporated palliative care educational and clinical initiatives into their projects. This will be the only major federal funding for geriatrics in the coming years; it is critical to leverage this opportunity and learn from this experience. Thus far, the GWEP roll out has received little attention within the palliative care field.

This session will explore the full range of palliative GWEP initiatives. The moderator will introduce the background to the GWEP geriatrics-palliative care collaborations and panelists will briefly describe current projects in several categories while identifying target learners, sites of care, clinical/educational methods and special patient populations. Attendees will then rotate freely among breakout tables exploring projects devoted to: nursing home care, curricular innovations, patients with dementia, home/hospice care and primary care/community initiatives. Attendees will plan how to apply these new models to better collaborate with geriatrics colleagues back in their home institutions.

Building Our Future by Mentoring One Another (FR433)

Donna Zhukovsky, MD FACP FAAHPM, MD Anderson Cancer Center, Houston, TX. Eduardo Bruera, MD FAAHPM, MD Anderson Cancer Center, Houston, TX. Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY. Gary Rodin, MD, Princess Margaret Cancer Centre, Toronto, ON.

Objectives

- Identify the multiple areas in which mentoring can play a role in the development of hospice and palliative medicine.
- Differentiate among the roles that mentors, sponsors and coaches can play in professional, team and program development.
- Describe how individuals can access mentors and the mutual benefits that mentors and mentees can derive from a mentor-mentee relationship.

The field of palliative care is taking traction in mainstream medicine, with a growing role to play in patient care. Critical to narrowing the widening gap between workforce shortage and projected demand for hospice and palliative medicine providers is expanded access to and engagement in education and training. There are many challenges to meeting the educational needs of learners, including the diversity of professional backgrounds and experience of those involved, relative youth of the field, multiplicity of career paths prior to engaging in hospice and palliative medicine, varied care settings and population needs, function as an effective team member, cultural differences and the intricacies of teaching the human dimension of care. Despite the broad range and variation of these challenges, they all relate to individuals—those who led the way, those currently at the forefront and the myriad doing our daily work.

In this interactive session, we will take a broad look at the role of mentoring in the development of our field. The panelists, two medical oncologists, a geriatrician and a psychiatrist, all experienced palliative care clinicians, will start with a discussion of the different roles that mentors, coaches and sponsors play in professional, team and program development. Panelists, who combined have a broad mentorship experience in clinical care, program development, research, public policy and resiliency, will offer their perspectives on what makes a good mentor-mentee relationship, mutual benefits of mentoring for the mentor and mentee and how to "get the most" from your relationship. There will be ample time for discussion among session participants and panel members. By the end of the session, it is anticipated that participants will have an improved understanding of the role that mentorship can play in professional development, ways to access local and distant mentors and the mutual benefits of mentoring.

Who Let the Dogs IN: Helping our Four Legged Friends Visit at the Bedside (FR434)

Rodney Tucker, MD MMM FAAHPM, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL. Ashley Nichols, MD, University of Alabama at Birmingham Hospital, Birmingham, AL. Paul Tatum, MD CMD AGSF MSPh FAAHPM, University of Missouri, Columbia, MO. Elizabeth Byrd, MSN RN CCNS, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Articulate the benefits of allowing pet companions to visit loved ones in palliative care inpatient settings.

- Describe the necessary steps to ensure compliance with infectious control barriers that may impede allowing pet visitors to be with patients and families.
- Review a set of best case examples from other institutions with formal pet visitor policies.

With the increasing number of inpatient palliative and hospice units housed within the walls of acute care and skilled nursing facilities, it is an increasingly common request and practice to allow patient or family pets to visit at the bedside of a loved one. Many facilities have relationships with organizations that have trained pet therapy or visitor groups that comply with necessary training and regulation; however, these visits do not replace the loving relationships that many of our patients have with their own animal family members. In inpatient acute care settings, there are multiple considerations that can become barriers to allowing patients to have their pets visit, such as infectious disease protocols, potential allergies or fear of animals on the part of staff, issues to address pet hygiene, etc. This session will focus on an increasingly common issue facing hospitals and palliative care programs as we move toward more patient and family centered care. Presenters will provide a review of the evidence that supports use of pets in the healthcare setting as well as materials from over 10 institutions' policies and procedures for the audience, presenting it in a usable and entertaining format. Strategies to advocate for pet visitation polices that led to administrative buy-in and culture change will be discussed.

Caring for our Tiniest Patients: Taking the Latest Research in Perinatal Palliative Care to Practical Clinical Applications (FR435)

Erin Denney-Koelsch, MD FAAHPM, University of Rochester, Rochester, NY. Charlotte Wool, PhD RN, York College of Pennsylvania, York, PA.

Objectives

- Describe the methods of a comprehensive literature review.
- Describe needs of parents in the setting of lethal fetal diagnoses.
- Describe what is known about Perinatal Palliative Care Programs in the US.

Compared to other areas of research in palliative care, the literature on perinatal palliative care (PPC) is sparse, but slowly growing. Some important developments have occurred since the most recent State of the Science, published in Wool, 2013. PPC programs are increasing in number (over 200 worldwide), though wide variation exists in setting, composition, and services, and there is little to guide programs in what is standard practice and quality care. The authors will report on a thorough literature search from 2013-2016, presenting high quality studies that add to the 2013 State of the Science.

We will also present major findings of one author's qualitative study that sought to understand parents' experiences of pregnancy with a lethal fetal diagnosis and parents' needs from the health care system.

We will also present major findings from the authors' work, including the only survey of PPC programs in the US, which reviewed structure, processes and outcome measures, and assessed how these aligned with the National Consensus Project domains of care. We surveyed PPC program representatives from 30 states (n=75), using an online cross-sectional survey design. We found that 70% of programs are <10 years old. Programs vary widely in setting (academic medical centers, regional or community hospitals, local hospices, or community based organizations), programmatic structure, and outcome measures. Formal quality assessment measures are present in only 38% of programs. Nonetheless, program responses revealed a consistent and pervasive philosophy of patient-centered care.

The authors will synthesize the results of these recent studies and the review of recent literature to offer both provider- and system-level recommendations for practical clinical applications, and share with the audience a table of recommendations to take home to their own programs.

Planning Advance Care Together: Implementing Advance Care Planning Practices Across an Academic Medical Center (FR436)

Erik Fromme, MD MSCRFAAHPM, Oregon Health & Science University, Portland, OR. Seiko Izumi, PhD RN, Oregon Health & Science University, Portland, OR. Matthew Diveronica, MD, Oregon Health & Science University and VA Portland Health Care System, Portland, OR. Ellen Distefano, MN RN CEN, Oregon Health & Science University, Portland, OR.

Objectives

- Describe barriers and facilitators to implementing advance care planning practices in a large academic medical center.
- Discuss strategies to implement advance care planning practices in a large academic medical center engaging all team members from various disciplinary background, roles and functions.
- Discuss how to promote cultural shift incorporating advance care planning into the routine practice of every healthcare provider.

Despite the increasing awareness about the importance of advance care planning (ACP) in public and among healthcare providers, challenges to making ACP routine practice persist. This institution-wide initiative to implement ACP for all patients has become our academic medical center's top quality improvement priority. Challenges the initiative's steering group has faced include 1) reluctance of clinicians to embrace ACP in their practice because of their confusion or misunderstanding about ACP, and 2) different views, needs, and practice patterns associated with ACP among clinicians and staff in various disciplines, departments, and units. We employed a multipronged strategy to disseminate ACP practice targeting a variety of clinician groups and units based on their interest, needs, and practice patterns. One of the learnings that guided our approaches is that ACP must be a team effort. Educating and expecting one profession to practice all aspects of ACP is neither effective nor sustainable. Each healthcare team member who touches the patient in various stage of illness (including primary care providers, specialists, hospitalists, intensivists, nurses, social workers, and medical assistants in outpatient clinics and hospitals) can play a role in facilitating ACP. We have used different approaches tailored to different clinician groups and units depending on the workflow and function of the clinician in a particular setting. In this concurrent session, we will describe models and tools we developed to clarify confusion, facilitate shared understanding, and communicate about ACP within the healthcare team and patients and families. We will also share our experiences and lessons learned from specific approaches we employed for different target groups (e.g., residents, attending physicians, nurses, social workers, medical assistants).

The Future is Now: Overcoming Billing and Other Financial Challenges in Inpatient and Outpatient Palliative Care (FR437)

Christopher Jones, MD FAAHPM, Main Line Palliative Care, Radnor, PA. Arif Kamal, MD MHS MBA FAAHPM, Duke Cancer Institute, Durham, NC. Jean Acevedo, CHC CPC LHRM CENTC, Acevedo Consulting Inc., Delray Beach, FL. Janet Bull, MD HMDC FAAHPM, Four Seasons, Flat Rock, NC.

Objectives

- Discuss how the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will impact Palliative Care program revenues through implementation of Merit-Based Incentive Payments (MIPS) and Alternative Payment Models (APMs).
- Describe 5 common misunderstandings palliative care clinicians have of clinical reimbursement for Medicare patients.
- Describe when and how to use Advance Care Planning (ACP) codes.

Palliative Care (PC) programs are flourishing nationally, buoyed by a change in healthcare reimbursement models away from volume-driven fee-for-service care and toward payment for value. Under a value-based system, cost avoidance, sometimes a byproduct of care focused on patients' goals, values, and preferences, no longer represents lost revenue to organizations. Unfortunately, cost avoidance is invisible on a balance sheet and clinical revenues are receiving more scrutiny as health systems tighten their fiscal belts. To survive, PC programs must reach for opportunities to maximize revenue within the current reimbursement system to limit health system or hospice program subsidies.

How can PC clinicians understand the complex world of healthcare billing and financing? In this interactive, concurrent session, our group of PC clinicians and a nationally-recognized PC billing and coding expert will integrate four articles we have written around the Business of PC. After gathering audience members' challenges with billing and coding in HPM, we will offer background on the current and future healthcare reimbursement environment and focus on changes, like MIPS and APMs, coming in the next 3 years due to MACRA. Our session will then turn to program level opportunities we have encountered while consulting with dozens of PC programs in the last 2 decades, sharing 10 straightforward tips to eliminate errors made in the inpatient and outpatient PC settings. Advance Care Planning codes will be thoroughly discussed as these represent a significant new revenue source that dovetails perfectly with the work of PC clinicians, allowing non-provider members of the IDT to be reimbursed for care.

Upon completion of the session, participants will be better able to navigate payment changes coming in the future, remedy billing and coding mistakes common in today's practice, and implement or fine-tune new methods of clinical revenue generation to ensure their programs' ongoing financial health.

I Can't Stop the Dancing: Management of Restless Leg Syndrome in Hospice Care (FR438)

Martina Meier, MD, Providence TrinityCare Hospice, Los Angeles, CA. Mary Lynn McPherson, PharmD BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Eric Prommer, MD HMDC FAAHPM, Greater Los Angeles Healthcare, Los Angeles, CA. Jessica Besbris, MD, Cedars-Sinai Medical Center, Los Angeles, CA.

Objectives

- Discuss how to evaluate the patient with restless leg syndrome.

- Discuss how to use a wide variety of analgesics in restless leg syndrome.
- Identify the augmentation syndrome in the restless leg syndrome.

Restless legs syndrome (RLS), also referred to as Willis-Ekbom disease (WED), is a chronic neurological disorder that is lifelong, distressing and unfortunately becomes a frustrating symptom in patients with advanced illness. RLS is a circadian disorder of sensory-motor integration manifested by an urge or a need to move the limbs to stop unpleasant sensations in the evening or while at rest. Consisting of specific diagnostic criteria, symptoms usually occur in the legs, but can become generalized. As the disease worsens, the circadian pattern can be overridden and symptoms may be present 24 hours a day (augmentation). RLS is found in many diseases encountered by the palliative care physician including renal failure and Parkinson's disease. Iron dysregulation plays a role in its pathogenesis. The impact of RLS on sleep, particularly sleep-onset insomnia, contributes to the overall adverse impact on quality of life, often leading to serious psychosocial impairment. Disturbed sleep is usually the primary reason a patient seeks medical attention. Additionally, there is also a strong association between untreated RLS and depression. Therapy includes pharmacologic approaches and preventive measures as well as a wide variety of drug therapies including dopamine agonists, calcium channel alpha-2-delta ($\alpha2\delta$) ligands, opioids and even iron therapy. Augmentation or worsening of symptoms can occur and must be recognized. Loss of medication effectiveness occurs. A multidisciplinary team of pharmacists, neurologists and palliative care specialists will enable the attendees to become proficient in the management of this troublesome syndrome.

The session will enable attendees to

1.) Efficiently evaluate the patient with RLS;
2.) Understand proper dosing and scheduling of medications;
3.) Recognize and manage augmentation and loss of medication efficacy.
4.) Treat insomnia associated with RLS and
5.) Recognize other analgesic approaches in refractory cases. An algorithm for treatment will be presented.

Compassion, Resiliency, and Hope: Nurturing Our Innate Qualities Through Contemplative Practices (FR439)

Lucille Marchand, MD BSN FAAHPM, University of Washington, Seattle, WA. Kevin Dieter, MD FAAHPM, Hospice of the Western Reserve, Cleveland, OH.

Objectives

- Distinguish the innate qualities of compassion, resiliency and hope, and what separates us from these qualities, giving rise to burnout, compassion fatigue and hopelessness.
- Describe practical and effective contemplative and self-reflective practices that connect us to our innate qualities and help us be more resilient in the face of overwhelming challenges and emotions.
- Complete 3 brief exercises including mindfulness, breath work and a self-reflective writing/storytelling exercise that help connect us to our resilience, compassion and hope in challenging situations.

Burnout, compassion fatigue and hopelessness are important issues facing our palliative care clinicians at all levels of training and practice. Compassion, resiliency and hope are innate qualities, which are nurtured through mindfulness, and contemplative and self-reflective practices. The arts and humanities create a safe space for our emotions to be expressed and understood. Without the nurturance of our innate qualities that give us deep satisfaction and meaning in our work, clinicians become increasingly vulnerable to emotional exhaustion. Working with our own and others grief and loss are a critical component of healthy PC teams and practitioners. Palliative care is demanding. What are the practices that are effective yet practical in our busy practices? Burnout alone, in a recent study, affected 62% of PC physicians. This session will discuss what conditions disconnect us from our innate qualities that called us to palliative care. What is the nature of our calling to PC service? What sustains us in challenging times? How do we care for ourselves when emotions feel overwhelming? What new practices can we incorporate into our daily lives to nurture and sustain us? This session will explore the nature of calling, our innate qualities, what disconnects us from our true selves, how narrative medicine connects us to relationship and meaning, how we can promote healthy emotions, and how mindfulness and self-reflective practices help us connect to our deepest selves and others so that resiliency, compassion and hopefulness are our predominant state of being.

Paper Sessions

Is Symptom Burden Associated with Advanced Care Planning in Individuals Who Die of Cardiovascular Disease? (FR440A)

Joy Goebel, PhD MN RN, California State University Long Beach, Long Beach, CA. Olga Korosteleva, PhD, California State University, Long Beach, CA. Elizabeth Ortega, MS, California State University, Long

Beach, Long Beach, CA. Yemisrach Lodebo, MSc, California State University Long Beach, Long Beach, CA. Timothy Manning, MS, California State University Long Beach, Long Beach, CA.

Objectives

- Discuss Advance Care Planning approaches used by cardiovascular disease decedents in a nationally representative sample.
- Identify significant symptoms experienced in the last year of life for decedents of cardiovascular disease.
- Describe the association of symptom burden with the proclivity to engage in advance care planning in individuals dying of cardiovascular disease.

Original Research Background. The unpredictable disease trajectory for persons dying from cardiovascular disease (CVD) may make planning for future care challenging. In addition, research suggests these individuals may suffer with significant symptomatology in late life.

Research Objectives. To describe symptom burden and advance care planning (ACP) in individuals dying of CVD, and examine the association between symptom burden and ACP in this population.

Methods. A cross-sectional design using Health Retirement Survey 2002-2012 data (a nationally representative survey) addressed the research Objectives. Proxies were asked about decedent's symptom burden (experiences with significant pain, anorexia, depression, vomiting, confusion, and fatigue), and ACP activities (the presence of a durable power of attorney for healthcare [DPOA], or a living will, or a conversation about care preferences at the end of life). Clinical and demographic information was obtained.

Results. Complete data was available for 1304 decedents. Mean age at death was 85.75 (range 65-105, SD 7.13); 37.5% died in hospitals, 27.8% died in skilled nursing facilities, and 34.8% died at home or with hospice. Decedents had a mean of 3.3 symptoms "most of the time" in the last year of life (range 0-6, SD 1.69). Pain (65.5%) and fatigue (62.4%) were the most common symptoms. Proxies reported engaging in ACP (any type) with 78.0% of decedents, 60.3% reported the presence of a DPOA, 47.3% reported a living will, and 56.5% reported a conversation about care preferences. Higher symptom burden was associated with all types of ACP (DPOA: X^2=40.5, p<0.000; living will: X^2= 28.91, p=0.001; conversations: X^2=36.66, p<0.000; any type of ACP: X^2:55.91, p<0.000).

Conclusion. In this sample, CVD decedents with higher symptom burden were more likely to engage in ACP.

Implications for research, policy or practice. Because ACP encourages care consistent with patient preferences and improves patient satisfaction, approaches to improve rates of ACP in CVD should target populations with low symptom burden.

Association of POST Form Use with Quality End-of-Life Care Metrics in Cancer Patients: Update from the West Virginia Registry (FR440B)

Sandra Pedraza, MD, West Virginia University School of Medicine, Morgantown, WV. Mark Knestrick, MD, West Virginia University School Of Medicine, Morgantown, WV. Stacey Culp, PhD, West Virginia University, Morgantown, WV. Evan Falkenstine, BSBA, West Virginia Center For End-of-Life Care, Morgantown, WV. Alvin Moss, MD FACP FAAHPM, West Virginia University School of Medicine, Morgantown, WV.

Objectives

- Understand the impact of the use of POST forms in advanced cancer patients.
- Identify the potential for a statewide POLST Paradigm program to improve respect for advanced cancer patients' end-of-life treatment preferences.

Original Research Background. The West Virginia Physician Orders for Scope of Treatment (POST) form, a POLST Paradigm form (www.polst.org), translates the preferences of patients with advanced illness for whom their physicians would not be surprised if they died in the next year into medical orders for system-level interventions. Few studies have evaluated POST form use in cancer patients.

Research Objectives. To compare the outcomes associated with POST form versus advance directive (AD) use on end-of-life care quality metrics in cancer patients.

Methods. A retrospective study of West Virginians who submitted POST forms or ADs to the West Virginia e-Directory Registry and died from cancer between 1/1/2011 and 2/4/2016.

Results. Of patients in the West Virginia e-Directive Registry during the study period, 2159 patients died from cancer: 1108 (51.3%) with ADs and 1051(48.7%) with POST forms. Of patients with POST forms, 524 (49.9%) were admitted to hospice compared to 299 (27.0%) with ADs (p<.001). In-hospital death occurred in 310 (28.0%) with ADs compared to 150 (14.3%) with POST forms; the unadjusted odds ratio for an out-of-hospital death for patients with POST forms compared to ADs was 2.33 (p<.001). Of the 1051 POST forms, 41 oncologists completed 130 (12.4%), 22 palliative care physicians completed 355 (33.8%), and 286 primary care physicians completed 566 (53.9%). Median time from POST form completion to death was 1 month.

Conclusions. Use of POST forms compared to advance directives in cancer patients is associated with higher achievement of two quality end-of-life care metrics: admission to hospice and out-of-hospital death. Greater oncologist use of the surprise question as a trigger for end-of-life care conversations and POST form discussions may result in earlier POST form completion leading to higher quality end-of-life care for patients with advanced cancer.

Implications for research, policy or practice. Implementation of POLST programs in all states as recommended by the Institute of Medicine will likely improve end-of-life care for cancer patients.

Implementation and Impact of Lay Navigator-Led Advance Care Planning for Cancer Patients (FR440C)

Gabrielle Rocque, MD, University of Alabama at Birmingham, Birmingham, AL. James Dionne-Odom, PhD RN, School of Nursing, University of Alabama at Birmingham, Birmingham, AL. Courtney Williams, MPH, University of Alabama at Birmingham, Birmingham, AL. Bradford E. Jackson, PhD, Research Institute, JPS Health Network, Fort Worth, TX. Richard Taylor, DNP CRNP ANP-BC, University of Alabama at Birmingham School of Nursing, Birmingham, AL. Maria Pisu, PhD, University of Alabama at Birmingham, Birmingham, AL. Edward Partridge, MD, University of Alabama at Birmingham, Birmingham, AL. Elizabeth Kvale, MD, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL. Chao-Hui Sylvia Huang, PhD, University of Alabama at Birmingham, Birmingham, AL. Soumya J. Niranjan, BPharm MS, University of Alabama at Birmingham, Birmingham, AL. Karina I. Halilova, MD, University of Alabama at Birmingham, Birmingham, AL. Kelly M. Kenzik, PhD, University of Alabama at Birmingham, Birmingham, AL. Linda A. Briggs, MSN MA RN, Gundersen Health System, La Crosse, WI.

Objectives

- Understand implementation of lay navigator-led ACP.
- Describe navigator self-efficacy in conducting ACP before and after training.
- Compare resource utilization (hospitalization, ICU admissions) between cancer patients who did and did not participate in navigator-led ACP.

Original Research Background. The Institute of Medicine, American Society of Clinical Oncology, and American Academy of Hospice and Palliative Medicine recommend that persons with serious, life-limiting illness engage in advance care planning (ACP), but implementation is time-consuming for medical personal. One potential solution for cancer patients is to delegate ACP tasks to lay navigators.

Research Objectives:. Understand implementation of lay navigator-led ACP

Describe navigator self-efficacy in conducting ACP before and after training

Compare resource utilization (hospitalization, ICU admissions) between cancer patients who did and did not participate in navigator-led ACP

Methods. A convergent, parallel mixed-methods study was used to evaluate implementation of a lay navigator-led ACP program across 12 Southeastern US cancer centers. Data collection included: (1) electronic records of ACP conversations initiated, declined, on-going, and completed (2) pre- and post-training surveys completed by navigators measuring navigator self-efficacy and knowledge (n=45), and (3) Medicare claims-based patient outcomes (n=820) including hospitalizations, ICU admissions, chemotherapy within last 14 days of life, and hospice use.

Results. Between 6/1/14-12/31/15, 50 navigators were certified as Respecting Choices® First Steps ACP Facilitators. Navigators initiated 1571 ACP conversations; 672 completed; 412 were on-going; 487 were declined. The mean score for feeling prepared to conduct ACP conversations increased from 5.6/10 pre-training to 7.5/10 after training (p=0.001). In comparison to navigated patients declining participation in ACP (n=167), there was a trend toward fewer hospitalizations (47% and 55%, p=0.06) and ICU admissions (17% vs 24%, p = 0.05) 30 days prior to death for decedents engaging in ACP with navigators (n=409).

Conclusion. A navigator-led ACP program was able to be widely disseminated and may be associated with lower rates of hospitalizations and ICU admissions near EOL.

Implications for research, policy or practice. Lay navigator-led ACP conversations may hold promise in cancer centers with limited palliative care resources. Further research is needed to understand training needs and improve the skills of navigators facilitating ACP.

"Our Life Is a Story, and We All Want a Good Ending to the Story": Navigators on Advance Care Planning Conversations in Older Patients with Cancer (FR440D)

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Objectives

- Describe factors that function as facilitators of lay navigator facilitated ACP conversations.
- Describe factors that function n as barriers to lay navigator facilitated ACP conversations.
- Identify impact of lay navigation and opportunities for future examination.

Original Research Background. National guidelines endorse advance care planning (ACP) as essential; however, few patients engage in such planning due, in part, to pragmatic challenges in delivering ACP in cancer care settings. Little is known about whether certified lay navigators can facilitate ACP conversations in older adults with cancer.

Research Objectives. To describe facilitators and barriers associated with implementation of certified lay navigator-led ACP discussions.

Methods. Semi-structured interviews were conducted at 11 Southeast cancer centers with 26 lay navigators who were certified as Respecting Choices™ First Steps ACP Facilitators. Interview topics included quality of ACP training, knowledge and comfort in having ACP conversations, barriers and facilitators to conducting ACP, and perceived role in navigating patients with advanced cancer. Audio-recorded interviews were transcribed verbatim and uploaded into NVivo 10 software; 2 primary coders identified themes using thematic analysis employing Nvivo coding. Inter-rater agreement was assessed using Cohen's Kappa (=0.81, high agreement).

Results. Navigators (n=26) completed 672 ACP conversations. Three domains of Facilitators and Barriers emerged: patient, navigator, and system domains. At the patient level, prior experience with a family member was a facilitator while barriers included limited health literacy, fears, lack of readiness, and a "battle" mentality. At the navigator level, established rapport was a necessary facilitator while personal discomfort and timing issues were barriers. System facilitators included physician engagement and oncology-team consultation support. Barriers included lack of time and space, lack of stakeholder buy-in, and cultural suspicion.

Conclusion. Navigators identified both facilitators and barriers related to facilitating advance care planning conversations with older cancer patients in various cancer settings. Lay navigators identified several areas where additional training and infrastructure support might further enable ACP conversations in patients with advanced cancer.

Implications for research, policy or practice. Future work should explore design and evaluation of healthcare delivery models to support navigator-led ACP conversations, and evaluate outcomes such as alignment between patient preferences and care received.

Interprofessional Teamwork When Meeting with a Family in the Pediatric Cardiac Intensive Care Unit (FR441A)

Jennifer Walter, MD MS PhD, University of Pennsylvania, Philadelphia, PA. Emily Sachs Children's Hospital of Philadelphia, Philadelphia, PA. Aaron Dewitt, MD, Perelman School of Medicine/Children's Hospital of Philadelphia, Philadelphia, PA. Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA. Chris Feudtner, MD MPH PhD, The Children's Hospital of Philadelphia, Philadelphia, PA.

Objectives

- Identify the recommended roles of team members in conducting family meetings as presented in the literature and identify patterns of team behavior in the pediatric critical care unit.
- Identify what constitutes empathic opportunities and responses in a family meeting, how to assess parental understanding and understand the difference between open and closed ended questions.

Original Research Background. Parents of children in the pediatric cardiac intensive care unit (CICU) report inadequate communication and a lack of empathy during conversations with their clinicians.

Research Objectives. To evaluate communication behaviors and inter-professional team interactions during family meetings in the pediatric CICU.

Methods. Meetings of family members and CICU clinicians were audio recorded. We used quantitative case-coding to compare the duration of contributions made by attendees, and used the SCOPE codebook to measure assessment of parental understanding, closed and open-ended questions, and empathic statements in response to opportunities. Qualitative coding identified major themes regarding content discussed in the meetings.

Results. In the 10 meetings, CICU attendings spoke for an average of 64% of each meeting (SD=17%), parents 17% (SD=12%), registered nurses 7% (SD=6%), social workers 3% (SD=5%), and nurse practitioners 1% (SD=1%). In two meetings, parental understanding was assessed at the beginning of the meeting; in no meeting was this assessed at the end. Clinicians asked parents 132 closed-ended questions (86%) and 21 open-ended questions (14%). The team missed empathic opportunities seven out of 17 (41%) occasions. CICU attendings had the highest number of expressions of empathy at 12 (57%), followed by social workers at 2 (10%). Social workers were the team member most likely to initiate discussions about parents' worries or concerns. Nurses' contributions were largely to clarify a CICU attending's statement or to elicit any questions about nursing from the parents.

Conclusion. Clinical information is often given without checking for parental understanding but empathic opportunities were responded to frequently. Team members seem to serve different roles in the meetings, with physicians speaking for two-thirds of the time.

Implications for research, policy or practice. To optimize the results of family meetings for families, clinical team members may need to clarify core family meeting tasks and coordinate their communication and supportive activities.

Patients Preference Regarding Family Participation in Decision Making: A Multicenter International Study (FR441B)

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Objectives

- Understand Decisional Control Preferences (DCP) in Palliative care patients who prefer family make decisions regards to care on their behalf.
- Describe frequency and factors associated family deferred passive DCP.

Original Research Background. Communication regards to decisional control preferences (DCP) is critical for effective palliative care (PC). There are limited studies on role of family participation in DCP and factors that predict family making the decisions for the patient receiving palliative care.

Research Objectives. In this study we examined the frequency, characteristics, and factors associated with family making the decisions for the advanced cancer patients (ACP) receiving palliative care.

Methods. Secondary analysis of a study to determine the decisional control preferences in an international multicenter study involving patients receiving PC in USA, France, Spain, Brazil, Chile, Argentina, Jordan, India, Philippines, Singapore and South Africa. ACP receiving palliative care were surveyed using the Decision Control Preference scale and Understanding of Illness questionnaire. Descriptive statistics and Logistic regression analysis was performed.

Results. A total 1490 ACPs were evaluated. The median age was 58, 55% were female, 59% were married, 36.2% were educated college or higher degree. Shared, Active and Passive DCP were 33%, 44% and 23% respectively. In 100/333 ACPs who expressed passive DCP chose family DC (100/1490, 6%). Logistic regression analysis shows that gender (OR 8.45, P=0.004), age (OR .18, P=0.009), ACP who felt their cancer is curable (OR 3.49, P=0.038), and ACPs belonging to France and India were more likely to prefer family making the decisions for them.

Conclusion. ACP preference to family making decisions regards to their PC is uncommon. Lower age, female gender, country of origin and increased perception of curability more likely to significantly predict family DCP.

Implications for research, policy or practice. Individualized understanding DCP is important for optimal communication in PC, quality care and patient satisfaction outcomes.

Barriers and Facilitators to the Conduct of Timely Interdisciplinary Family Meetings in the ICU: Perspectives from a Diverse Sample of ICU Clinicians (FR441C)

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burgh, Imperial, PA. Douglas White, MD, University of Pittsburgh, Pittsburgh, PA.

Objectives

- List 3 clinician-level barriers to the conduct of interdisciplinary family meetings (IDFMs) in the ICU.
- List 3 unit-level barriers to the conduct of interdisciplinary family meetings (IDFMs) in the ICU.

Original Research Background. Leaders in critical care and palliative care (PC) have called for integrating PC practices into ICU care, since most ICU patients and families have unmet PC needs. Timely interdisciplinary family meetings (IDFMs) address core PC needs by providing a setting where family members can receive clinical information and emotional support; engage in elicitation of patient values; and thoughtfully deliberate about treatment choices. However, fewer than 20% of ICU patients have an IDFM within 5 days of ICU admission.

Research Objectives. Guided by an implementation science framework, the purpose of this study is to understand clinician-, unit- and institutional-level barriers and facilitators to holding timely IDFMs and to elicit clinicians' ideas for future interventions.

Methods. We conducted in-depth, semi-structured telephone interviews with ICU clinicians to elicit perceived barriers and facilitators to the conduct of timely IDFMs. Using the AHA database we purposively sampled doctors, nurses and care managers in a range of practice settings (e.g., geographic region, size, academic affiliation, and intensivist involvement). We performed constant comparative content analysis to generate a matrix of themes, ceasing enrollment with thematic saturation.

Results. We interviewed 13 clinicians. All value IDFMs for their ability to achieve clear communication among and between clinicians and family members. Clinician-level barriers include: discomfort with end-of-life conversations; perception that attending IDFMs is not a nursing priority; and belief that IDFMs are time consuming. Unit-level barriers include: absence of unit-based protocols for IDFMs; meeting occurrence being dependent upon individual physicians; and holding meetings only when a decision is needed. Clinicians endorsed preemptive scheduling upon admission and buy-in at all levels —administrative, physician, nursing to promote timely IDFMs.

Conclusion. IDFMs are valued, but barriers may impede their routine conduct. Participants describe promising unit- and institution-level intervention components to overcome barriers.

Implications for research, policy or practice. Interventions that incorporate these components merit development and testing to address this gap in clinical care.

Psychometric Properties of the Comfort with Communication in Palliative and End-of-Life Care (C-COPE) Instrument (FR441D)

Mary Isaacson, PhD RN CHPN, South Dakota State University, Brookings, SD. Patricia Da Rosa, MSc, South Dakota State University, Brookings, SD. Mary Minton, PhD RN CNS CHPN, South Dakota State University, Brookings, SD. Shana Harming, BS, South Dakota State University, Brookings, SD.

Objectives

- Describe the strategies used to develop the Comfort with Palliative and End-of-Life Care (C-COPE) instrument.
- Discuss the results and the decisions made because of the results from the psychometric analysis of the C-COPE.

Original Research Background. Caring for patients and families experiencing life-limiting illness requires that healthcare professionals are comfortable in initiating crucial palliative and end-of-life (EOL) care discussions. Nurses spend the most time with patients and must feel at ease discussing palliative and EOL care options with patients and families. No validated instrument exists which assesses nurse comfort specific to palliative and EOL care communication.

Research Objectives. The aim of this study is to report the psychometric properties of the Comfort with Communication in Palliative and End-of-Life Care (C-COPE) instrument among rural and urban nurses.

Methods. The authors designed a 28-item survey (C-COPE) to assess nurse comfort with palliative and EOL communication. Four experts evaluated content validity prior to survey delivery. Using an online format, the survey was distributed to a convenience sample of rural and urban nurses (N=271). To assess test-retest reliability, the questionnaire was administered twice, two weeks apart and computed with the Wilcoxon signed-rank test. Internal consistency was measured via Cronbach's alpha. Factor analysis included principal axis factoring, parallel analysis, and oblique rotation (direct oblimin) and was conducted on N=250 complete C-COPE surveys.

Results. The overall content validity index was acceptable at 0.98. Median differences between tests were not significantly different. The four factors extracted from the oblique factor analysis had an accumulative variance of 63%: (1) Patient Symptomatology, (2) Values, (3) Team Communication, and (4) Decision-making. The Cronbach's alpha coefficient for the total score was 0.91 and for factors 1 through 4 was 0.85, 0.87, 0.88, and 0.87, respectively.

Conclusion. The C-COPE demonstrated satisfactory content validity, internal consistency, and stability in measuring nurse comfort with palliative and EOL communication.

Implications for research, policy or practice. The four factor structure suggests relevant communication foci necessary to assess nurse communication competence. Testing of this instrument is recommended in a larger more diverse sample.

3–4 pm

Concurrent Sessions

Primary Palliative Care Education: A Case Study in Needs Assessment and Curricular Development (FR450)

Thomas Carroll, MD PhD, University of Rochester, Rochester, NY. Neal Weisbrod, MD, University of Rochester, Rochester, NY. Laura Hogan, MSN RN NP-C ACHPN, University of Rochester, Rochester, NY. Timothy Quill, MD FACP FAAHPM, University of Rochester Medical Center, Rochester, NY.

Objectives

- Describe the process of designing needs assessment and survey instruments.
- Describe the process of curriculum development for professional learners.
- Utilize needs assessment to drive curriculum development and implementation.

Given the ever-worsening shortage of palliative care clinicians in the United States, it is imperative that the field continues to focus on educational efforts. If successful, education expands the capabilities of non-palliative care specialists to provide basic palliative care services to patients and families who may otherwise go without. Educational efforts can take any number of forms, from bedside teaching of trainees to informal curbside opinions for colleagues to formal curricula.

Although there are many possible explanations when an educational effort fails, one that should not be overlooked is a major mismatch between self-perceived educational needs and curricular offerings. This is frustrating for all involved and leads to lost educational opportunities. It is imperative that before undertaking any educational effort, regardless of setting or method, potential learners' willingness/desire to learn is accurately assessed. Only then can the education effort be tailored appropriately to maximize the likelihood of success.

This workshop will demonstrate the process of designing a complimentary needs assessment/curriculum pair, and present needs assessment, curriculum development and needs reassessment as a continuous cycle, similar to that of continuous quality improvement. Through didactics and small group discussion, a needs assessment instrument and curriculum developed by the authors will be used to illustrate this process. Opportunities will be provided for participants to share their own experience, and to consider what the crucial next steps they might initiate to begin a similar process at their own institution.

"Is This Patient Appropriate for Hospice?" Lively Perspectives from the Hospice Liaison, Medical Director, and Executive Vice President (FR451)

Stanley Savinese, DO HMDC FAAHPM, Temple University Hospital, Hahnemann University, Philadelphia, PA. Jane Feinman, MSN RN, VNA/Hospice of Philadelphia, Philadelphia, PA. Linda McIver, MSN RN, Hospice of Philadelphia, Philadelphia, PA.

Objectives

- Foster a concrete understanding regarding which potential patients are appropriate for admission to hospice care by participating in lively discussion with faculty members.
- Develop strategies to work through determining whether or not hospice care can meet the needs of the changing and complex patients they are asked to evaluate for admission.

Hospice eligibility is no longer straightforward. Hospices are being called upon to care for patients with diseases which do not have a predictable trajectory. Patients are living longer and better with chronic illnesses, and complex interventions for chronic issues such as heart failure can blur the line between comfort and aggressive treatment. Interpretation of hospice regulations to foster the patients' best interest is challenging. Many pressing issues surround hospice enrollment including establishing timely dispositions for hospitalized patients, maintaining a hospice census that is able to sustain the necessary resources, ensuring that the hospice can provide the promised interventions, and avoiding undue scrutiny from regulatory bodies that can disrupt revenue. Determination of eligibility is not for the faint of heart. A multidisciplinary approach and open discussion is essential.

Three Palliative Care Models in Population Health Management Systems (FR452)

Joshua Lakin, MD, Harvard Medical School, Boston, MA. Catherine Arnold, MSW LICSW, Brigham &

Women's Hospital, Boston, MA. Rachelle Bernacki, MD MS FAAHPM, Dana-Farber Cancer Institute, Boston, MA. Rebecca Cunningham, MD, Brigham & Women's Hospital, Boston, MA. Julia Gallagher, MD, Massachusetts General Hospital, Boston, MA. Martha Quigley, MS GNP-BC ACHPN, Massachusetts General Hospital, Boston, MA. Jan Lamey, MS, Brigham & Women's Physicians Organization, Boston, MA. Arjun Rangarajan, MPH MBBS, Brigham & Women's Physicians Organization, Boston, MA.

Objectives

- Describe the state of the science of population health management and the potential intersections with palliative care.
- Discuss the rationale, design and target populations for 3 programs designed to deliver earlier palliative care to specific subpopulations of patients within a PHM system.
- Describe opportunities and challenges in implementing palliative care interventions across the spectrum of patient illness in population health management programs.

Population Health Management (PHM) is an emerging model of care that has developed in response to the transition from fee-for-service to value-based, shared-risk care. PHM aims to systematically and proactively address the unmet or undermet needs of a targeted group of patients, such as preventative aspects of care, psychosocial determinants of health, and chronic care needs. PHM algorithms often identify patients with the highest health care costs ("high utilizers"), many of whom have significant unmet palliative care needs. These needs include earlier advance care planning, symptom management and psychosocial and spiritual support.

The Institute of Medicine in its recent publication, *Dying in America,* calls for ongoing integration of social and medical services in meeting palliative care needs for all patients; a call that mirrors many of the core activities of PHM. Additionally, a growing evidence base suggests that palliative care, when delivered along with usual medical care, improves the value of the care delivered to the patient, increasing quality while decreasing costs: an outcome that aligns with the PHM model of care. Given these reasons, PHM systems and palliative care programs would appear to be natural collaborators in developing innovative, patient-centered models of care. In this session, we explore the role of palliative care programs in PHM by presenting three programs as examples, using didactic presentation, cases, and facilitated group work to derive practical implementation tips for participants to take back to their home institutions.

Creating a Village and Supporting Culture Change: Facilitating Advance Care Planning by Teaching Everyone How to Have an "Introductory Conversation" (FR453)

Gordon Wood, MD FAAHPM, Northwestern University, Chicago, IL. Eytan Szmuilowicz, MD, Northwestern University, Chicago, IL. Katie Clepp, MA MEd, Northwestern University, Chicago, IL.

Objectives

- Describe a model for the "Introductory Conversation" by which any staff member can introduce advance care planning and/or respond when a patient or family member expresses a concern or need.
- Practice an "Introductory Conversation".
- List one way this model could be applied to catalyze culture change at the participant's home institution.

Although the benefits of advance care planning have been repeatedly demonstrated in the literature, many patients and providers still do not participate in these discussions and, even if they do, many systems are not set up to consistently and effectively honor these care plans. Calls for culture change abound but there is no clear method to achieve this aim.

The Preference-Aligned Communication and Treatment (PACT) Project is a multi-site, multi-year advance care planning initiative currently underway in Illinois. To help achieve culture change, the project has created an innovative approach in which everyone involved in the care of the patient (doctor, nurse, nursing assistant, physical/occupational/respiratory therapist etc.) receives training so they understand the importance of advance care planning and can bring it up if they sense a need or respond appropriately if the patient brings it up. This conversation, based on a novel framework called "SONAR," is a cyclical process in which the clinician is continuously sending and receiving messages by observing, naming emotions, asking questions, and acknowledging what the patient has shared.

This session will describe this initiative and model in more detail and share how it is being implemented across 10 hospitals and 20 post-acute care sites in Illinois with plans to expand further in subsequent cohorts. Participants will witness and be able to discuss a sample "Introductory Conversation" and will have the opportunity to practice the conversation themselves. The session will close with a discussion of how participants may be able to use these techniques to catalyze culture change at their home institution.

Together We Can Go Farther: Using Palliative Care Registries and Collaboratives to Drive Quality Improvement (FR454)

Katherine Ast, MSW LCSW, American Academy of Hospice and Palliative Medicine, Chicago, IL. Christine Ritchie, MD FAAHPM, University of California San Francisco, San Francisco, CA. Steven Pantilat, MD FAAHPM, University of California San Francisco, San Francisco, CA. Kara Bischoff, MD, University of California San Francisco, San Francisco, CA. Arif Kamal, MD MBA MHS FAAHPM, Duke Cancer Institute, Durham, NC. Tamara Dumanovsky, PhD, Center to Advance Palliative Care, New York, NY. Maggie Rogers, MPH, Center to Advance Palliative Care, New York, NY.

Objectives

- Discuss the current landscape of quality measurement and why it's important for program development, quality improvement (QI), monitoring the field, and reporting for quality and payment.
- Describe an overarching palliative care quality strategy that can be used to improve the quality of care at attendees' local institutions.
- Describe how our separate quality strategies meet these needs and how they will collaborate into one overarching quality initiative for our field coordinated by AAHPM.
- Describe the advantages of participating in data collection collaboratives such as the Palliative Care Quality Network (PCQN), Global Palliative Care Quality Alliance (GPCQA), and the National Palliative Care Registry™.
- Describe how to use comparative data to evaluate your own palliative care program, improve your quality of care, and enable the Measuring What Matters initiative, The Joint Commission quality reporting, and other national quality reporting programs.

As palliative care programs face increasing pressure to demonstrate their quality in order to advocate for support and expansion and to be paid by insurers, standardization in collection and reporting of quality data is increasingly important to allow for benchmarking and reporting. Three initiatives address these needs: the Palliative Care Quality Network (PCQN), the Global Palliative Care Quality Alliance (GPCQA), and the National Palliative Care Registry™. This session provides an overview of these initiatives, describes their collaboration, and discusses how they are together advancing quality improvement and positioning our field for reporting and payment.

The PCQN and GPCQA are quality improvement (QI) collaboratives that support teams to collect prospective, standardized data on key care processes (e.g. advance care planning activities) and patient-level outcomes (e.g. daily symptom scores). Members of the collaboratives use standardized data to drive multisite QI initiatives. These growing networks allow benchmarking and identification of best practices to promote greater gains in QI than any service could make alone.

The National Palliative Care Registry™ is a national annual survey focusing on composition and operations of palliative care programs. The goal of the Registry is to: assist palliative care programs in tracking their development year-to-year; and promote standardization and improve the quality of palliative care. The Registry provides actionable information that programs can use to secure, expand and retain resources for delivery of high-quality palliative care. Data from the registry can also support the establishment of new palliative care programs where none exists.

In this session, attendees will learn about these initiatives and how together they support the improvement and expansion of palliative care programs in complementary ways. Data from each contribute to our understanding of practice and quality and addresses essential issues regarding reporting and payment. Attendees will learn how these efforts fit into an overarching palliative care quality strategy.

Truth-Telling in Pediatric Palliative Care: Challenges and Opportunities (FR455)

Tracy Hills, DO, Vanderbilt Children's Hospital, Nashville, TN. Adam Marks, MD, University of Michigan, Ann Arbor, MI. Christian Vercler, MD MA, University of Michigan, Ann Arbor, MI.

Objectives

- Review the existing data regarding practices and perceptions of truth-telling for children faced with a terminal disease.
- Understand the ethical principles as they pertain to truth-telling in pediatric palliative care.
- Review effective communication techniques for truth-telling and for navigating potential sources of conflict around truth-telling.

Truth-telling, or the act of disclosing factual information to patients and/or their families, is common practice in western societies and is largely related to an emphasis on respect for patient autonomy. In pediatrics, the relationship between the family and physician is often complex with multiple facets contributing to how and what information is communicated. The family often becomes the gate keeper to what information their child knows. This dynamic becomes more complex when the child transitions to adolescence and young adulthood, where the patient's autonomy comes in conflict with that of the parents. In addition, truth-telling is not a globally accepted practice with many factors, including culture, religion, personal beliefs, and family dynamics playing a role. This can lead to conflicts between the family and the health care team who hold to the societal norms of truth telling and respect for individual autonomy.

We will begin this session with a case report of a young adult with metastatic cancer being treated in a pediatric institution for whom truth-telling was resisted by the parents. We will then review the literature regarding truth-telling and disclosing prognosis to children and young adults, followed by an ethical analysis of truth-telling and how it applies to our case. Finally, we will end with a discussion of strategies health care providers can use to assess the appropriateness of truth-telling in individual cases, as well as methods for talking with children and young adults about death.

The Depressive Spectrum (FR456)

Erin Zahradnik, MD, Icahn School of Medicine at Mount Sinai, New York, NY. Priya Krishnasamy, MD, Mount Sinai Hospital, New York, NY. Jodi Smith, LMSW, Mount Sinai Beth Israel, New York, NY.

Objectives

- Distinguish between clinical depression, demoralization, and grief reactions.
- Explain what demoralization is and how it manifests in serious illness.
- Describe grief reactions and how they differ from demoralization.

Depressive symptoms are common in palliative care patients, though the etiology is often complex. Given the heterogeneity of depression, it can be useful to characterize it as a spectrum. Depressive syndromes occur along this spectrum, only part of which is represented by diagnosable clinical depression. Distinguishing these different syndromes can be difficult, which complicates treatment for patients, thus impacting their quality of life.

Demoralization, a psychological reaction to difficulty coping with serious illness, can initially appear to be major depressive disorder. Similarly, grief reactions, not only in response to impending loss of life, but also to loss of function, physical abilities, and other changes common in serious illnesses, can manifest with depressive symptoms. Distinguishing these phenomena is important in order to effectively treat these symptoms in patients at the end of life.

In this concurrent session, we utilize our backgrounds in psychiatry, palliative medicine, and social work to explain the similarities and differences between major depressive disorder, adjustment disorders, grief reactions, and demoralization. Through lecture, case studies, and group discussion, we formulate potential treatment approaches, including psychotherapy, medication, and psychosocial interventions from the interdisciplinary team for various manifestations of the depressive spectrum.

The Emerging Business Case for Community-Based Palliative Care (FR457)

J Brian Cassel, PhD, Virginia Commonwealth University, Richmond, VA. Kathleen Kerr, BA, Kerr Healthcare Analytics, Mill Valley, CA.

Objectives

- Understand the impact of community-based PC on costs and revenues.
- Apply the principles of the business case to getting resources and support needed for community-based PC.
- Access tools and resources to help quantify and make a compelling business case for community-based PC proposals.

The fact that inpatient palliative care reduces hospital costs is well-established, with much research describing how and why. The business case for inpatient palliative care is clear for hospitals: reducing costs in the context of case-rate payments for hospital care. In contrast, the business case for community-based palliative care is just emerging. There has been less research demonstrating the impact on utilization and costs. There is also a more complex set of considerations regarding whose costs and revenues would be affected by providing better care for patients with advanced, life-limiting diseases, and doing so earlier in the disease course than inpatient PC and hospice do currently.

In this session, we will first review the published research on the impact of home-based and clinic-based palliative care programs, especially in terms of the impact on emergency visits, hospitalizations, and overall healthcare costs. This will answer questions about whose costs (hospitals? payers? both?) are reduced when community-based PC makes hospitalizations unnecessary. Second, we will review the shifting landscape of healthcare reimbursement, pointing out scenarios such as Accountable Care Organizations where there is greater interest in increasing quality of care and in reducing costs. We then put the two together, describing how successful community-based PC programs have found sponsors and resources where the clinical (patient-centered) and financial (business-centered) outcomes are aligned.

Case studies of prominent home-based and clinic-based palliative care programs will be described, as will tools and resources provided by the California HealthCare Foundation focused on making the case for community-based palliative care. Audience participation will include discussion of instances where such arguments for community-based palliative care have worked, and where they have not.

The Intersection of Research and Clinical Practice: The Art and Science of Reading a Paper (FR458)

Donna Zhukovsky, MD FACP FAAHPM, MD Anderson Cancer Center, Houston, TX. David Hui, MD MS MSC, MD Anderson Cancer Center, Houston, TX. Ronit Elk, PhD, University of South Carolina, Columbia, SC.

Objectives

- Review the process of searching for relevant articles to the clinical question of interest.
- Demonstrate an overview of a systematic process for critically evaluating quality of quantitative manuscripts reporting clinical research.
- Provide a paradigm to evaluate applicability of research results to hospice and palliative care clinical practice.

With the recent explosion of technology and social media platforms, busy clinicians are continuously bombarded with data. Not all data are worthy of the same attention or have implications for the practice of hospice and palliative medicine. Using a journal club format, the presenters, a palliative care tenured physician scientist, an academic palliative care clinician and a PhD researcher and former American Cancer Society study section program director, will discuss the art of scientific reading. We will start by discussing how to identify relevant studies by formulating the appropriate clinical question. As busy clinicians and researchers often do not have time to read beyond the abstract, we will then illustrate the importance of reading beyond the abstract, as a thorough review of the manuscript often provides important insights, and may sometimes lead the reader to reach a different conclusion, highlighting the need to “dig deeper.” Next, we will demonstrate an efficient way to screen published research in order to decide if the work is of sufficient quality to merit further review and to determine if study results are valid and clinically significant. Moving on we will apply the evidence-based medicine framework to critically appraise some recently published research articles, answering 3 key questions: “Are the results valid?” “What are the results?” “Are the results applicable to my practice?” Emphasis will be placed on the process of assessing the methods (e.g. sample size, study dates, eligibility criteria, nature of control group, outcome measures). Finally, the panelists will discuss the process of knowledge translation and how to make sense of the rapidly evolving literature to inform clinical decision making. By the conclusion of the session, it is anticipated that participants will be better able to efficiently incorporate evidence-based medicine into their clinical practice.

Caring for Patients Whose Decision-Makers Have Questionable Capacity: Ethical and Clinical Concerns (FR459)

Jeffrey Berger, MD FACP, Winthrop Hospital, Mineola, NY. Joel Frader, MD FAAP, Lurie Children’s Hospital, Chicago, IL. Bridget Sumser, LMSW ACHP-SW, University of California San Francisco Medical Center, San Francisco, CA.

Objectives

- Describe the phenomenon of decision makers with questionable capacity and its ethical implications in adult care.
- Explore the ethical implications and obligations associated with care of pediatric patients whose decision makers may lack adequate capacity to make needed decisions.
- Discuss strategies for managing situations involving decision makers suspected of being impaired.

Palliative care clinicians commonly face high complexity and stressful decision making. Decisions by surrogates occur for 25%-30% of hospitalized adults, and in pediatrics parents usually serve as legal surrogates. The ethical and legal authority for such decisions is well established. However, not well described are problems with decision-makers suspected of impaired decisional capacity. These individuals may have well-recognized or undiagnosed psychiatric disorders, impairment from substance abuse, or cognitive disorders such as dementias. Unfortunately, clinicians caring for the index patient have no standing to formally assess surrogates, to substantiate suspicions that the decision maker are impaired, or to direct them to health care services. In some circumstances, e.g., suspected abuse or neglect of minors or elders, clinicians may have options for reporting surrogates to public authorities. In all cases, clinicians may have ethical obligations to intervene on behalf of dependent, vulnerable patients. Clinicians may also have ethical duties to the impaired decision maker, even without a clinician-patient relationship. How ought clinicians manage these circumstances? In this presentation we discuss these challenges from the perspectives of a pediatric palliative care physician, an adult palliative care physician, and a palliative care social worker.

Neither Hastening nor Prolonging Death: Hospice in a State with Legalized Physician-Assisted Death (FR460)

Krista Harrison, PhD, University of California San Francisco, San Francisco, CA. Margaret Bourne, MD

HMDC, Hospice by the Bay, San Francisco, CA. Courtney Campbell, PhD, Oregon State University, Corvallis, OR. Laura Petrillo, MD, Veterans Affairs Medical Center, San Francisco, CA. Laura Koehler, LCSW ACHP-SW, Hospice by the Bay, San Francisco, CA.

Objectives

- After attending this session, participants will be able to analyze a relevant case regarding considerations of hospice organizations developing policies to respond to legalized physician-assisted death.
- After attending this session, participants will be able to explain how hospices in Oregon and Washington responded to the legalization of physician-assisted death in their states.
- After attending this session, participants will be able to list the specific challenges of legalized physician-assisted death in California.

The End of Life Option Act, which gives patients with a terminal illness the ability to request medication to end their lives, went into effect in California in June 2016. This makes California the fifth state to legalize physician-assisted death (PAD), though legislation is under consideration in seventeen more. After PAD becomes legalized, health care organizations must develop new practices to respond to requests from patients. Since laws define the steps a physician must take to write a prescription, organizational responses typically focus on the early part of the process of requesting hastened death. However, evidence from Oregon and Washington suggests the vast majority of terminally ill individuals who request PAD are hospice patients. Hospices must consider issues such as managing communication with family, effects on interdisciplinary team members, and issues around ingestion, while accounting for a hospice philosophy that clinicians will neither hasten death nor prolong life.

For clinicians and leaders in states that have recently legalized or may soon legalize physician assisted death, this concurrent session highlights the PAD-related policies and practices of hospice organizations in Oregon, Washington, and California. Dr. Harrison, a health policy researcher, will review the current nationwide policy context for PAD and engage the audience in a case discussion. Dr. Campbell, an expert in hospice ethics, will describe ethical dilemmas encountered by hospices in Oregon and Washington responding to legalized PAD. Dr. Petrillo, palliative care physician and organizer of the California End of Life Option Act Response Conference, will report on the challenges of legalized PAD in such a large and diverse state. Dr. Bourne, hospice Chief Medical Officer, will share the experiences of a consortium of Bay Area hospices eight months after California legalization. Ms. Koehler, hospice Director of Clinical Services, will describe the impact of legalized PAD on hospice interdisciplinary team dynamics.

Paper Sessions

What Is In The Palliative Care Syringe? Key Activities of an Outpatient Palliative Care Team at an Academic Cancer Center (FR461A)

Kara Bischoff, MD, University of California San Francisco, San Francisco, CA. Eleanor Yang, BA, University of California San Francisco, San Francisco, CA. Gayle Kojimoto, BA, University of California San Francisco, San Francisco, CA. Nancy Shepard Lopez, MS RN ACHPN, University of California San Francisco, San Francisco, CA. Brook Calton, MD, University of California San Francisco, San Francisco, CA. Bruce (bj) Miller, MD, University of California, San Francisco & Zen Hospice Project, San Francisco, CA. Sarah Holland, RN, University of California San Francisco Medical Center, San Francisco, CA. Michael Rabow, MD, University of California San Francisco Medical Center, San Francisco, CA.

Objectives

- Understand the key functions of an outpatient palliative care team.
- Understand areas for improvement for an outpatient palliative care team.

Original Research Background. The field of outpatient palliative care (PC) is growing rapidly and there is not yet consensus about key elements of this work.

Research Objectives. Describe the activities of an outpatient PC team at an academic cancer center.

Methods. Providers at the outpatient PC clinic (the “Symptom Management Service”) at University of California, San Francisco’s comprehensive cancer center completed a checklist following each visit between 03/23/2015 and 06/14/2016 to document topics covered during the visit.

Results. Data was analyzed from 1288 visits during the study period. Initial PC visits (n=333) most commonly focused on symptom management (92%), an introduction to PC (69%), support for family/caregivers (47%), communication with other clinicians (38%), and assessment of patients’ understanding of their medical treatments (36%). Follow-up visits (n= 909) commonly focused on symptom management (93%) and less often included support for family/caregivers (27%), communication with other clinicians (19%), assessment of patients’ understanding of their medical treatments (14%), and support for decision-making (12%).

From analysis of data from the 89 patients who initiated their care and died during the study period, we found that initial PC visits occurred an average of 135 days prior to death. Most patients received care focused on symptom management (96%), an introduction to PC (70%), support for family/caregivers (67%), and communication with other clinicians (55%). However, most patients did not have the following topics addressed at any point during their ambulatory PC: preferred place of death (93%), discussion of hospice (85%), completion of an advance directive or Physician Orders for Life-Sustaining Treatment form (83%), support for decision making (80%), and designation of a healthcare proxy (73%).

Conclusion. Key functions of our ambulatory PC team are symptom management, support, and care coordination. However, many elements of advance care planning are not commonly provided during clinic visits.

Implications for research, policy or practice. Our data help describe outpatient PC and highlight opportunities for improvement.

Designing a Value-Based Care Delivery Model for Complex Older Adults Based on Geriatric and Palliative Care Principles (FR461B)

Ankur Bharija, MD, Stanford University Medicine, Palo Alto, CA. Astrid Block, RN CNS, Stanford Healthcare, Palo Alto, CA.

Objectives

- Identify patient characteristics in the older adult population, which have a high likelihood of association with poor patient outcomes and high health care utilization.
- Identify triggers for predicting a decline in the aging and serious illness trajectories so geriatric and palliative care principles can be integrated upstream in the care continuum.

Original Research Background. Complex older adult population is a segment we often refer to as 'high utilizers' and most 'at-risk' of sub-optimal care. This segment may benefit most from upstream integration of geriatric and palliative care principles in the care plan. Our biggest challenge may be early identification of this cohort, at the onset of decline in health status.

Research Objectives. Identify patient characteristics and triggers in the older adult population, which have a high likelihood of association with poor patient outcomes and high health care utilization.

Methods. As part of assessing senior care needs at Stanford Hospital, we piloted a new consult service "ACE – Acute Care for Elders". We created a simple inpatient consult trigger – "Age 75 years and older with evidence of recent decline in health state". A comprehensive assessment was done which included elements of a palliative care consult and a comprehensive geriatric assessment.

Results. From January 1st to June 30th, 2016, eighty-four patients were seen. The mean age was 85 years with evidence of serious illness in 68%, functional impairment (dependence in two or more ADLs) in 87%, and cognitive impairment in 73% at baseline. During hospital stay, 56% had evidence of delirium, 46% had physical symptom burden, 35% had psycho-social distress. 60% had two or more hospital or ED visits in the prior six months and 40% had been readmitted within 30 days. 7% passed away during hospital stay and 10% were discharged with hospice.

Conclusion. We may be able to identify this cohort early by using markers of frailty (dependence of ADLs, cognitive impairment) and utilization (ED visits).

Implications for research, policy or practice. In the environment of value-based purchasing, health systems and policymakers are looking at identifying complex patient populations at risk of poor outcomes and high utilization. Also, patient-centric outcomes (function, symptom and communication) in the value equation may increase likelihood of impact.

Projecting the Impact of Implementing Palliative Care for Older Adults: What Does the Evidence Support? (FR461C)

Adam Singer, PhD, Rand Corporation, Santa Monica, CA. Duncan Ermini Leaf, PhD, University of Southern California, Los Angeles, CA. Manali Patel, MD, Stanford University, Stanford, CA. Karl Lorenz, MD MSHS, Stanford University, VA Palo Alto, Palo Alto, CA. Daniella Meeker, PhD, University of Southern California, Los Angeles, CA.

Objectives

- Learn about the potential future impacts of effective palliative health services interventions.
- Learn about the applications of a powerful simulating model for projecting changes over time in end-of-life populations.

Original Research Background. A 2014 Institute of Medicine report concluded that broad improvements in end-of-life care are within reach. However, many currently available evidence-based palliative health services interventions have not been implemented on a large scale.

Research Objectives. Informed by our recent systematic review of 124 RCTs of palliative health services interventions from 2001 to 2015, we projected changes from 2016 to 2040 in health care costs, quality of life, and mortality resulting from the implementation of a palliative care team (PCT) for cancer patients and palliative case management (CM) for CHF patients.

Methods. The Future Elderly Model is a microsimulation model derived from the Health and Retirement Study and Medicare data that projects the health status, quality of life, and economic outcomes of the US adults over age 50. We informed the model with parameters from RCTs identified in our systematic review.

Results. From 2016 to 2040 in the absence of any intervention, projections show increases in life expectancy and societal health care costs, and worsening pain, depression, and ADL difficulties. The PCT intervention directly reduced depression in cancer patients by 75.6% (sensitivity analysis, 70.6%-80.4%) and the PCM intervention directly reduced average ADL difficulties in CHF patients by 33.7% (19.4%, 37.1%). Both interventions reduced per capita societal health care costs, increased QALYs, and reduced mortality. The PCT intervention reduced societal health care costs by $103 billion ($95.4 billion, $109 billion).

Conclusion. In the absence of changes in current practices, cost and quality of life outcomes at the end of life in cancer and CHF patients are projected to worsen over time. Palliative health services interventions have the potential to positively impact these outcomes over time.

Implications for research, policy or practice. Policymakers and payers should consider investing in and implementing evidence-based palliative approaches, as they may reduce costs and have an array of positive quality of life impacts in cancer and CHF.

Gaps in the Use of Palliative Care in US Hospitals (FR461D)

Jocelyn Vaughn, MA, Vizient, Chicago, IL. Marilyn Szekendi, PhD MSN RN, UHC, Chicago, IL.

Objectives

- Describe the prevalence of patients in US academic medical centers who are appropriate for palliative care referral.
- Identify the varying levels of palliative care referrals, consultations, and services among the hospitals that participated in the study.
- Discuss the individual, programmatic, and organizational characteristics that result in differing levels of palliative care coverage for patients appropriate for palliative care referral.

Original Research Background. The approach to care for individuals with serious, life-threatening illness seems to be shifting. However, the extent of unmet need for palliative care in US hospitals remains largely unknown.

Research Objectives. We conducted a multi-site cross-sectional, retrospective point prevalence analysis to determine the size and characteristics of the population of inpatients at 33 US hospitals who were appropriate for palliative care referral, as well as the percentage of these patients who were referred for and/or received palliative care services.

Methods. Patients appropriate for palliative care referral were defined as adult (≥18 years) patients with any diagnosis of a poor-prognosis cancer, New York Heart Association Class IV congestive heart failure, or oxygen-dependent chronic obstructive pulmonary disease who had inpatient status in one of 33 hospitals on May 13, 2014. Qualitative assessment involved interviews of palliative care team members and non-palliative care frontline providers.

Results. Nearly 19% of inpatients on the point prevalence day were deemed appropriate for palliative care referral. Of these, approximately 39% received a palliative care referral or services. Delivery of palliative care services to these patients varied widely among participating hospitals, ranging from approximately 12% to more than 90%. Factors influencing differences in referral practices included non-standardized perceptions of referral criteria and variation in palliative care service structures.

Conclusion. This is the first multi-site study designed to estimate the prevalence of hospitalized patients appropriate for palliative care referral in US hospitals. The findings demonstrate the need to expand the availability of palliative care services, including primary palliative care delivered by frontline providers.

Implications for research, policy or practice. The study provides useful information to guide providers, administrators, researchers, and policy experts in planning for optimal provision of palliative care services to those in need.

4:30—5:30 pm

Concurrent Sessions

Words Matter: Improving the Palliative Care Message (FR470)

Lisa Morgan, BA, Center to Advance Palliative Care, New York, NY. Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Identify the top evidence-based messages that best define palliative care.

- Illustrate the visual messages that patients and families respond to most.
- Identify three strategies that present ideal positioning opportunities.

The field continues to use confusing language and convey mixed messages. Words matter. Primary, generalist, specialist, advanced, serious, supportive. How meaningful are these terms to our key audiences—especially in diverse settings?

Palliative care has a positioning problem. It is already an established medical subspecialty that has been shown to improve the quality of care patients receive. Even so, research conducted in spring 2011 found three in four Americans (78%) knew nothing about palliative care. Physicians also often do not refer patients who could benefit from palliative care.

Improving awareness of, and demand for, palliative care is prerequisite to increased access and urgently needed policy changes in payment, accreditation, regulation and training. Therefore, in order to make palliative care compelling and relevant to patients and families, providers, payers and policymakers, there is an urgent need to educate all Americans. Only by making palliative care meaningful to people will the palliative care field be successful in engaging and reaching Americans in need.

So how do you make palliative care compelling and top-of-mind when the vast majority of Americans know nothing about it? How do you reposition it from end-of-life care to quality-of-life care, positioning its role in relieving suffering for people of any age and at any stage in a serious illness? And how do you make patients and caregivers aware of it and know to ask for it? These are the challenges facing the field of palliative care as a whole.

Improving our ability to get and stay on message as a field is prerequisite to our success. Through a didactic presentation, introduction to new market research and interactive Q&A, we will illustrate what "staying on message" means and why it is critical for the field's brand.

The Ever-Evolving Role of the Hospice Medical Director: Quality, Regulations, Narratives, Relatedness, and the Hospice Formulary—Part 1 of 2 (FR471)

Robert E. Crook, MD FACP, Mount Carmel Hospice and Palliative Care, Columbus, OH. Judi Lund Person, MPH CHC, National Hospice and Palliative Care Organization, Alexandria, VA. Joan K. Harrold, MD MPH FACP FAAHPM, Hospice & Community Care, Lancaster, PA.

Objectives

- Discuss the current hospice regulatory environment.
- Apply best practice to physician documentation of the CTI and relatedness.
- Discuss how to develop hospice coverage guidelines and a hospice formulary.

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 understand best practice for documenting CTIs as well as 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; the development and structure of a persuasive CTI; and tools to help your program to determine relatedness of diagnoses and coverage of medications.

But the Parents Wanted Us to "Do Everything": Using Values Guided Decision Support in Pediatric ICUs (FR472)

Kenneth Pituch, MD, University of Michigan, Ann Arbor, MI. Tessie October, MD, Children's National Health Systems, Washington, DC. Kathleen Meert, MD, Children's Hospital of Michigan, Detroit, MI. Maureen Giacomazza, MA RN, C.S. Mott Children's Hospital, University of Michigan, Ann Arbor, MI. D'Anna Saul, MD, University of Michigan Hospitals, Ann Arbor, MI. Patricia Keefer, MD, University of Michigan, Ann Arbor, MI. Tracy Hills, DO, Vanderbilt Children's Hospital, Nashville, TN.

Objectives

- Identify language used in framing an ICU decision using the "needs frame."
- Identify language used in framing an ICU decision in the "parental autonomy frame."
- Demonstrate language that elicits values and builds trust.

Pediatric staff working in intensive care units (ICU's) at children's hospitals are increasingly caring for more chronically critically ill children. Decisions regarding initiation, continuation, escalation, or de-escalation of life-prolonging interventions occur frequently in our NICUs, PICUs and Pediatric Cardiac ICUs. Staff often perceive that decisions in the best interest of these children and their families are not always being made. Studies of substituted decision making in adult ICU's suggests that a guided recommendation, as opposed to asking surrogates, "what do you want us to do?" leads to better acceptance of decisions, and perhaps better outcomes. We are sharing an approach that is becoming a part of the curriculum for professionals and trainees at our children's hospitals.

Objectives

- After attending this session learners will be able to

- Identify three ways in which providers frame decisions regarding life-prolonging interventions: the needs frame (paternalistic), the parental autonomy frame (informational, often collaborative) and the values-guided decision support frame (collaborative and deliberative).
- Demonstrate specific language that can elicit values and build trust.
- Demonstrate specific language that uses identified parental values to present a recommended decision that is shared by the family, but in which the burden of the decision is not borne by the parents alone.
- Demonstrate the ability to listen for acceptance or the need for further conversation.

Methods. Participants will watch two short videos in which conversations between parents and providers demonstrate common ways in which decisions are framed. This will be followed by a review of the literature regarding the framing observed in clinical practice, as well as the ethics literature regarding surrogate and shared decision making. A third short video will model language used to elicit values, establish trust and make a values guided recommendation. The importance of silence, and listening for parental feedback will be highlighted.

Bridging the Gap Between the Health Delivery Systems, Community Organizations and Faith-Based Communities in Managing Advanced Illness (FR473)

Cynthia Carter Perrilliat, MPA, Alameda County Care Alliance, Oakland, CA. Valerie Steinmetz, BA, Public Health Institute, Oakland, CA.

Objectives

- Discuss the formation and operation of the Alameda County Care Alliance Advanced Illness Care Program.
- Discuss the training and deployment of faith-based community care navigators.
- Describe effective ways to provide resources and information to predominantly African American, low-income persons needing advanced illness care and their caregivers.

Evidence suggests that routine care for individuals with advanced illness does not align treatment plans with patients' personal goals, and fails to prepare them for increasingly severe illness. Moreover, there are well-documented racial/ethnic disparities in the uptake of advanced illness care including palliative care and hospice—despite the fact that these services are shown to both improve quality of life and extend survival compared to "usual care".

The Alameda County Care Alliance (ACCA) Advanced Illness Care Program™ (AICP) is a faith-based program designed to address the need for advanced illness care in a diverse population of individuals served through a consortium of five churches. The AICP leverages key attributes of a diverse faith-led infrastructure that are critical for improving the care of the person needing advanced illness care (PNAIC) and their caregivers in Alameda County, including access to health and other community services, trust, and spiritual guidance.

To our knowledge, the AICP is the first community-faith-health system partnership of its kind in the nation initiated by the faith community. The ACCA AICP (1) prepares and empowers faith leaders to proactively counsel their congregants through spiritual issues related to advanced illness, (2) deploys community care navigators to closely support PNAIC and caregivers in four overarching program domains (physical, psychological, spiritual, and advance care planning), (3) supports and trains caregivers, and (4) integrates its services between hub churches and community resource organizations.

Through discussion, use of case examples, and review of ACCA AICP pilot data, this workshop will present practical information for forming partnerships with faith-based community led organizations and how to reach vulnerable populations with advanced illness care needs beyond the healthcare delivery system through the training and deployment of community care navigators.

Home Based Palliative Care: Road to Success in Non Academic Multispecialty Physician Group (FR474)

Lama El Zein, MD, Summit Medical Group, Summit, NJ. Betty Lim, MD, Summit Medical Group, Summit, NJ. Sarah Masucci, MSW LCSW LCADC, Summit Health Management, New Providence, NJ.

Objectives

- Identify the need for different types of home based program in your clinical setting.
- Build a home based palliative care program using your current resources including referral process, screening for appropriateness, and the description of visits and follow up.
- Expand the role of palliative care in the management of complex homebound patients in the new era of value-based healthcare delivery models.

Palliative care deals with patients with serious illnesses at various stages. With the shift in the healthcare system towards a value-based model, it is obvious that palliative care, which improves quality and decreases cost, will have an important role in caring for patients with chronic illnesses.

Within our practice, we identified multiple areas where palliative care can play a key role. One of these areas was the care of patients who are permanently home bound, patients with debility and severe symptoms post hospital discharge, as well as patients who have high palliative care needs and are unable to visit our office for consultation. In addition, with the trend of merging of outpatient practices, it is becoming increasingly difficult for individual clinicians to perform home visits due to the geographic scattering of patients.

Our palliative care team created a comprehensive home visit program: first we standardized the referral process from all providers by creating a unique referral form, second we screened each referral to identify the specific needs of each patient, and third we categorized patients into three different groups (home based primary care, home based palliative care and post-discharge care). Each of these three groups has specific inclusion criteria and a variety of services; all provided with an interdisciplinary approach with focus on quality of life, goal of care and patient and family education about disease and medication. Our team worked closely with the group's social services team as well as care managers to identify and manage this high risk population.

In this session, clinicians will learn how to centralize home visits into one program and how to equip palliative care teams for this task by working collaboratively with patients' physicians to avoid unnecessary hospitalization and increase quality care for patients in their homes.

How to Survive as a New Palliative Care Advanced Practice Registered Nurse (FR475)

Laura E. Tycon, MSN CRNP, University of Pittsburgh Medical Center, Pittsburgh, PA. Margaret C. Root, MSN RN CPNP CHPPN, University of California San Francisco, San Francisco, CA. Mary Ersek, PhD RN FPCN, University of Pennsylvania, Philadelphia, PA.

Objectives

- Describe strategies used to manage expectations for the new graduate palliative care APRN.
- Summarize resources available to guide the new APRN in cultivating a sustainable professional practice.
- Give examples highlighting the importance of mentorship for the new palliative care APRN.

Advanced practice registered nurses (APRNs) have been a key to the expansion of palliative care programs throughout the country. Unfortunately, a standardized pipeline for the support and development of new palliative care APRNs does not yet exist. This can leave new palliative care APRNs feeling unsupported and lost in their new role, and may predispose them to the burnout and caregiver fatigue that already plague our clinical community. New graduate palliative care APRNs and the teams that look to hire this desired group of clinicians as part of an interdisciplinary palliative care team need to have in place a framework for professional practice. This session will use case studies and current literature to describe strategies used to manage expectations for the new graduate palliative care APRN, map out resources for the new APRN to support sustainability and longevity in the field, and highlight the importance of mentorship for the new palliative care APRN. We will provide framework to assist the APRN in identifying and defining their professional role within the context of the palliative care team and larger health system. This concurrent session will provide structure for negotiating an employment contract and navigating the collaborative physician relationship. Lastly, we will identify both clinical resources and career tools for the new APN to help make their way through uncharted territory as a palliative care clinician.

"Life Support": A Play about Palliative Care (FR476)

Madeline Leong, MD, Johns Hopkins Hospital, Baltimore, MD. Jay Baruch, MD, Brown University Alpert Medical School, Providence, RI. Bonnie Marr, MD, Johns Hopkins Hospital, Ellicott City, MD.

Objectives

- Identify factors that lead to effective patient-provider communication.
- Discuss how complex psychosocial issues affect patient care.
- Reflect on a patient's journey through illness.

For this session, we propose a unique educational strategy: combining live theater with a talkback/reflective exercise. First, we will perform "Life Support", a 90-minute play about palliative care. "Life Support" tells the story of a complicated patient who transitions to hospice. After the play, attendees will have an opportunity to debrief through a facilitated discussion. Goals of this session are: to teach communication skills, promote self-reflection, and highlight complex psychosocial issues.

According to the literature, theater can enhance empathy [1], improve case presentation skills [2], and facilitate discussions about "hot button" issues

[3]. For example, at AAHPM 2016, Ms. Elaine Magree presented a play about the AIDS crisis.

The play "Life Support", by Madeline Leong, was presented at Johns Hopkins Hospital in April 2016. It received substantial press and excellent reviews. Technical requirements are simple. For more information about the play, please contact the primary author.

In "Life Support", the characters participate in several goals of care discussions, including a discussion of Advance Directives and what it means to receive hospice care. These topics are especially relevant given the known benefit of early palliative care and advance care planning and the public's frequent misconception of these phrases. During the talkback, attendees will discuss the patient-provider communication in the play. Attendees will also have the option to fill out a one-page survey about the play. The purpose of the reflective exercise is to act as an interactive adjunct to the inherent educational value of the play. Yasmina Reza wrote, "Theater is a mirror." In this session, we hope to use theater as a mirror to demonstrate the nuances of patient-provider communication and the importance of the words we choose and how we speak them. We also hope to create a unique educational experience that contributes to clinician wellness and burnout prevention.

New Drugs and Drug News: The 411 and Implications for Palliative Care (FR477)

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

Objectives

- List new drugs approved by the FDA in 2016. For each drug the participant will be able to describe the approved indication, unapproved uses of the medication, common adverse effects and drug interactions.
- Describe the burden-to-benefit ratio and the role of the medication in caring for patients with advanced illness for each new relevant medication approved in 2016.
- Analyze important drug alerts and their relevance to drug therapies commonly used in hospice and palliative care patients.

Up to 100 new drugs and dosage formulations are approved every year by the Food and Drug Administration (FDA). Some of these are new molecular entities, while others are new formulations, new indications, generic drug approvals or labeling revisions. Even if a drug is a "new" molecular entity, it may not be "improved" over molecular entities already commercially available. In caring for patients with advanced illnesses, practitioners must make prudent drug therapy choices. Part of this decision-making process is a careful assessment of the burden-to-benefit ratio, including the financial burden of using each medication.

This concurrent session is a follow-up to previous year's very popular update on new drugs. For relevant drugs approved in 2016, participants will learn about the FDA-approved indication for using the medication, unapproved uses of the medication (particularly as it applies to palliative care patients), if it is a controlled substance and the schedule (if appropriate), adverse effects, major drug interactions, dosing, and financial implications of drug procurement and monitoring if relevant.

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

AAHPM Review of the USMLE Step Examinations (FR478)

Robert M. Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA. Gary T. Buckholz, MD HMDC FAAHPM, University of California San Diego, San Diego, CA. Elise C. Carey, MD FAAHPM, Mayo Clinic Rochester, Rochester, NY. Jeffrey C. Klick, MD, Children's Healthcare of Atlanta, Atlanta, GA. Laura J. Morrison, MD FAAHPM, Yale-New Haven Hospital, New Haven, CT. Joseph Rotella, MD MA HMDC FAAHPM, American Academy of Hospice and Palliative Medicine, Chicago, IL. Solomon Liao, MD FAAHPM, University of California Irvine Medical Center, Orange, CA. Stacie K. Levine, MD FAAHPM, University of Chicago, Chicago, IL.

Objectives

- Describe the current gaps and focus areas of content related to hospice and palliative care in the USMLE Step examinations.

- Discuss the opportunities for collaboration with the NBME to integrate key concepts of HPC into the USMLE.
- Apply the implications of the results of the review to their own programs.

Most residents will care for people with serious illnesses, terminal illnesses, and those near death. Nine Hospice and Palliative Medicine Subspecialists completed a review of the USMLE Step examinations used for licensing to test the knowledge required to provide this care. The review was planned and developed in consultation with the National Board of Medical Examiners (NBME) in early 2016 and completed at the NBME office in Philadelphia, June 15-16, 2016. At the time of this writing, the data from the review and the report on the process and outcomes are under development. By the time of Annual Assembly, the team will have data to report about the content related to hospice and palliative care and a summary of gaps in content and initial recommendations for content enhancement to assess progressive student level content in the Step examinations.

In addition to reviewing the multiple choice questions, the team toured the Communication Skills Exam Center where Step 2 exams are completed. The review process provided the opportunity for the team to explore the strategies currently used to assess communication skills and to begin to collaborate with NBME on future strategies as this is a core competency in Hospice and Palliative Medicine. Representatives from the review team believe it is important for educators to be aware of this review, what was learned, and be able to discuss opportunities to continue to improve the hospice and palliative content in the USMLE Step exams.

Eliciting, Documenting, and Honoring Patient's Goals of Care and Life-Sustaining Treatment Decisions: Building Systems to Ensure Success (FR479)

Shaida Talebreza, MD HMDC FAAHPM, University of Utah, Salt Lake City, UT. Jill Lowery, PsyD, National Center for Ethics in Health Care, Veterans Health Administration, Durham, NC. Rachelle Bernacki, MD MS FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Describe gaps in the current health care system that serve as barriers to honoring patient's goals of care and life-sustaining treatment decisions.
- Describe steps required to ensure that goals of care conversations and life-sustaining treatment decisions are documented and honored.
- Discuss strategies for implementation of these initiatives within health care systems.

It is widely accepted that treatment decisions should not be based on medical considerations alone but also on individual patients' goals, values, and preferences for care. It is also widely accepted that for patients with serious life-limiting illnesses, advance directives can be insufficient, and goals of care conversations and medical orders are needed to inform medical decisions. Yet too often goals of care conversations are not initiated before a medical crisis occurs, or patient preferences are not captured in a way that is clear and easy to locate in the health record. As a result, patients' wishes may never be known or honored. Addressing this problem requires significant changes in both provider practices and organizational systems. In this session faculty will present and discuss innovative approaches to this problem developed by two major health care systems: Dana-Farber Cancer Institute and Veterans Health Administration. These approaches include establishing standards for when and how goals of care conversations should occur, establishing an electronic record template to document patient's goals of care and life-sustaining treatment decisions, translating patients' decisions into medical orders, training multiple audiences in conducting goals of care conversations, and applying proven methods of organizational change. Faculty will discuss strategies for implementation of these initiatives within health care systems including concept development, usability testing, staff education, pilot testing, implementation, and evaluation. Faculty will also discuss the experiences of clinicians who use these electronic record tools in their care for seriously ill patients and the impact of these innovations on patients.

Targeted Therapy Jeopardy: An On-Target Update (FR480)

Eric Prommer, MD HMDC FAAHPM, Greater Los Angeles Healthcare, Los Angeles, CA. Mary Buss, MD, Beth Israel Deaconess Medical Center, Boston, MA. David Hui, MD MS MSC, MD Anderson Cancer Center, Houston, TX. Arif Kamal, MD MHS MBA FAAHPM, Duke Cancer Institute, Durham, NC.

Objectives

- Learn the mechanisms of action for targeted and immune therapies.
- Identify and manage adverse effects associated with targeted and immune therapies.
- Recognize clinical responses of these agents and how they differ from traditional chemotherapy.

New cancer therapies such as targeted therapies and immune therapies attack the machinery of cancer cells that regulate tumor growth, progression, and survival. These therapies have been added onto chemotherapy or have replaced chemotherapy based on molecular characteristics of the cancer. The onslaught of new treatments with confusing names, unusual response patterns, and unusual adverse effects overwhelms even most oncologists. For palliative care specialists it can be challenging to understand how these agents sometimes change the “rules” for how treatment is evaluated by oncologists and may affect options with regard to symptom management as well as counseling regarding decision-making about treatments. Improved knowledge of these agents enhances palliative care participation in the care of patients using these agents. This session will be presented by a panel of palliative oncologists with stated goal of providing on the spot learning by didactic and short clinical presentations and creating an easily accessible reference for the clinician encountering these agents. The attendee will quickly learn essentials which they can immediately bring into clinical care. By directly involving the audience after each session, participants and audience will learn key items related to the management and mechanisms of action of these agents. The presentation session will be divided into 4 sessions. Each session will be started with on the point didactics and finish with a jeopardy session with audience participation. The session will cover: 1.) Mechanisms of action of targeted and immune therapies; 2.) Adverse effects of targeted and immune therapies and their management; 3.) Clinical responses of these agents and how they differ from traditional chemotherapy and 4.) An overview of where these agents fit in common malignancies. New agents on the horizon will be discussed.

Paper Session

Natural Language Processing: An Opportunity to Make Chart Data Come Alive in Palliative Care Research (FR481A)

Charlotta Lindvall, MD PhD, Dana-Farber Cancer Institute/Harvard, Boston, MA. Alexander Forsyth, MEng student, Massachusetts Institute of Technology, Cambridge, MA. Regina Barzilay, PhD, MIT, Cambridge, MA. James Tulsky, MD FACP FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Describe strengths and limitations of using natural language processing to extract text embedded data for palliative care research.
- Described how NLP may facilitate population-based palliative care research.

Original Research Background. Medical notes and reports in the electronic health record (EHR) describe the complete picture of a patient’s experience, including symptoms and concerns as well as responses to treatment plans. In addition to subjective descriptions, text data may also contain important physiological descriptors, not otherwise stored in the EHR as discrete data points. Currently, palliative care researchers rely on manual chart review to extract variables embedded in medical notes. This method is labor intensive and risks human error. Natural Language Processing (NLP) enables computers to process unstructured text data.

Research Objectives. To validate NLP in a palliative care setting, we tested how well NLP could identify heart failure patients who decline following Cardiac Resynchronization Therapy (CRT).

Methods. We examined EHR data from a retrospective cohort of 970 consecutive CRT patients. Python NLP was used to extract left ventricular ejection fraction (LVEF) from cardiology reports and these findings were compared to the result of manual chart abstraction in the same population. Progressive heart failure was defined as <5% improvement in LVEF one-year post CRT.

Results. Using NLP, we analyzed 50,796 cardiology reports and identified 579 patients with baseline and one-year LVEF measurements of whom 261 (45%) met criteria for progressive heart failure. We compared these results to a published manual chart review of the same cohort and found 18% discordance between manually and NLP extracted LVEF. Heart failure patients often have multiple LVEF measurements in the year following CRT implant. Human data extraction biased towards selecting the highest follow up value which inflated CRT success rate. In contrast, NLP consistently selected the LVEF measurement most proximal to one-year post CRT implant.

Conclusion. NLP is a rapid method to extract text embedded data for palliative care research. NLP may also help reduce biases in data collection.

Implications for research, policy or practice. NLP may help scale data collection for palliative care research.

Survival and Disposition of Patients 75 Years or Older Following Mechanical Ventilation of 7 or More Days (FR481B)

Kristina Newport, MD FAAHPM, Hospice & Community Care Lancaster PA, Lancaster, PA. Thomas Miller, MD, Hospice & Community Care, Lancaster, PA. Robin Hicks, DO, Heart of Lancaster Regional Medical Center, Lititz, PA. Sarah Svetec, BA pending, Haverford College, Haverford, PA. Lisa Estrella, MS, Lancaster General Health/Penn Medicine, Lancaster, PA. Mike Horst, PhD MPHS, MS, Lancaster General Hospital, Lancaster, PA. Shanthi Sivendran, MD, Penn Medicine at Lancaster General Health, Lancaster, PA.

Objectives

- Describe mortality and disposition of patients 75 years or older who require mechanical ventilation 7 or more days.
- Describe implications of high mortality, dependent care and readmission rates on decisions regarding mechanical ventilation for patients 75 years or older.

Background. When elderly patients are intubated for a week or more, decisions regarding additional aggressive support such as tracheostomy or feeding tube placement are based on expectations of recovery. For patients over age 75 years, little data is available on the effect of intubation ≥7 days on mortality or care needs.

Research Objective. Determine mortality and disposition of patients 75 or older who require ≥7 days of mechanical ventilation.

Methods. Electronic medical records (EMR) from one community health system were reviewed, retrospectively, for outcomes and covariates. Public internet searches were performed to determine date and location of death if not in the EMR.

Results. 88 patients aged 75 or older required mechanical ventilation for ≥7 days from 5/1/11 to 4/30/15. 46.5% of patients died in hospital while 76.1% died within one year of discharge. Of those discharged alive, the vast majority (93.6%) required care in a facility. Only 3.4% of patients returned home after discharge and 2/3 of them had hospice services. None of the patients returned home completely independent. 47.6% of surviving patients were re-hospitalized within 1 year. 87.5% of patients in the study died or were re-hospitalized within 1 year.

Conclusion. Patients 75 years or older have high mortality and caregiving needs following ≥7 days of mechanical ventilation, with no patients able to live independent from medical services immediately after hospital discharge and only 24% surviving 1 year later.

Implications for Practice, Policy and Research. Based on these data, elderly patients may decide against initial or prolonged intubation, or tracheostomy and feeding tube placement. Critical care providers, hospitalists and palliative care clinicians may utilize these data to better advise elderly patients and researchers may use them as a basis for further research on the appropriate use of mechanical ventilation in patients age 75 or older.

The Self-Care Practices of Family Caregivers of High Mortality Cancer Patients: Differences by Varying Levels of Caregiving Well-Being and Performance (FR481C)

James Dionne-Odom, PhD RN, University of Alabama at Birmingham, Birmingham, AL. Wendy Demark-Wahnefried, PhD RD, University of Alabama at Birmingham, Birmingham, AL. Richard Taylor, DNP CRNP ANP-BC, University of Alabama at Birmingham School of Nursing, Birmingham, AL. Gabrielle Rocque, MD, University of Alabama at Birmingham, Birmingham, AL. Elizabeth Kvale, MD, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL. Maria Pisu, PhD, University of Alabama at Birmingham, Birmingham, AL. Edward Partridge, MD, University of Alabama at Birmingham, Birmingham, AL. Marie Bakitas, DNSc NP-C FAAN, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Describe the self-care behaviors of family caregivers of high-mortality cancer patients that are associated with poor well-being and performance.
- State possible reasons why caregivers with low engagement in self-care may concurrently have poor well-being and performance.

Original Research Background. Caregivers of individuals with high-mortality cancer perform vital tasks that may disrupt their health-preserving self-care practices, such as eating healthy, staying physically active, getting adequate rest, balancing solitude and social interaction, and staying spiritually connected.

Research Objectives. We assessed differences in caregiver self-care practices associated with varying levels of caregiver well-being and performance.

Methods. Cross-sectional mail survey within eight community-based Southeastern U.S. cancer centers. Family caregivers of Medicare beneficiaries ≥65 years with pancreatic, lung, brain, ovarian, head & neck, hematologic, or stage IV cancer completed measures of self-care practices (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, stress management, and sleep), well-being (anxiety, depression, and health-related quality of life [HRQoL]), and performance (caregiver competence and preparedness and decision-making self-efficacy). Differences in individual self-care practices were calculated using Kruskal-Wallis test by tertiles of well-being and caregiver performance.

Results. Caregivers (n=294) averaged 66 years, were mostly female (72.8%), white (91.2%), Protestant (76.2%), retired (54.4%) and patients' spouse/partner (60.2%). Approximately half were rural-dwellers (46.9%) with incomes <$50,000 (53.8%). Most provided support 6-7 days/week (71%) for >1 year (68%). Nearly a quarter (23%) reported high depression and 34% reported borderline or high anxiety. Low engagement in all self-care practices was associated with worse caregiver anxiety, depression, and mental HRQoL (all p-values<.05). Caregivers with lower health responsibility, spiritual growth, interpersonal relation, and stress management scores had poorer performance scores (lower competence, preparedness, and decision-making self-efficacy).

Conclusion. A significant proportion of caregivers simultaneously report low engagement in all forms of self-care practices, high depression and anxiety, and low HRQoL mental health scores.

Implications for research, policy or practice. Caregiver well-being and performance might be optimized through interventions targeted at enhancing health responsibility, stress management, interpersonal relationships, and spiritual growth self-care practices.

Cancer Stage Makes a Difference: Results from a Pilot RCT Integrating Palliative Care into Breast Cancer Self-Management (FR481D)

Dena Schulman-Green, PhD, Yale School of Nursing, West Haven, CT. Sarah Linsky, MPH, Yale University, West Haven, CT. Catherine Adams, MD PhD, St. Peter's Hospital, Albany, NY Orange, CT. Sangchoon Jeon, PhD, Yale University, West Haven, CT.

Objectives

- Name three specific aims of the pilot RCT of the Managing Cancer Care intervention.
- Identify key outcomes of the pilot RCT of the Managing Cancer Care intervention.
- Identify differences in outcomes of the pilot RCT by stage of breast cancer and race.

Original Research Background. Many cancer patients remain unaware of the nature and benefits of palliative care. Our purpose was to test *Managing Cancer Care (MCC)*, an intervention to improve patients' knowledge and integration of palliative care into breast cancer self-management.

Research Objectives. We evaluated effects of MCC on patients' knowledge of palliative care among other care options (curative and hospice care), behaviors (role in self-management, goals of care conversations, medical communication, management of transitions, health care utilization) and feelings (self-efficacy, anxiety, depression, uncertainty).

Methods. In this pilot RCT, we enrolled patients with Stage I-IV breast cancer receiving any type of treatment. We gave the intervention group MCC and gave the control group a symptom management toolkit. MCC is a set of seven printed modules covering care options, self-management, communication with family and providers, transitions, self-efficacy, and symptom management. We collected data at baseline, one, and three months.

Results. Participants (n=71) had a mean age of 51.5 years (range 28-74). 46.5% were White and 53.5% were Black and other minorities. Breakdown of cancer stage was 59.1% early (I or II) and 40.8% late (III or IV). Compared to controls and after controlling for race, the intervention group showed a large effect size for improved knowledge of palliative care (partial η^2=.127). Intervention participants with late stage cancer showed medium effect sizes for increased desire to self-manage and for reduced anxiety and depression (partial η^2= .05, .05, .07, respectively).

Conclusion. MCC appears to be more effective among patients with late stage cancer.

Implications for research, policy or practice. Further study among a larger sample is needed to explain the relationship between breast cancer stage and self-management outcomes.

4:30—6:30 pm

Interactive Educational Exchange (FR482)

Autopsy Conference Collaboration: A Memorable Inter-Professional Learning Opportunity

Karen Blackstone, MD, Washington DC Veterans Affairs Medical Center, Washington, DC. Anca Dinescu, MD, Washington DC Veterans Affairs Medical Center, Washington, DC. Edina Paal, MD, Washington DC Veterans Affairs Medical Center, Washington, DC.

Elizabeth Cobbs, MD, Washington DC Veterans Affairs Medical Center, Washington, DC.

Objectives

- Recognize autopsy as an opportunity for palliative care inter-professional education.
- Describe the elements of a successful autopsy conference program.

Background. Autopsies provide valuable information for families and health care providers. Palliative Care teams are increasingly involved in the care of dying hospitalized patients and may be catalysts in requesting autopsies and organizing conferences.

Methods. A palliative provider speaks with most families after the death, to share condolences of the team and discuss autopsy benefit. A coaching tool has been developed for decedent affairs staff. When family consents, a post-autopsy conference is coordinated with invitations to treating hospitalist and specialist teams, as well as to all inter-professional trainees rotating in palliative care/geriatrics. A palliative medicine physician and a pathologist lead a thirty-minute conference in the morgue including discussion of the patient's clinical course and a "hands-on" review of the gross pathologic findings of the major organs. Faculty lead the discussion based on specific patient concerns and general topics of prognostication, symptom management, communication with families before/after death, benefits of autopsy, and autopsy procedures. Faculty facilitate reflection on person-centered care, grief and bereavement.

Results. 30% of families consented to autopsy (Jan-Jun 2016, 30 autopsies/99 deaths in hospital and VA nursing home). The rate of consent increased from 22% the previous year after the coaching tool was implemented. More than one hundred conference attendees included: Palliative Medicine/Geriatrics faculty and fellows, Pathology faculty and fellows, internal medicine and family medicine residents (PGY1-3), medical students, nurses and nurse practitioner students, pharmacy students, social workers and social work students. Most reported no experience in autopsy viewing and discomfort talking with families about consenting for autopsy.

Discussion. Faculty, staff and trainees reported the experience as memorable and appreciated opportunity to examine organs thoroughly and discuss their own challenges and barriers in caring for dying patients and communicating with families. Those who had experienced "anatomy lab" or a single autopsy as a student reported the experience as extremely rich, to have followed clinical medical training, "it's fantastic to see and touch now that I actually am taking care of patients."

Conclusion. Person-centered autopsy conferences present unique and memorable learning opportunities to improve end-of-life care, communication, inter-professional teamwork, and personal reflection. Collaboration between decedent affairs, palliative, and pathology teams enhances autopsy rates. This program may be readily adapted to other hospital training program sites. We will share our coaching tools, challenges, and successes.

Raising the Bar: Applying a Mastery Learning Approach to Communication Skills Training

Julia Vermylen, MD MPH, Northwestern University, Chicago, IL. Gordon Wood, MD MSCI FAAHPM, Northwestern University, Chicago, IL. Diane Wayne, MD, Northwestern University, Chicago, IL. William McGaghie, PhD, Northwestern University, Chicago, IL Elaine Cohen, MEd, Northwestern University, Chicago, IL.

Objectives

- Develop a checklist to assess the quality of a BBN conversation.
- Develop a BBN mastery-learning curriculum.

Background. Small group role play methods, such as those developed by VitalTalk, have become the standard at many sites for teaching communication skills. Recent data, however, showed that these methods did not improve patient-level outcomes and had some negative effects. One possible explanation is that some learners may have completed the training but did not acquire sufficient skills to transfer to later patient encounters. Mastery Learning is an educational methodology where learners engage in deliberate practice until they reach a Minimum Passing Standard (MPS). In the mastery model, time varies while learning outcomes are uniform.

In this study, we sought to apply Mastery Learning principles to small group communication skills training in breaking bad news (BBN).

Methods. A panel of 12 education and palliative care experts convened to review the literature and develop a new gold-standard assessment tool that could be implemented in a Mastery Learning model. A pilot group of fourth-year medical students completed a pretest simulated patient encounter and received feedback based on the checklist. After a 4-hour session featuring 3 hours of communication skills practice, students completed a posttest simulated patient encounter using the same assessment tool. An expert panel then convened to review the data from the testing to set the mastery MPS using the Angoff and Hofstee methods.

Results. A 15-point checklist and 3 global rating scale questions were developed. During the pilot intervention, students (N=16) improved from a mean of 62.0% (SD 16.1%) to 83.75% (SD 10.6%) ($p < 0.001$) on the checklist and from a mean simulated patient-rated quality of communication (QOC) score of 5.4 (SD 2.17) to 6 (SD 0.96) ($p = 0.34$) on a scale of 0-10. The expert group set the MPS at 80% of the checklist items correct and at least a score of 6 on the QOC score. During this academic year, students will complete deliberate practice of BBN skills until they achieve the MPS.

Discussion. A rigorous curriculum for medical students produced significant improvement in BBN conversations. Future work will involve assessing the impact of BBN mastery learning on patient-level outcomes.

Conclusion. Integrating small group role play into a Mastery Learning model is feasible. Boosting BBN communication skills to uniformly high levels may potentially yield a more robust impact on patients and families.

Master of Science in Palliative Care: On Becoming a Palliative Care Community Specialist

F. Amos Bailey, MD, University of Colorado, Aurora, CO. Regina M. Fink University of Colorado, Aurora, CO. Shaun Gleason University of Colorado, Aurora, CO.

Objectives

- Develop a case-based on-line interprofessional PC educational program for mid-career working professionals who wish to provide high quality PC in their community.
- Use patient/family/provider dialogues to ground on-line education in the clinical experience.
- Provide an educational experience with a woven curriculum of bio-medical content and psycho-social-spiritual-ethical and communications lessons to replicate in-person preceptorship.
- Define a PCCS as a provider of high-quality consultative PC outside an academic setting.

Background. Workforce issues related to an inadequate supply of physicians and other providers educated in Palliative and Hospice Care are well documented. The recent IOM report called for alternative and expanded training opportunities for providers to expand the workforce and supplement primary palliative care (PC) across all settings. There is significant untapped demand for rigorous PC education options for mid-career providers who need to stay in their community and practice. Our newly developed Master of Science in Palliative Care (MSPC) will prepare healthcare providers (nurses, pharmacists, physicians, and physician assistants) to become Palliative Care Community Specialists (PCCS).

Methods. A 36-credit hour MSPC program has been designed to be completed over 24 months of continuous study. Students may choose flexible completion options; courses are currently offered once per academic year. Education will include:

- Case-based learning and problem-solving methodologies within a caring framework of PC approaches encompassing the whole person;
- Intensive education and practice in communication skills;
- Pain and non-pain symptom assessment and management;
- Interdisciplinary team support for psycho-social-spiritual distress;
- Ethical principles and decision-making methodologies

Results. Seventeen students representing all disciplines have enrolled; classes begin August 2016. Extensive evaluation has been integrated. We will report on student learning and reaction to learning of the first two courses: Palliative Care Concepts and Communication Skills (on-line with on-campus intensive) and Basic Pain Management with IDT Care (on-line).

Discussion. PCCSs will receive education and skill development enabling them to provide high quality PC to patients/families in the community whose needs are greater than can be provided by Primary Care Providers, and neither need nor desire care in an academic tertiary medical center. The PCCS will be linked to tertiary PC experts, creating a network of PC services that may better support the needs of patients/families throughout the care continuum across settings.

Conclusion. We have found there is a need and demand for educational options to expand PC services. The PCCS may be an important part of the solution to the workforce deficit issue.

The "Opioid Square": A Novel Educational Tool for Making Opioid Conversions

Heidi Young, MD, Georgetown University Hospital, Washington, DC. James Shear, MD, Virginia Hospital

Center, Arlington, VA. Yvonne Hernandez, PhD, Georgetown University School of Medicine, Washington, DC. Peggy Compton, PhD RN FAAN, Georgetown University School of Nursing and Health Studies, Washington, DC.

Objectives

- Determine the degree to which the "Opioid Square" tool assists 2nd year medical students in correctly calculating opioid conversions.
- Evaluate the student's preference to use the "Opioid Square" in comparison to the classic equianalgesic tables to calculate opioid conversions.

Background. Equianalgesic conversions between opioid drugs and oral and intravenous formulations are a clinically important skill, for all practitioners who treat pain. Accuracy is critical to preventing serious adverse events. Opioid conversion tables are a commonly used tool for teaching this skill, however a needs assessment at our institution reveals the classic conversion table is difficult for learners to understand. A novel visual tool, the "Opioid Square" was developed to provide a different visual framework for opioid conversions.

Methods. The sample consisted of 200 students at a single academic institution who were learning opioid conversions for the first time during their Pharmacology class. Students were taught conversions using both the standard conversion table, and the "Opioid Square" method. An eight item conversion quiz followed, on various opioid drugs and formulations of each. Students were allowed to use either tool and preferences were assessed with qualitative comments.

Results. 187/200 students participated in the study. Accuracy of the eight conversion questions was generally good (85%-100% correct), and without any statistical differences in accuracy between the Square and the Table. Incorrect conversions were more likely on two-step problems (i.e., IV fentanyl to oral morphine). A slight majority of students (53%) indicated that they preferred the "Opioid Square" over the Conversion Table, and 35% noted they would prefer to use both tools if given the option in the future.

Discussion. Providing an alternative visual tool to the classic opioid conversion table was well received by students in this study. Our presentation will include an "Opioid Square" pocket card and explanation of how to use and teach this method in other institutions.

Conclusion. The novel "Opioid Square" tool is not inferior to the classic opioid equianalgesic table for helping students make accurate conversions. As many students preferred the "Square," this tool may provide educators with an alternative visual framework for teaching opioid conversions.

Use of Google Glass to Enhance Communication Education

Laura Dingfield, MD, Hospital of the University of Pennsylvania, Philadelphia, PA. Stacey Kassutto Hospital of the University of Pennsylvania, Philadelphia, PA. Jessica Dine Hospital of the University of Pennsylvania, Philadelphia, PA.

Objectives

- Use Google Glass to enhance communication education and provide feedback.
- Assess feasibility of using Google Glass in a simulated setting.
- Assess trainee perceptions of video recording of goals of care discussions.

Background. Behavioral modeling, direct observation, and use of standardized patients are the primary strategies used to educate trainees on having goals of care conversations. Incorporation of technology like Google Glass may offer novel mechanisms to enhance communication, education and provide feedback. Little is known about perceptions of video recording to enhance communication education and provide formative feedback.

Methods. Thirty-four second and third year medicine residents participated in a half-day goals of care communication workshop, with presentation of a framework for discussing goals of care and two role play exercises. One role play exercise was enhanced using Google Glass. Patient actors wearing Google Glass recorded interactions with participants. Residents completed pre and post-workshop surveys, and also participated in a structured focus group regarding their impressions of current opportunities for communication education and Google Glass video recording.

Results. Twenty-three residents completed the pre-workshop survey and 17 completed the post-workshop survey. Increased confidence in discussing goals of care was reported by 76% (13/17) of residents. Residents were ambivalent about whether Google Glass enhanced their educational experience during simulation, with 82% (14/17) reporting neither positive nor negative impressions. Forty-seven percent (8/17) of residents reported comfort with video recording using Google Glass in simulated settings, and 41% (7/17) thought they would be comfortable recording real patient-care conversations. Themes that emerged during the focus groups included concern that video recording of simulated or real-world patient encounters may change physician or patient behavior during these sensitive discussions, and concern with creation of a permanent video record to use for evaluative purposes.

Discussion. Google Glass is simple to incorporate into simulated communication education for trainees, and this workshop could be adapted for use at other institutions to increase trainee confidence in having goals of care discussions. Google Glass recordings could be helpful in providing point-of-view feedback on verbal and non-verbal communication. Although impressions of use of Google Glass and video recording were mixed, this technology has the potential to offer new opportunities for provision of formative feedback on communication skills in a variety of patient care settings.

Conclusion. More work needs to be done to understand how to incorporate new technology, like Google Glass, into communication education and evaluation.

Advanced Illness Care Training for Nurse Care Managers

Rebecca Yamarik, MD MPH, Evolent Healthcare, Arlington, VA. Nancy Lentz, MSN BSN, Evolent Healthcare, Arlington, VA. Matt Estes Evolent Healthcare, Arlington, VA. Scott La Forte Evolent Healthcare, Arlington, VA.

Objectives

- Prognosticate patients in the last 1-2 years of life.
- Understand the symptoms associated with advanced illness and their treatments.
- Explore goals of care in a culturally sensitive manner with advanced illness patients and their families.
- Deal successfully with difficult situations such as patients/families who “want everything done” and suspected abuse and neglect.

Background. Americans are receiving aggressive care at the end of life, which is often contrary to their values and goals. Their providers often lack either training in goals of care communication or the time necessary to have those discussions. Use of ICU in the last months of life is increasing while average length of stay on hospice is decreasing. To increase access to goals of care discussions, we developed Advanced Illness Care, a nurse care manager program designed for patients in the last 1-2 years of life.

Methods. We developed a blended learning model to train the care managers. This involved 2 books and 5 web based courses that participants completed prior to coming to a 2 day in-person training. The modules were designed by instructional designers along with a content expert and covered: advanced care planning, hospice, prognosis, symptom management and ethics and culture. The in-person training was interactive and used a board game, role-play, cases, and small group discussions. The lecture component was minimal. The “Fragility of Life” activity asked participants to care for a raw egg during their 2 days of training to demonstrate the intensity of managing a patient in advanced illness. Kindle tablets were given to each small group that contained a “story-sync” that threaded an interactive patient case throughout the training to give real-life examples of the topics.

Results. Thirty nurses, social workers, and NP/PAs completed the first training in late July 2016 and the program launched officially in August 2016. The training was well received by the participants, praised particularly for the interactive components. By the time of the conference we will have data to share. The training is being revised based on participant feedback to improve the story sync and board game.

Discussion. The training is being revised based on participant feedback to improve the story sync and board game. Working with instructional designers with a background in web education enhances the educational experience for participants.

Conclusion. A blended learning model, where participants gain knowledge using web-based courses prior to a classroom component, is an effective method for teaching Palliative Care.

Saturday, February 25

8:15–10 am

Plenary Sessions

The State of the Science: Update in Hospice and Palliative Care (104)

Nick Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham School of Nursing, Birmingham, AL. Cardinale 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.

10:30–11:30 am

Concurrent Sessions

Integrating Palliative and Oncology Care: Where Do We Go from Here? (SA500)

Scientific Research Award Winner. Jennifer Temel, MD, Harvard Medical School, Massachusetts General Hospital Cancer Center, Boston, MA.

Objectives

- Be familiar with unmet palliative care needs in patients with advanced cancer.
- Understand data on benefits of early palliative care and unanswered questions about how to integrated palliative care.
- Gain insight into the clinical implications of the early palliative care model.

Patients with advanced cancer experience both physical and psychological symptoms due to their illness. Their family caregivers are also significantly impacted by their disease and experience distress surrounding their loved one's diagnosis. Patients with advanced cancer and their family caregivers also face difficult communication about their prognosis and end of life care. Unfortunately, data suggest that the majority of patients with advanced cancer hold overly optimistic perceptions of their prognosis and only engage in discussions about their end of life care preferences late in their illness. Based upon the experiences of these patients and their families, earlier involvement of palliative care services may improve their quality of life and care. Several randomized trials demonstrate that early involvement of palliative care in the outpatient care setting improves both patient and family caregiver outcomes. Specifically, early palliative care improves patients' quality of life, mood, prognostic awareness, coping, and communication about end of life care preferences. Importantly, early palliative care also improves the delivery of end of life care with less chemotherapy administration at the end of life and earlier referrals for hospice services. Family caregivers also benefit from early palliative care with lower rates of depression and improved quality of life. However, questions remain about how to measure the impact of early palliative care, how to best integrate palliative care across cancer populations, and how to disseminate palliative care services in the face of limited resources. Implementing palliative care in the outpatient care setting also requires operational oversight and support and collaboration with oncology.

We're Stuck! Please Help!! Palliative Care to "The Goals of Care" Rescue (SA501)

Erin Stevens, DO, Stanford University Medical Center, Stanford, CA. Michael Westley, MD FACP FCCP, Stanford University, Palo Alto, CA.

Objectives

- Describe a "differential diagnosis" of how patients/families use information and how they "process" it to make difficult choices.
- Identify methods and tools for Palliative Care clinicians to better understand the patient/family perspective of their decisions.
- Recall methods to assist patients/families to move forward once their perspective is clear and recog-

nize when to ask for additional assistance when these methods seem ineffective.

Requests to clarify GOC are among the most frequent reasons Palliative Care is consulted and ability to lead these discussions is a key competency milestone for Palliative Care Fellows. Some patients/families clarify their choices easily and not all need the expertise of Palliative Care. On occasion these conversations are complex with both patients/families and the care team struggling. Challenging GOC conversations have many dimensions and benefit from the communication skillfulness of Palliative Care clinicians.

In this interactive, case-based session we will explore the more challenging GOC conversations, specifically focusing on how patients with their families make difficult, often life-changing choices under uncertainty and how Palliative Care clinicians can become better guides and coaches. We will demonstrate how insight from cognitive psychology and neuroscience will lend an understanding to this decisional framework and how this knowledge will add to the Palliative Care clinician's skills. We will review best practices for determining and communicating risk and prognoses and discuss how patients/families interpret this information and incorporate it into their decisions. Using case examples throughout the work shop, we will demonstrate methods to better understand where patients and families seem "stuck" and tools to guide them to move forward.

Love Me "Tinder": Speed Dating with the Pharmacy Ladies (SA502)

Kathryn Walker, PharmD BCPS CPE, Medstar Health, University of Maryland School of Pharmacy, 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 Five. Complex medication decisions are an integral part of treating palliative care patients. Pharmacists have a unique perspective on using these medications creatively and effectively. This one hour session will flirt with tips and tricks on using medications appropriately for patients facing advanced diseases. Whether debriding a medication profile, aggressively treating symptoms or strategizing a dosage formulation, it can be hard to commit to medication decisions. Two pharmacists will speed-date their way through medication tips designed to highlight important and little known medication facts that are important in palliative medicine. 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! Find a tip that you are compatible with that may just change your life.

Pay-for-Quality Is Here: Now What? (SA503)

Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI. Arif Kamal, MD MHS MBA FAAHPM, Duke Cancer Institute, Durham, NC.

Objectives

- Describe the current and immediate future state of value-based reimbursement (VBR or "pay-for-quality"), including the Merit Incentive Payment System (MIPS), Alternative Payment Models (APMs), and others.
- Summarize key features of quality measurement tools that can position palliative care clinicians to participate successfully in VBR paradigms.
- Evaluate, modify or explore development of your own quality measurement strategy to meet the current and future realities of pay-for-quality.

Value-based reimbursement (VBR) is now a reality in the US healthcare system. Driven by a rising imperative to improve health care for patients and populations while controlling cost growth, payment systems are changing rapidly to incentivize care that improves quality, reduces cost, or both.

The Centers for Medicare and Medicaid services (CMS) continues to implement elements of the Medicare and CHIP Reauthorization Act (MACRA) to drive VBR, including creating two payment pathways in the Medicare fee-for-service system: the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Both the MIPS and APM pathways create both significant payment incentives for quality measurement and performance, as well as significant payment loss for failure to do so. Medicare Advantage and other commercial payers are adopting analogous "upside/ downside" payment systems to inform their VBR paradigms.

This session will feature leading national experts in palliative care quality measurement and payment, who will discuss the impact of VBR on palliative care providers and practices. Topics will include: details of MIPS and APMs relevant to palliative care providers; specific considerations for quality measurement and reporting in palliative care; and options for palliative care providers and programs to evaluate, modify or develop quality strategies to meet reporting requirements for VBR participation.

Participants will then be invited to share their own experiences with quality measurement and reporting strategies, and/or VBR programs. Our presenters will serve as a panel to respond and stimulate discussion about best practices, and overcoming barriers to success.

The Write Stuff: How to Increase Your Writing Productivity (SA504)

Irene Yeh, MD MPH, Dana-Farber Cancer Institute, Boston, MA. Barbara Reville, DNP ANP-BC ACHPN, Dana-Farber Cancer Institute and Brigham & Women's, Boston, MA.

Objectives

- Identify common challenges that are faced when starting or completing a writing project.
- Demonstrate how to form a writing accountability group (WAG).
- Explore different writing exercises to improve overall writing fitness.

Many of us encounter challenges in writing when the stakes are high. Starting and completing a journal article, business plan, or even a conference abstract can be difficult for many reasons. Participants in this session will explore common writing barriers and how to overcome them and establish good writing habits. While writing is ultimately a solitary activity, there is evidence that joining with other motivated writers can facilitate achievement of your writing goals.

All writers, whether famous or unknown, deal with writing blocks such as lack of ideas, time constraints, or a harsh inner critic. While the challenges of the individual writer are personal, there are effective strategies to exercise your writing "muscles." Just as an athlete practices regularly to improve performance, establishing a regular writing practice can increase productivity and creative expression.

This session will be both informative and interactive. Individual writing and group brainstorming will help participants share and discover strategies to unblock their writing and find a writing voice. Group work will focus on how to form a writing accountability group at one's workplace to overcome the isolation of writing and improve one's writing productivity.

Measuring What Matters for Families and Caregivers: But How? (SA505)

Rodney Tucker, MD MMM FAAHPM, University of Alabama at Birmingham Center for Palliative and Supportive Care, Birmingham, AL. Ashley Nichols, MD, University of Alabama at Birmingham Hospital, Birmingham, AL. Katherine Ast, MSW LCSW, American Academy of Hospice and Palliative Medicine, Chicago, IL. Christopher Brainard, MSHA FACHE, University of Alabama at Birmingham Health System, Birmingham, AL.

Objectives

- Define the barriers and opportunities associated with measuring family and caregiver satisfaction with palliative care services in inpatient and ambulatory settings.
- Review the Measuring What Matters (MWM) project within AAHPM and the unique challenges in this arena.
- Delineate the next steps in linking palliative care patient and family experience data and measurement to hospitals that are focused on patient perception of care surveys.

As the provision of palliative care (PC) services in inpatient care settings grows, the need for standardized methods of obtaining patient and family satisfaction data will be increasingly important. This has been highlighted in the Measuring What Matters project within AAHPM and in several large healthcare organizations. Measurement of "satisfaction" or experience with PC services can be difficult since families of patients who die in these settings do not receive standardized surveys as a matter of routine. Furthermore, live patients who are seen by PC teams may be surveyed in small quantities insufficient to determine any positive effect. Consistent and quantifiable measurement can highlight the role, effectiveness, and value added of PC services in the realm of patient experience for hospitals.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys which are mandated by CMS and the subsequent Value Based Purchasing (VBP) payment system has brought increased attention to the potential effects of quality PC services through an emphasis on communication skills, coordination of care, pain management and goals of care discussions. This session will highlight the experience of a large academic setting attempting to use a standardized bereavement or caregiver survey through a national vendor and will link the importance of continued efforts in this realm. Attendees will be better equipped to link the potential benefits of measuring PC experience to hospitals overall experience and will also be provided with a check list of key questions to return to their organizations administration to help guide future efforts around this type of data collection.

Resilience, Compassion, and Communication: How the Schwartz Center Rounds Promotes Primary Palliative Care (SA506)

Steven M. Radwany, MD, Summa Health System, Akron, OH. Pamela Mann, MSSA, The Schwartz Center For Compassionate Healthcare, Boston, MA. Rod Myerscough, PhD, Summa Health System, Akron, OH. Aileen Jencius, MLIS, Summa Health System, Akron, OH.

Objectives

- Recognize the value of an interdisciplinary forum that promotes collaborative working relationships to advance patient-centered care.
- Demonstrate how these Rounds promote enhanced palliative care skills among attendees while promoting positive culture change and provider resilience in a healthcare organization.
- Plan and promote Schwartz Center Rounds within your home institution borrowing from the experiences of a program led by palliative care providers.

Most palliative care providers and programs struggle to grow the skill set of primary providers to help them address the basic palliative care needs of the growing population of patients with advanced and serious illness. Established in 1995, the Schwartz Center for Compassionate Healthcare is committed to promoting compassionate health care and has become nationally recognized as a vibrant and valuable organization that creates and supports groundbreaking educational programs for multidisciplinary caregivers, their patients, and the health care community. A significant contributor to the Schwartz Center's success has been its landmark program Schwartz Center Rounds®, which offers multidisciplinary caregivers the unique opportunity to discuss social and emotional issues inherent in patient care. What began in 1997 at one hospital is now taking place across the country at over 400 health care settings across the nation, and over 135 sites in other countries. Schwartz Center Rounds has become a national model for productive discussions on compassionate care and can serve as a valuable vehicle for promoting palliative care precepts broadly across an integrated delivery system.

Schwartz Center Rounds demonstrates how a cost-effective and well managed program has made a significant impact on participants. Formal evaluation data support that Rounds participants report increased insight into psychosocial aspects of care, enhanced compassion, and increased ability to respond to patients' social and emotional issues. Participants also report how Rounds have helped them develop skills to communicate with more sensitivity and empathy when dealing with patients and patients' families, which translates into better overall care. Rounds have also been a catalyst for changes in policy and development of new programs within individual health care institutions.

State of the Science in Pediatric Palliative Care (SA507)

Jennifer Hwang, MD MHS, The Children's Hospital of Philadelphia, Philadelphia, PA. Lisa Humphrey, MD, Nationwide Children's Hospital, Columbus, OH. Elissa Miller, MD, Nemours/Al DuPont Hospital for Children, Philadelphia, PA. Lindsay Ragsdale, MD, Kentucky Children's Hospital, Lexington, KY. Cheryl Thaxton, MSN FNP-BCCHPPN, Medical City Dallas/ Medical City Children's, Dallas, TX. Tiffany Webster, MDiv, University of California San Francisco, San Francisco, CA. Nicole Parente, MSW, Nationwide Children's Hospital, Columbus, OH.

Objectives

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

With the growth of Pediatric Palliative Care, it is essential for practitioners to find ways to stay current on the most recent literature. In the spirit of the State of the Science plenary which is part of each Assembly, the presenters will endeavor to review the literature published since 2015 which should inform the practice of Pediatric Palliative Care. Our transdisciplinary team of co-presenters includes representatives from medicine, nursing, social work and chaplaincy and will look at the academic literature relevant to the multiple disciplines represented. In addition to highlighting recent literature, the presenters hope to inspire session participants to consider how new knowledge will influence their practice and how they can personally contribute to the published knowledge base.

Paper Session

Does Expectation of Death Explain Racial and Ethnic Disparities in Death in the Hospital (SA508A)

Rafael Romo, PhD RN PHN, University of Virginia School of Nursing, Charlottesville, VA. Brie Williams, MD, University of California San Francisco, San Francisco, CA. Alexander Smith, MD MPH MS, University of California, San Francisco Division of Geriatrics, San Francisco, CA.

Objectives

- Explain the relationship between expectation of death and racial/ethnic differences in death in the hospital.
- Explain how the expectation of death acts differently among racial/ethnic groups.

Original Research Background. Older black and Latino Americans are more likely than white Americans to die in the hospital. These minority groups may seek more hospital-based aggressive end-of-life care because they are less aware that they have a limited prognosis.

Research Objectives. To determine if family's expectation of death moderates or mediates racial/ethnic differences in site of death.

Methods. We analyzed interviews conducted after death among next-of-kin who participated in the Health and Retirement Study, a nationally representative study of U.S. adults, and responded to the question: "Was the death expected?" We tested for an interaction between race/ethnicity and the expectation of death with death in the hospital and used multivariate modeling to calculate unadjusted and adjusted relative risk of death in the hospital by race/ethnicity.

Results. The sample included 5979 decedents. Overall, 55% were women, 79% were white, 14% black, and 7% Latino. Death was expected for 59% of participants. Whites and Latinos were >15% less likely to die in the hospital when death was expected than when it was not; with no difference among African Americans (interaction $p<0.001$). Overall compared to whites, blacks and Latinos were more likely to die in hospital (blacks, $RR=1.24$; Latinos, $RR=1.90$, both $p<0.001$). Adjusting for potential socio-demographic and health-related confounders (age, gender, clinical prognosis) attenuated the differences (blacks, $RR=1.23$; Latinos, $RR=1.14$, both $p<0.001$), but further adjusting for the expectation of death did not (blacks: $RR= 1.21$, $p<0.001$, Latinos: $RR=1.13$, $p=0.009$).

Conclusion. Among a nationally-representative sample of older adults, we found that the expectation of death did not fully account for site of death and played a greater role among whites and Latinos than among black Americans.

Implications for research, policy or practice. Discussing prognosis by itself is unlikely to address racial/ethnic disparities. Other factors appear to play an important role that need to be understood.

Apoyo con Cariño: Patient Navigation to Improve Palliative Care Outcomes for Latinos with Advanced Cancer (SA508B)

Stacy Fischer, MD, University of Colorado Health Sciences Center, Aurora, CO. Sung-joon Min, PhD, University of Colorado Anschutz Medical Campus, Aurora, CO. Danielle Kline, MS, University of Colorado Denver School of Medicine, Aurora, CO. Regina Fink, PhD RN APN CHPN AOCN FAAN, University of Colorado, Aurora, CO.

Objectives

- Identify methodologic strengths and weaknesses involving palliative care delivery research.
- Understand the role of patient navigators to promote and support primary palliative care in the cancer care setting.

Original Research Background. Efforts to increase access to palliative care (PC) must maximize primary PC and community-based models to meet the ever growing need in a culturally-sensitive manner. Our pilot data suggest that a culturally tailored patient navigator intervention has the potential to improve PC outcomes for Latinos with advanced cancer.

Research Objectives. To conduct a multi-site randomized controlled trial testing the effectiveness of a patient navigator intervention to improve PC outcomes.

Methods. Latino adults with advanced cancer were randomized to control (educational materials) or intervention (educational materials and ~5 navigator visits). Measured 3 month outcomes: Brief Pain Inventory, McGill QOL Questionnaire, and a process measure; 6 months: documented advance directives (AD) in EMR; Ongoing data collection: hospice utilization, length of stay, and aggressiveness of care at end-of-life.

Results. 223 patients enrolled and were randomized to control (111) or intervention groups (112). Intervention group patients reported an average pain severity score (0-10) of 2.88 (±2.52) versus control 3.52 (±2.90), $p=0.12$ and pain interference of 3.36 (±3.27) versus control 3.83 (±3.56), $p=0.37$. Only physical subscale showed a significant effect in QOL (6.86±2.53 intervention vs. 5.76±2.86 control, $p=0.007$). Documented AD in the EMR 69% (66) of intervention versus 33% (28) control, $p<0.0001$. Process outcomes: 84% of intervention patients reported discussing advance care planning with families and providers (60%), compared to control (55% and

35%, respectively), p<0.0001 and p=0.001, would recommend hospice for loved ones (88%) or themselves (88%) in intervention group compared to control (65% and 66% respectively), p=0.0004 and 0.0005.

Conclusion. A culturally tailored patient navigator intervention can increase advance care planning and help patients align with a palliative approach in Latinos with advanced cancer.

Implications for research, policy or practice. An effective, widely disseminated patient navigator intervention has the potential to reduce cancer-related disparities, improve PC for cancer patients, and improve access to quality PC care in rural communities.

Apoyo con Cariño: A Qualitative Analysis of Palliative Care Focused Patient Navigator Visits for Latino Patients with Advanced Cancer (SA508C)

Regina Fink, PhD RN APN CHPN AOCN FAAN, University of Colorado, Aurora, CO. Stacy Fischer, MD, University of Colorado Health Sciences Center, Aurora, CO. Danielle Kline, MS, University of Colorado School of Medicine, Aurora, CO.

Objectives

- Describe 3 key components of a patient navigator intervention to improve palliative care outcomes of Latinos with advanced cancer.
- Identify 5 common roles of a lay patient navigator to improve palliative care outcomes.

Original Research Background. A lay patient navigator (PN) model was used to deliver a culturally tailored intervention aimed at improving palliative care (PC) outcomes for Latinos with advanced cancer at 3 urban and 5 rural cancer centers. Five PN-initiated home visits were delivered over three months to 112 patients assigned to the intervention arm of this RCT. While the PN visits addressed three PC domains (advance care planning, pain/symptom management, and hospice care), each visit was grounded in core Latino values and responsive to patient/family needs.

Research Objectives. To explore and describe the content of PN visits with advanced cancer Latino patients and their families.

Methods. Three members of the research team reviewed and analyzed field notes of four Latina PNs comprising 499 visits to 112 patients. Based on our previous work, codes were established *a priori* to identify different ways the PN might help patients/families. Using Atlas.Ti, key words and comments from the field notes were classified into categories. Additional codes were established during multiple readings of the field notes and researcher team meetings. These codes were then grouped into common themes to expand our understanding of patient/family PC needs.

Results. Eight common themes emerged: Activation/empowerment, advocacy, education, building rapport/support, improving access, clarifying values and goals, screening for symptoms, and exploring self-care. Exemplars will be presented.

Conclusion. PNs often helped the patients and their families in ways beyond the conceptualized scope of the intervention. PNs used advocacy, activation, education, and motivational interviewing to help address patient/family concerns. The relationships established between PNs and patients/families helped reduce barriers to quality PC in both urban and rural settings.

Implications for research, policy or practice. An opportunity exists to use a lay PN model to provide PC support and education to patients/families. Incorporating this model in PC work with other cultures has a chance to improve PC access to disparate populations.

Comparison of the Risk for Substance Abuse in Heart Failure and Cancer Patient Populations Using the Opioid Risk Tool and Urine Drug Screen (SA508D)

Gene Freeman, MD, Cone Health, Greensboro, Greensboro, NC. Joshua Barclay, MD MS MSC FACP, University of Virginia, Charlottesville, VA.

Objectives

- Describe risk factors for substance misuse.
- Describe method for effective utilization of screening protocol for substance misuse in outpatient clinic setting.

Original Research Background. Opioid abuse has reached epidemic levels. Palliative care commonly includes congestive heart failure (CHF) patients, yet little is known about their substance abuse risk.

Research Objectives. Characterize substance misuse risk in CHF patients using the Opioid Risk Tool (ORT). Compare substance misuse risk in CHF patients to that of outpatient cancer patients.

Methods. University of Virginia Palliative Care sees patients in oncology and CHF clinics. Charts from cancer and CHF populations from respective clinics for the month of December 2015 were reviewed. Demographic variables, payer source, primary cancer, etiology of CHF (ischemic vs non-ischemic), ORT variables, UDS results, and presence of opioid prescriptions were recorded. Bivariate analysis compared cancer versus CHF with demographic variables and risk for opioid diversion. Logistic regression examined the correlation between moderate to high ORT score and cancer site, etiology of CHF, palliative diagnosis (cancer vs. CHF), insurance type, use of opioids, and sex.

Results. Charts of 271 patients were reviewed (202 cancer patients, 69 CHF). 80.69% of cancer patients were prescribed opiates versus only 20.29% of CHF patients ($p<0.0001$), but ORT scores were similar, with 39.11% of cancer patients scoring moderate to high risk versus 23.19% of CHF patients ($p=0.052$). In logistic regression, site of cancer, etiology of CHF, and palliative diagnosis were not associated with ORT risk, while opioid use (OR 3.86, CI = 1.72 - 8.96) and Medicaid insurance (OR 3.81, CI = 2.023 − 7.172) were associated with higher scores.

Conclusion. While fewer CHF patients are prescribed opiates, the risk of substance abuse was similar to cancer patients. Use of Medicaid was associated with higher ORT scores.

Implications for research, policy or practice. Almost one fourth of CHF patients were moderate to high risk for substance misuse. Screening rates are low in palliative clinics nationwide. As providers expand into CHF populations, appropriate screening is essential for safe and effective treatment.

Noon—1 pm

Critical Conversations: Opioids in Hospice and Palliative Care—Balancing Access and Safety (SA510)

1:15—2:15 pm

Concurrent Sessions

The Practice of Palliative Medicine in Developing Countries—Part Three (SA511)

Eunice Omoyeni, MBBS Dip PallMed, University College Hospital, Ibadan. NigeriaLee Ai Chong, MBBS, MRCPCH, Grad Cert Pall Care, Hospis Malaysia, Kuala Lumpur, Malaysia. Maria Isabel Cuervo Suarez, MD, Fundación Valle de Lili, Santiago de Cali, Columbia.

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.

The Importance of Medical-Legal Partnerships: Helping Children with Life-limiting Illness with Do-Not-Attempt-Resuscitation Orders in Schools (SA512)

Maureen Giacomazza, MA RN, C.S., Mott Children's Hospital, University of Michigan, Ann Arbor, MI. Debra Chopp, JD, University of Michigan Law School, Ann Arbor, MI. Kenneth Pituch, MD, University of Michigan, Ann Arbor, MI.

Objectives

- Identify frequent contradictions between school policies and state laws which deny parents' rights to have DNAR wishes honored.
- Discuss effective strategies to advocate for the delivery of appropriate emergency plans for children with life-limiting illness at school.
- Identify effective emergency plans which can lead to improved quality-assurance measures for children in their schools and their community.

Parents of children with life-limiting illness often reach a point where they recognize that aggressive medical treatment will cause more harm than good, and their goals of care shift to a focus on comfort. In collaboration with their medical team, parents make a decision to implement a Do-Not-Attempt-Resuscitation order for their child. Once parents decide to create a DNAR order for their child within the hospital setting, they expect that the order will be honored and their child will be spared futile and painful resuscitation attempts outside of the hospital setting as well. This is not always the case. Many school districts across the nation will not honor a DNAR declaration for a child in school. Medical-legal partnerships can help. In this session, we will review policies in the state of Michigan as they pertain to DNAR orders and will identify collaborative advocacy strategies for palliative care professionals to challenge these policies in their own clinical practice community.

Methods. Literature and case review will be used as the basis for discussion. We will describe successes, lessons learned, and explore other potential avenues for change.

The Ever-Evolving Role of the Hospice Medical Director: Quality, Regulations, Narratives, Relatedness, and the Hospice Formulary—Part 2 of 2 (SA513)

Robert E. Crook, MD FACP, Mount Carmel Hospice and Palliative Care, Columbus, OH. Judi Lund Person, MPH CHC, National Hospice and Palliative Care Organization, Alexandria, VA. Joan K. Harrold, MD MPH FACP FAAHPM, Hospice & Community Care, Lancaster, PA.

Objectives

- Discuss disease-specific commonly-related conditions and the hospice provision of medications.
- Discuss the current hospice regulatory environment and how it relates to the hospice provision of medication for specific conditions.

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 understand best practice for documenting CTIs as well as 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; the development and structure of a persuasive CTI; and tools to help your program to determine relatedness of diagnoses and coverage of medications.

Thinking Big: How You Can Develop a Palliative Care Program at Population Health's Leading Edge (SA514)

Christopher Jones, MD FAAHPM, Main Line Palliative Care, Radnor, PA. Stacie Pinderhughes, MD, Banner Health, Phoenix, AZ. Julie Lehn, PharmD, Banner Health, Phoenix, AZ. Arif Kamal, MD MHS MBA FAAHPM, Duke Cancer Institute, Durham, NC.

Objectives

- Articulate how Palliative Care (PC) is a solution to Population Health needs.
- Describe the varied historical drivers of PC program development.
- Utilizing the Banner Health experience as a guide, create a path forward within your institution to focus on PopH needs using the PC program.

Population Health (PopH), defined most broadly, includes every health system, behavior, outcome, and person in the world. This definition can be so overwhelming as to be useless. More narrowly defined through a health system's lens, PopH requires knowing the system's population and engineering care models to optimize their health. As PC moves from predominantly end-of-life care to upstream care of the seriously ill, we are well positioned to improve PopH by impacting two of the three pillars of the Institute for Health Improvement's (IHI) Triple Aim—improving patient experience and reducing cost. The third pillar, improving the health of populations, will be impacted by PC programs that understand PopH and self-design using a population-focused approach.

How are programs to shift their thinking away from program-focused growth toward cutting edge PopH-focused growth? In this concurrent session, our team will present a new way forward for programs looking to grow. Using IHI's Triple Aim as the impetus for this new thinking, we will discuss old and modern definitions of PopH and relate each of them to PC's broad applicability to populations with serious illness. We will present historical growth patterns within PC and show that the focus has been on patient-level needs using workforce or leadership driven designs that typically lack a PopH focus. After explaining data-driven PopH assessment techniques like hotspotting and mapping, the Banner Health experience creating a multi-state, integrated, standardized PC program focused on PopH will be thoroughly explored and lessons learned during the process will be shared to help programs avoid common mistakes.

No longer can health systems care only for patients who walk through their doors. This session will provide a leading-edge, PopH approach to PC program development to ensure PC programs can continue to meet patients' and communities' needs.

Challenging the Paradigm of "The Lethal Condition": The Case of Trisomy 13 and 18 (SA515)

Katherine Nelson, MD, Hospital of Sick Children, Toronto, ON. Christopher A. Collura, MD, Mayo Clinic Children's Center, Rochester, MN. Kevin Madden, MD, MD Anderson Cancer Center, Houston, TX. Jordan Miraglia, MS LISW-CP, Hands of Hope Hospice and Palliative Care, Columbia, SC.

Objectives

- Discuss the evidence (and areas of uncertainty) about survival and surgical interventions in trisomy 13 and 18.
- Describe neonatal resuscitation, intensive care, and potential barriers to family-centered care for neonates with life-threatening illness common in Trisomy 13 and 18.
- Compare and contrast the medical issues that face children with Trisomy 13 and 18 across their life span.
- Demonstrate the need for psychosocial intervention specific to life limiting illness in neonates.

How we describe diagnoses matter. Most palliative care clinicians are exquisitely sensitive to this fact. However, phrases like "lethal condition" remain in common medical parlance and shape how all of us—providers and families alike—conceptualize certain diseases. This session will explore the power of this phrase and how its use may influence our conversations with families.

Trisomy 13 and 18 (T13/18) are relatively common genetic diagnoses. While most children die in the first year of life, emerging research suggests that longer-term survivors live well into childhood. These diagnoses have variable severity of illness across multiple organ systems, potentiating this prognostic uncertainty.

Parents of patients with T13/18 often face medical decision-making during multiple time points in the child's life, from prenatal birth planning to discussions regarding invasive interventions for the infant or child.

Many families choose to focus on the baby's comfort at birth through perinatal hospice services while others advocate for surgical interventions. Disagreements between health care providers and parents about the child's best interest are common. Palliative care and hospice clinicians are often asked to provide expertise in navigating goals of care, symptom management, and psychosocial support. Given this consultative role, a strong knowledge base of the current evidence in care for these patients is needed.

This session will be framed across two epochs in the child's life: the perinatal-to-infant period, and the longer-term survivor period (childhood-to-adolescence), and it will describe the latest population-based research for each phase. The session will focus on interdisciplinary considerations, including psychosocial challenges for families, as well as reviewing supportive resources. It will explore shared decision-making including common medical and surgical considerations. Discussion about both time periods will contain symptom-management guidance during hospitalizations and at end-of-life. The session will include perspectives from pediatrics, epidemiology, neonatology, intensive care, palliative care, and hospice.

See One, Do One, Coach One: How Clinical Coaching Can Help Trainees and Colleagues Just When They Need It with Just What They Need (SA516)

Juliet Jacobsen, MD, Massachusetts General Hospital, Boston, MA. Elizabeth Lindenberger, MD, Icahn School of Medicine at Mount Sinai, New York, NY. Cardinale Smith, MD PhD MSCR, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- Describe and demonstrate a clinical coaching model for teaching primary palliative care skills.
- Illustrate how the clinical coaching model can be used in different settings and with different types and disciplines of learner, ranging from faculty to medical students.
- Explore challenges of clinical coaching including how to measure outcomes, find resources, and develop a program.

With severe palliative care workforce shortages and growing needs of an aging population with serious illness, the demand for specialty level palliative care will greatly exceed availability within the current established models of palliative-care delivery. The solution proposed here is, through clinical coaching, to teach front-line clinicians how to provide primary palliative care. The goal of clinical coaching is to use expert teaching and communication practices to make it easier for clinicians of all levels to ask for and receive help.

In this session, we will describe a basic model of clinical coaching and illustrate how this model can be used with individual learners in the workshop or clinical setting. We will then describe three different applications of clinical coaching currently used at 2 different institutions across multiple disciplines and specialties: (1) family meeting communication coaching through two methods, i.e. direct observation of palliative care fellow trainees and an easy-access office hours approach for attendings; (2) a structured communication coaching intervention with oncologists in the outpatient setting; and (3) a service-delivery model that offers "coaching consultation" to inpatient clinicians. Finally, we will discuss challenges of implementing clinical coaching including how to find resources, develop a program for referring clinicians, and measure outcomes.

Moral Injury: Invisible Wounds of Combat (SA517)

John Franklin, MD HMDC, Ralph H. Johnson VA Medical Center, Charleston, SC. John Painter, PhD MDiv, Ralph H. Johnson VA Medical Center, Charleston, SC. Kelly Cooke, DO, ProHealth Care, Waukesha, WI. John Schluep Doctor of Ministry, First Congregational Church of Tallmadge, Tallmadge, OH.

Objectives

- Define and understand Moral Injury as defined in recent scholarship and how it differs from PTSD.

- Discuss examples of moral injury using actual veteran stories.
- Understand the impact of moral injury upon veterans at the end of life.

Various definitions of moral injury exist. Jonathan Shay describes it as "a betrayal of what's right, by someone who holds legitimate authority, in a high stakes situation." Brett Litz defines moral injury as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations."

Moral injury as an entity has only recently been recognized and efforts to address it begun. At the present time, it is not accepted as a diagnosis by the Department of Defense or the Veterans Administration. Moral Injury related to combat is a concept as old as war itself. It is referred to in ancient Greek literature and throughout history. When the noble cause for which one volunteered is compromised a moral injury occurs. Several centers across the country are now conducting research about moral injury and its treatment. Spiritual and faith communities have taken a significant role in addressing and healing moral injury.

Outcomes of moral injury include: shame, guilt, anger, isolation, desperation, despair, demoralization, self-handicapping behaviors and self-harming behaviors including suicidality. Unresolved moral injury can complicate the care of Veterans with serious, life limiting, or life-threatening illnesses and have serious effects on their quality of life. Therefore, it is very important that palliative care providers caring for Veterans have a good understanding of the complexities of moral injury.

This concurrent session will review the definition of moral injury and how it differs from PTSD. Using stories of combat Veterans, role play and short video presentations, causes of moral injury will be discussed. The effects of moral injury on the care of Veterans in general and Veterans dealing with serious, life limiting, or life-threatening illnesses in particular will be illustrated. This multidisciplinary panel will discuss current treatment options both in the mental health and chaplaincy fields.

Paper Session

Palliative Care for Dementia: A Randomized Controlled Study of a Replicable and Financially Viable Model for Organizations Providing Caregiver Support (SA518A)

Gillian Hamilton, MD PhD, Hospice of the Valley, Phoenix, AZ. Maribeth Gallagher, DNP FAAN, Hospice of the Valley, Phoenix, AZ. Kristen Pierson, BA, Hospice of the Valley, Phoenix, AZ. Susan Lowes, PhD, Teachers College, Columbia University, New York, NY. Peiyi Lin, EdD, Teachers College, Columbia University, New York, NY. Rosio Ortega, BS, Hospice of the Valley, Phoenix, AZ.

Objectives

- Identify an opportunity to initiate and advance excellent practice of palliative care for dementia with public and private health care insurers in our changing health care environment.
- Assess the symptoms of a patient with dementia and recommend a behavioral and medication management care plan based upon best available evidence to maximize comfort and quality of life.

Original Research Background. The Palliative Care for Dementia (PCD) model supports caregivers for persons with early, mid-stage, or advanced dementia who are not yet eligible for hospice. Literature review isolated critical components for program design. Program components include Dementia Educator home visits twice a month for the first month and then monthly for a minimum of three months; 24/7 triage nurse phone support for challenging behaviors; and geriatrician phone consultations.

Research Objectives.

1. Develop a cost-effective model to reduce care giver stress and improve quality of life for persons with dementia and caregivers.
2. Demonstrate that the model saves health care costs and thus can be adopted by public and private health care insurers.

Methods. 240 managed care Medicaid members with a diagnosis of dementia were determined by the plans to be at a nursing home level of care but resided in private or group homes. Each pair of referrals was randomized into two groups. 120 members received the PCD model; 120 members received usual care. All health care costs for both groups were tracked for one year. Both groups completed satisfaction surveys after three months, and PCD members completed Zarit Burden Interviews (ZBI) on admission and after three months.

Results. Preliminary results showed a savings of $398/member/month, $123 beyond the $275/member/month cost of the program. Satisfaction surveys indicated 88% satisfaction, with no difference between groups. ZBI showed significant reduction in stress ($p<.05$).

Conclusion. The PCD program reduced stress and saved costs when compared with a control group.

Implications for research, policy, or practice. Satisfaction, burden reduction, and cost savings data convinced the Medicaid plan to contract to pay for the program in the coming year, and is a viable option for other insurance plans nationally. The program, which combines social and medical intervention in a cost-effective manner, can be easily duplicated. Methods and materials for program replication will be provided.

Who Should Discuss Advance Care Planning? A Survey of Preferences Among Hospitalized Patients with Serious Illness (SA518B)

Jennifer Faig, MD, Beth Israel Deaconess Medical Center, Boston, MA. Mary Buss, MD, Beth Israel Deaconess Medical Center, Boston, MA. Lauge Sokol-Hessner, MD, Beth Israel Deaconess Medical Center, Boston, MA. Elizabeth Targan, MD, Beth Israel Deaconess Medical Center, Boston, MA. Kenneth Mukamal, MD, Beth Israel Deaconess Med Center, Boston, MA.

Objectives

- Define a population of non-oncology patients with serious illness using disease specific criteria.
- Identify with whom non-oncology hospitalized patients with serious illness prefer to have advance care planning conversations.
- Apply this data to educate outpatient physicians about the importance of advance care planning conversations.

Original Research Background. Advance care planning (ACP) is the process whereby patients articulate their preferences regarding medical care at the end of life. For the seriously ill, ACP is a priority; however it is unclear with which provider patients prefer to have those conversations.

Research Objectives. 1.To determine with which provider seriously ill, hospitalized, non-oncology patients prefer to have ACP conversations. 2. To identify factors associated with a patient's provider preference.

Methods. Investigators developed a survey to assess patients' preferences, adapting items from a prior instrument.[1] In conjunction with disease experts, investigators developed criteria to define 'seriously ill' inpatients with common non-oncologic diseases (CHF, ESRD, COPD, and cirrhosis). Patients were eligible if they met 'seriously ill' criteria and/or one year mortality was high as determined by the 'Surprise Question.' Patients on the medicine inpatient services at an academic hospital were surveyed.

Results. A total of 54 of 69 approached patients consented to participate. The majority (94%) (95% CI 89-100%) thought ACP was important; a minority (38%) [95% CI 25-53%] discussed ACP with a doctor before hospitalization; 14% [95% CI 6-26%] had an ACP conversation with a doctor during the index hospitalization. Most (85%) [95% CI 72-93%] prefer to discuss ACP with an outpatient provider (66% primary care physician (PCP), 19% outpatient specialist). Age, gender, frequency of outpatient visits and inpatient hospitalizations were not associated with physician preference. Longer duration and increased strength of the relationship were associated with preference for PCP ($p=0.08$ and $p = <0.0001$, respectively).

Conclusion. Seriously ill, hospitalized non-oncology patients prefer to have ACP conversations with outpatient physicians, most commonly their PCP. Longer and stronger relationships are associated with PCP preference.

Implications for research, policy or practice. This study provides the medical community with the perspective of seriously ill, hospitalized patients regarding ACP. The results should encourage PCPs and outpatient specialists to initiate ACP.

1. Lamont 2000. J Palliative Med.

Advanced Dementia: The Black and White of Mechanical Ventilation for Pneumonia and Septicemia (SA518C)

Joan Teno, MD MS, University of Washington, Seattle, WA. Rashmi Sharma, MD MHS, University of Washington, Seattle, WA. J Randall Curtis, MD MPH, University of Washington, Seattle, WA. Nita Khandelwal, MD MS, Harborview Medical Center, Seattle, WA. Ruth Engelberg, PhD, University of Washington, Seattle, WA. Vincent Mor, PhD, Brown University, Providence, RI. Pedro Gozalo, PhD, Brown University School of Public Health, Providence, RI. David Meltzer, MD, PhD, University of Chicago, Chicago, IL.

Objectives

- Explore the natural history of mechanical ventilation in pneumonia in hospitalized persons with advanced dementia.
- Understand the variation of increasing use of mechanical ventilation in pneumonia/septicemia in persons with advance dementia.

Original Research Background. Over the past decade, feeding tube use in nursing home (NH) residents with advanced dementia has declined by 50% even among Blacks. Has a similar reduction occurred in other invasive interventions such as mechanical ventilation?

Research Objectives. Examine the use of mechanical ventilation in Black and White NH residents with advanced dementia who were hospitalized for pneumonia or septicemia.

Methods. Retrospective cohort study of Medicare Beneficiaries with advanced dementia hospitalized between 2000 and 2013 that examined the use of mechanical ventilation. Two multivariate logistic regression models examined the association between race and the likelihood of receiving mechanical ventilation, controlling for patients' demographics, function, and comorbidities. A fixed effect model examined the association of race within a hospital, while the second model used robust clustering to examine the overall association of race.

Results. Between 2000 and 2013, 211,124 advanced dementia patients were hospitalized for pneumonia or septicemia. During these hospitalizations, Whites' use of mechanical ventilation increased from 3.8% to 10.4% and Blacks' use increased from 7.6% to 17.1%. Among those ventilated, one-year mortality remained high with 83.9% of Whites vs. 83.7% of Blacks dying in 2012. Compared to Whites, Blacks had a higher odds of receiving mechanical ventilation in the fixed effect (within hospital) model (AOR 1.33; 95% CI 1.27-1.38) and in the model with robust clustering AOR 1.77; 95% 1.63 -1.91).

Conclusion. Unlike feeding tube use, mechanical ventilation use among advanced dementia patients has substantially increased, with Blacks having a larger increase compared to Whites that is based, in part, on the hospitals where Blacks receive care.

Implications for research, policy or practice. Reductions in feeding tube use in advanced dementia suggests change is possible and our findings suggest that over-utilization of mechanical ventilation should be the next target. Efforts are needed to ensure that advanced dementia patients receive care consistent with their informed preferences and likely outcomes of care.

Predicting a Six-Month Prognosis in Patients with Alzheimer's Dementia: A Shot in the Dark? (SA518D)

Sonali Wilborn, MBBS MD MBA, Seasons Hospice & Palliative Care, Madison Heights, MI. Navdeep Grewal, MD, Seasons Hospice and Palliative Care, Madison Heights, MI.

Objectives

- Retrospectively analyze our patient data to evaluate the accuracy of the current prognostic indicators used to predict hospice eligibility for patients with Alzheimer's Dementia.
- Evaluate for the presence of other clinical criteria that may be used to predict a 6 month prognosis in patients with advanced Alzheimer's Dementia.

Original Research Background. Alzheimer's Dementia is the second most common non cancer hospice diagnosis (12.5%). With the increased burden of caring for an aging population there is a need to accurately evaluate the prognosis of patients with Alzheimer's Dementia. Predicting mortality, assessing prognosis is a challenging task for physicians and hospice organizations. Nationally, 25% of patients on hospice with a diagnosis of Dementia had > 6 M LOS. Hospice organizations constantly struggle to follow strict Medicare hospice guidelines while remaining sensitive to the clinical needs of these patients.

Research Objectives. Retrospectively analyze our patient data to evaluate the accuracy of current prognostic models, possibly identify other clinical criteria that may accurately predict prognosis in patients with Alzheimer's Dementia.

Methods. A detailed analysis of admission profiles of patients admitted to SH&PC in 2013 under ICD - 9 code 331 (Alzheimer's Dementia). All patients studied met the current hospice prognostic criteria.

Results. 221 patients with Alzheimer's dementia were identified for analysis. Of these patients, 29% survived longer than six months (mirroring national data) and 71% died within six months. Patients surviving longer than 6 months had mean MMI of 7.7 and those surviving less than six months had a mean MMI of 9.5 (Risk estimates of death within 6 M, 40.4% and 57% respectively). Ethnicity was a significant factor in predicting 6 M prognosis; a much lower percentage of African American patients lived longer than 6 M as compared with other ethnic groups and almost 60% of them resided in NHs.

Conclusion. Predicting mortality using current prognostic guidelines, fails in approximately 30% Alzheimer's patients, indicating a need for additional work in this area

Implications for research, policy or practice. More research into identifying specific, sensitive prognostic models for Alzheimer's patients. Additionally; we could make the case for allowing for a longer length of stay on hospice (maybe 1 year) for patients with a dementia diagnosis.

2:30—3:30 pm

Concurrent Sessions

Using QI Methodology to Standardize Education for Families Considering Tracheostomy Placement and Permanent Mechanical Ventilation for Their Children: An Attempt at Full Disclosure (SA520)

Rachel Thienprayoon, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Lesley Doughty, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Hemant Sawnani, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Mark Meyer, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Dan Benscoter, DO, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Marsha Blount, MSN CNP APRN, Cincinnati Children's Hospital, Cincinnati, OH. Catherine Hart, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH. Lori Herbst, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

Objectives

- Attendees will understand the long-term implications and decision-making complexities surrounding tracheostomy placement and permanent mechanical ventilation, including caregiver burden of tracheostomy care and potential for limited community resources.
- Attendees will be able to describe the quality improvement methodology used to standardize communication around this decision in our institution.
- Attendees will be able to articulate novel approaches to use in their own institutions to improve communication around complex decision making for families.

The decision to place a tracheostomy tube in a child who will be ventilator-dependent for the duration of her life is complex. Family values, goals of care, family and community resources, homecare nursing, and risks and benefits of the procedure itself should be taken into account when counseling a family facing this decision. Frequently, these decisions are made during an admission for acute respiratory failure in which the child requires intubation and mechanical ventilation in the intensive care unit, and extubation has become impossible. Therefore families may approach this complex decision alongside providers who do not have continuity with the child or a broader appreciation of the family's values and goals of care. The approach to explaining this choice, and recommendations to guide the family, may differ based on the physician leading the conversation. While such providers may discuss the risks and benefits of the procedure and the impact on the child's immediate future, the larger context including long-term implications on the child and family may not be thoroughly explained and explored.

Therefore, our institution has sought to utilize quality improvement methodology to standardize communication surrounding the decision to place a tracheostomy tube in a child who will likely require lifelong mechanical ventilation. A "Trach/Vent Consult" team was created including providers from the intensive care unit, palliative care, otolaryngology, and pulmonology. Using a failure mode events analysis, potential interventions for improvement were identified: defining and educating the consult team, defining eligible patients/families, establishing a clear process for providers to consult the team, defining a script to utilize in family meetings, and educating key stakeholders in the institution regarding the process. The smart aim of this project is to increase the use of a standardized communication format for eligible patients/families considering tracheostomy placement from 0% to 100% by April 1, 2017.

Primary Pediatric Palliative Care—Teaching and Learning from the Bedside to the Community (SA521)

Kathy Perko, MS RN, Doernbecher Children's Hospital at Oregon Health & Science University, Portland, OR. Deborah Lafond, DNP NP PNP CHPPN CPNP CPON, Children's National Medical Center, Washington, DC.

Objectives

- Identify teaching opportunities and curriculum to provide primary palliative care to physicians, advanced practice nurses and bedside staff.
- Provide a framework for providing and supporting primary palliative care in partnership with community based adult hospices.

Over the past decades, hospital based pediatric palliative care programs have significantly increased, however, palliative care referrals are still often delayed and many children still die in the hospital. Primary palliative care education increases the ability for bedside clinicians as well as advanced practice nurses and physicians to advocate earlier for referrals and educates our adult hospice colleagues to allow more children to die with hospice support.

Innovative models are needed to improve access to care and continuity across the spectrum of services, as well as supporting bedside clinicians. Evidence shows palliative care improves patient and family satisfaction, symptom control, and QOL, eases burdens, and decreases health care utilization. Primary palliative care provided by bedside clinicians improves access to palliative care for children and families while decreasing moral distress for clinicians and improving palliative care clinical skills.

Professional education and development in palliative care is mandated in the 2014 IOM report. Other IOM mandates addressed by this model include: Delivery of Person-Centered, Family-Centered Care through provision of timely, seamless, high-quality, integrated, child and family-centered primary palliative care services augmenting the tertiary palliative care team and Clinician-Patient Communication and Advanced Care Planning through development of an enhanced communication skill set for the bedside to clarify goals of care and continue advance care planning discussions started by the primary medical team and/or tertiary palliative care team.

Most communities do not have access to a pediatric hospice. A program to integrate primary palliative care education and support through adult community hospices for pediatric patients will be presented. Discussion will include how education is provided, access to the tertiary palliative care program and successes and pitfalls. Using case studies, two programs will be highlighted, the PANDA Palliative Care Team at Children's National in Washington DC and Bridges at Doernbecher Children's Hospital in Portland, OR.

Diverse Models of Home-Based Palliative Care: Key Principles from Four Programs for Impact on Quality and Cost (SA522)

Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY. Richelle Nugent Hooper, MBA MSN FNP-BC ACHPN, Four Seasons, Flat Rock, NC. Dana Lustbader, MD, ProHEALTH, Lake Success, NY. Robert Parker, DNP RN CENP CHPN, Interim Healthcare, Lockhart, TX. Donna Stevens, BS, Lehigh Valley Hospital, Allentown, PA.

Objectives

- Describe the role of home-based palliative care in the continuum of palliative care programs.
- Describe the characteristics of diverse successful home-based palliative care models.
- Explain the challenges and opportunities of available home-based palliative care models in order to determine which characteristics best align with your community.

Not so long ago palliative care was available only through the Medicare hospice benefit for the terminally ill. Now, hospital palliative care is a routine service, especially in larger hospitals that serve the sickest and most complex patients. Yet, we are far from securing relative access to palliative care for our nation's seriously ill patients and their families because the great majority of them are neither dying nor in the hospital. In order to ensure access to palliative care where people need it, we must help communities build palliative care services that go to the patient and their family where they live.

Home-based palliative care is the future of quality medical care for the sickest and costliest patients and their families. Several home-based palliative care programs across the country are delivering this service to their patients; they serve as examples for others who want to implement this critical service for seriously ill patients. Panelists in this session will share replicable principles and practices from four pioneering home-based palliative care programs providing services to seriously ill patients in a variety of living situations—including their homes, assisted living residences, skilled nursing facilities, and homeless shelters. At the forefront of community-based palliative care, these programs are leaders in working with payers and in providing innovative, cost-effective approaches to providing quality home-based palliative care. They represent a variety of patient populations, geographic settings, payment models, and organizational homes: a large hospice and palliative care organization; a large home health and hospice organization; an integrated multispecialty clinician group; and a health care system. Program leaders will share how they aligned their programs with the needs and priorities of patients, families, community partners, and program stakeholders, as well as key principles and challenges and opportunities encountered. An interactive Q & A session will follow.

Caring for Our Own—How An Employee Health Incentive Plan Can Encourage Advance Care Planning (SA523)

Ira Byock, MD FAAHPM, Providence Health & Services, Torrance, CA. Matthew Gonzales, MD, Institute for Human Caring, Torrance, CA.

Objectives

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

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

Providence Health & Services is a large (35 hospitals, five state) healthcare system that is committed to employee health and seeks to exemplify goal-aligned care.

The Institute for Human Caring proposed—and senior leadership approved—an advance care planning (ACP) activity as a 2016 health incentive option. This is one part of a multifaceted plan to establish goal-aligned care as a quality standard across Providence, and make goals of care conversations a common expectation of clinicians, patients and families alike.

The Providence 2016 health incentive plan offered insured employees and their covered family members the opportunity to view a brief (4 min) online video regarding ACP, complete 8 reflective questions about their own beliefs about ACP, and decide what action to take as a result of reviewing their ACP. A traditional risk reduction activity was also available.

Over 51,000 individuals (91% of participating employees and spouses) chose the ACP incentive option and over 80% rated the experience as helpful or very helpful.

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

Early evidence suggests that this health incentive plan is helping to drive cultural change consistent with organizational core values and strategic priorities.

Hey, Doc, Can We Cut Down on the Pain Pills? Current Status of Opioid Tapering Guidelines and How to Do It (SA525)

Eric Prommer, MD HMDC FAAHPM, Greater Los Angeles Healthcare, Los Angeles, CA. Mary Lynn McPherson, PharmD MA BCPS CPE, University of Maryland School of Pharmacy, Baltimore, MD. Kathryn Walker, PharmD BCPS CPE, Medstar Health, University of Maryland School of Pharmacy, Baltimore, MD. Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA.

Objectives

- Learn how to safely taper patients who are on chronic opioids.
- Learn how to manage symptoms during opioid tapering.
- Identify resources for patient support during tapering.

Current guidelines for opioid therapy focus on how to safely and effectively prescribe opioids. With the growing number of palliative care clinics and moving palliative care "upstream" clinicians are facing patients who have non-malignant pain associated with their life-limiting illness. Growing evidence exists that long term opioid therapy may not be beneficial in non-cancer pain. This coupled with an increasing regulatory environment is leading clinicians to consider opioid tapering as an opioid management strategy when they encounter patients where the risk benefit ratio may be unfavorable. These may be patients who experience: 1.) lack of benefit (pain relief/functional improvement) despite repeated opioid escalation; 2) severe adverse effects despite opioid rotation; and 3.) resolution of their disease process and 4.) exhibit evidence of suspected diversion, addiction or chemical coping or opioid induced hyperalgesia. Surprisingly, current guidelines do little to help clinicians with the process of opioid tapering. The goal of this session be to allow attendees to gain confidence in opioid tapering. The session will be presented by a panel of pharmacists and palliative care clinicians. The session will focus on: 1.) Identifying the patient with an adverse risk benefit for opioid use. 2.) Identifying optimal regimens for opioid tapering. 3.) Learning how to identify and treat withdrawal symptoms and provide taper support. 4.) Learning how to identify and treat withdrawal symptoms and provide taper support. 5.) Identifying the optimal agents to use in the tapering process. 5.) Identifying other resources to support patients during the tapering process. 6.) Identifying risk mitigation strategies to protect physicians during this process.

Research 101: A Practical Introduction to Understanding, Evaluating, and Applying Palliative Care Research to Your Clinical Practice (SA526)

Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Katherine Ornstein, MPH PhD, Icahn School of Medicine at Mount Sinai, New York, NY. Marie Bakitas, DNSc CRNP ACHPN, University of Alabama at Birmingham, Birmingham, AL. Robert Arnold, MD FAAHPM, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Identify the rationale, strengths, weaknesses, and types of palliative care research questions that can be addressed by clinical trials, existing data analysis, and qualitative methods.
- Discuss strategies for evaluating the quality of published research, as well as for leveraging

research to inform clinical practice in hospice and palliative care.

As hospice and palliative care continues to mature and expand, so does the evidence base supporting our discipline. Understanding how to interpret research is an important skill for all clinicians, yet keeping up with the state-of-the-science in research methodology can be daunting. In this session, we will demystify three methodologies commonly used in hospice and palliative care research: clinical trials, existing (aka secondary) data analysis, and qualitative methods. All participants, regardless of fluency in research, will benefit from attending this session.

Our multidisciplinary, multi-institutional panel of palliative care researchers and clinician-researchers will use case-based approaches to explain each methodology, its strengths and weaknesses, considerations of using each method within the idiosyncrasies of hospice and palliative care, as well as the strategies that experts use to assess research quality. Dr. Ornstein, an epidemiologist, will discuss how quantitative data can and cannot be used to explore associations or to establish causality, touching upon concepts such as confounding and propensity score matching. Dr. Bakitas, a nurse-researcher, will explain the conceptual underpinnings of clinical trials, as well as common pitfalls in palliative care trials and their implications. Dr. Kavalieratos, a health services researcher, will provide an overview of qualitative designs often seen in the palliative care literature, illustrating their utility in both research and quality improvement. Lastly, Dr. Arnold will draw from his experiences as a clinician-administrator to provide examples of how to effectively apply findings from each type of study to clinical practice.

By the end of this session, participants will have a practical grasp of clinical research concepts leaving them better equipped to interpret and translate research into patient care. Participants are encouraged to come ready with questions to be discussed in a moderated question-and-answer session.

Paper Session

Acute Leukemia Patients' Unmet Needs: Qualitative Findings and Suggested Opportunities for Early Palliative Care (SA527A)

Nathan Boucher, DPH MPA MS PA, Durham VAMC GRECC/Duke University, Durham, NC. Kimberly Johnson, MD MHS, Duke University Medical Center, Durham, NC. Thomas LeBlanc, MD MA, Duke Cancer Institute, Durham, NC.

Objectives

- Explain 5 challenges experienced by patients with AML.
- Describe 5 ways that early palliative care could positively impact care for patients with AML.

Original Research Background. Patients with acute leukemias likely have unmet palliative care needs, yet little is known about the specific challenges they face, particularly during active treatment. Early concurrent palliative care with standard oncology care could help meet patients' needs regarding symptom management, social support, prognostic understanding, psychological distress, and care goals.

Research Objectives. We examined acute myeloid leukemia (AML) patients' expressed challenges, support sources, and mortality perceptions after intensive induction chemotherapy. We aimed to understand opportunities for palliative care interventions for AML patients.

Methods. This was a qualitative study of AML patients with high-risk disease at Duke University Hospital, Durham, NC. Multiple coders used descriptive content analysis to identify common and recurrent themes.

Results. We analyzed interview transcripts of 22 patients. Sample demographics included: 10 (45.5%) females, 12 (54.5%) males, mean age = 62 (SD 10.9), 19 (86.4%) non-Hispanic white, and 3 (13.6%) non-white/non-Hispanic. All had high-risk disease, either by age, relapse status, or molecular markers. Patients identified challenges in 5 key domains: physical symptoms, psychological issues, care coordination, uncertainty, and end-of-life care. Specific challenges included feelings of helplessness/hopelessness, activity restriction, fatigue, fevers, caregiver stress, geographic distance to care, and confusion about next steps in treatment/non-treatment. Sources of supports included hope, resilience, families'/friends' devotion, caregivers, scripture, and positive attitude. Interviewees reported relying on these supports to negotiate physical distress, psychological distress, and prognostic uncertainty. Perceptions related to mortality included death/dying acceptance, processes of saying goodbye to loved ones, and outlook incongruent with prognosis. Interviewees frequently reported poor communication/coordination by their care team, including treatment plan uncertainty.

Conclusion. AML patients face substantial challenges regarding symptoms, psychological distress, care coordination, uncertainty, and end-of-life care. These challenges signal unmet palliative care needs in high-risk AML patients.

Implications for research, policy, or practice. These findings highlight opportunities to develop targeted palliative care interventions addressing symptom management, social support, prognostic understanding, psychological distress, and communication in AML patients.

Symptom Burden in Patients Initiating Treatment for Metastatic Colorectal Cancer (SA527B)

Laura Cantino, MD, Icahn School of Medicine.at Mount. Sinai, New York, NY. Carling Ursem, MD, University of California San Francisco, San Francisco, CA. Christine Ritchie, MD FAAHPM, University of California San Francisco, San Francisco, CA. Michael Rabow, MD FAAHPM, University of California San Francisco, San Francisco, CA. Chloe Atreya, MD PhD, University of California San Francisco, San Francisco, CA. Kara Bischoff, MD, University of California San Francisco, San Francisco, CA.

Objectives

- Describe the most prevalent symptoms and concerns of patients with metastatic colorectal cancer.
- Summarize key features of a model to integrate outpatient palliative care into usual oncologic care for metastatic colorectal cancer.

Original Research Background. Current NCCN guidelines recommend early integration of palliative care (PC) into routine cancer care, particularly for patients with metastatic solid tumors. However, no study has yet focused on PC needs specific to patients with metastatic colorectal cancer (mCRC).

Research Objectives:.

1. To characterize PC needs of patients with mCRC.
2. To use findings to inform the design and implementation of an integrated PC program.

Methods. We are conducting a pre-post prospective cohort study of integrated PC for patients with mCRC. We enrolled patients within 90 days of diagnosis or of establishing care for mCRC. Patients were surveyed regarding symptoms, quality of life, psychosocial concerns, functional status and understanding of prognosis. During the pre-implementation phase, described here, patients received usual oncologic care, with referral to outpatient PC available at oncologist discretion.

Results. The 29 patients in the pre-implementation phase were enrolled a median of 48 days from the time of diagnosis of mCRC. Median age is 60 (range 22-86), 34% are women, 38% identified as non-Caucasian, and 28% have limited English proficiency. Seventy-two percent of patients reported at least 1 moderate or severe symptom, most commonly anorexia, decreased wellbeing, and fatigue. Large minorities reported psychosocial challenges and moderate or greater distress. Despite expressing satisfaction with the information received about their cancer, 62% of patients believed that they had at least a 50% chance of being cured of cancer.

Conclusion. Physical symptoms, psychosocial concerns and poor prognostic awareness are common among patients with mCRC. Based on these data, we designed and implemented an integrated PC program that includes weekly multidisciplinary meetings with oncology and PC providers, and proactive PC visits from the time of diagnosis, which are coordinated within the oncology clinic.

Implications for research, policy or practice. Patients have significant PC needs close to the time of diagnosis of mCRC, supporting integration of PC services into their routine cancer care.

Adherence to the American Society of Radiation Oncology Choosing Wisely Campaign Recommendations for Treatment of Bone Metastasis: Analysis of Medicare Data at 12 Centers in the Southeast US (SA527C)

Audrey Wallace University of Alabama at Birmingham, Birmingham, AL. Courtney Williams, MPH, University of Alabama at Birmingham, Birmingham, AL. Elizabeth Kvale, MD, University of Alabama at Birmingham Center for Palliative and Supportive, Birmingham, AL. Bradford Jackson, PhD, University of Alabama at Birmingham, Birmingham, AL. Maria Pisu, PhD, University of Alabama at Birmingham, Birmingham, AL. Edward Partridge, MD, University of Alabama at Birmingham, Birmingham, AL. Gabrielle Rocque, MD, University of Alabama at Birmingham, Birmingham, AL.

Objectives

- Understand adherence to Choosing Wisely guidelines from a radiation oncology perspective.
- Appreciate the impact of patient, practitioner, and system on choice of duration of treatment.

Original Research Background. The American Society of Therapeutic Radiation Oncology (ASTRO) Choosing Wisely (CW) campaign recommends avoidance of extended fractionation (>10 treatments) for palliation of bone metastasis with radiation therapy (RT).

Research Objectives. The purpose of this study is to analyze palliative fractionation schemes in a cohort of Medicare patients.

Methods. Data were for Medicare patients $>$ 65 with bone metastasis diagnosis from 12 cancer community networks affiliated with an academic center in Alabama, Mississippi, Georgia, Tennessee, and Florida. Stage IV cancer patients treated with radiation for bone metastasis from Quarter 1, 2012 to Quarter 1, 2015 were eligible and identified using ICD-9(198.5) and CPT/HCPCS codes. Adherence was measured by treatment duration $\leq$ 14 vs $>$14 calendar days.

Results. 2194 patients with bone metastasis were identified, 427 (19.5%) of which were treated with RT: 16.6% (2012), 37.5% (2013), 27.4% (2014), 18.5% (2015). Median age at diagnosis was 69.2 (IQR 9.0), and 1928 (87.8%) patients were Caucasian. In the 427 patients treated with RT, 25.8%, 37.0%, and 33.0% were treated in 2012, 2013, and 2014. The top 4 primary sites were: genitourinary (22.7%), breast (20.4%), gastrointestinal (15.7%), and lung (10.8%). Overall guideline adherence was 65.1%: 1 fraction in 33.3%, $\leq$14 calendar days in 31.9%, and $>$ 14 calendar days in 34.9%. Average adherence by upper, middle, and lower tertile of sites was 52.0%, 64.5%, 71.5%. Adherence by primary cancer type was similar: breast (58.6%), lung (65.2%), gastrointestinal (67.2), and genitourinary (72.5%). In patients treated $<$ 14 days, 4% were treated with either 1 or 2-5 fractions of stereotactic body radiotherapy.

Conclusion. While compliance was high overall with ASTRO CW recommendations, there remained a significant portion (36%) of patients who received a prolonged course of palliative radiation.

Implications for research, policy or practice. More research is needed in understanding patient, provider, and system factors leading to prolonged fractionation schemes for bone metastasis.

Palliative Care Involvement Is Associated with Less Intensive End-of-Life Care Characteristics in Adolescent and Young Adult Oncology Patients (SA527D)

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Objectives

- Describe the end of life characteristics of adolescent and young adult oncology patients.
- Recognize the value of and describe the possible outcomes of integration of palliative care into the routine oncology care of adolescent and young adult oncology patients.
- Develop prospective ways to evaluate the role and effect of palliative care involvement in adolescent and young adult oncology patients

Original Research Background. Adolescent and young adult oncology (AYAO) patients often receive intensive care and experience significant symptoms at the end of life (EOL). Integration of palliative care into the care of AYAO patients may help alleviate patient and family suffering.

Research Objectives. This study aimed to describe the characteristics of AYAO patients aged 15 to 25 years who died in the hospital and to compare the experiences of AYAO patients who did and did not receive palliative care.

Methods. An investigator-developed, standardized data extraction tool was used to collect information about demographics, treatment, EOL characteristics, and symptoms during the last month of life (LMOL) for 69 AYAO patients aged 15 to 25 years who died while hospitalized.

Results. AYAO patients who died in the hospital were more likely to have a hematologic malignancy and required considerable medical and psychosocial care and experienced numerous symptoms during the LMOL. When compared to those patients who received no palliative care involvement, patients followed by the palliative care team were less likely to die in the intensive care unit (38% vs. 68%, $P = 0.024$) and less likely to have been on a ventilator (34% vs. 63%, $P = 0.028$). They also received fewer invasive medical procedures during the LMOL (median, 1 v. 3 procedures, $P = 0.009$) and had a do-not-resuscitate order in place for a longer time before death (median, 6 vs. 2 days, $P = 0.008$).

Conclusion. AYAO patients who died as inpatients received intensive therapies, had numerous symptoms, and required significant support from the medical and psychosocial teams. Involvement of the palliative care team was associated with the receipt of less intensive treatments and fewer deaths in the intensive care unit.

Implications for research, policy or practice. Early integration of palliative care into the routine care of AYAO patients is recommended and should be prospectively studied.