like to take drugs." Third, *marginalization of caregiver concerns*: "They kept giving opiates which I had objected to but was told it was not my decision…by then they had him addicted." "I did not feel like he was a good candidate… (he) had a blood clot…diabetes, was weak… I asked, 'Do you really think he's a good candidate?'(The doctor) said, 'Yes' so that's what we did, but that was my complaint."

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

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

Engaging Primary Care Physicians: Lessons Learned Seeking Buy-In and Patient Referrals for a Home-Based Palliative Care Program (TH341D)

Alexis Coulourides Kogan, PhD MSG, University of Southern California, Los Angeles, CA. Michael Kersten, MDiv MPH, Hill Physicians Medical Group, San Ramon, CA. Torrie Fields, MPH, Blue Shield of California, San Francisco, CA.

Objectives

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

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

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

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

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

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

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

3—4 pm

Education Forums

State of the Science in Pediatric Palliative Care Forum (TH351)

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

Objectives

- Discuss with a colleague one new article relevant to the clinical practice of pediatric palliative care.
- Describe a fact, skill or attitude that you are reconsidering based on the information presented at this session.
- Identify a clinical population that your program serves that you could write about to educate the larger pediatric palliative care community.

With the growth of Pediatric Palliative Care, it is essential for practitioners to find ways to stay current on the most recent literature. In the spirit of the State of the Science plenary which is part of each Assembly, the presenters will endeavor to review the literature published since 2017 which should inform the practice of Pediatric Palliative Care. Our interdisciplinary team of co-presenters includes representatives from medicine, nursing, social work and chaplaincy and will look at the academic literature relevant to the multiple disciplines represented. In addition to highlighting recent literature, the presenters hope to inspire session participants to consider how new knowledge will influence their practice and how they can personally contribute to the published knowledge base.

Gender Equity and Career Advancement: Implications for Hospice and Palliative Medicine (TH352)

Kimberly S. Johnson, MD MHS, Duke University School of Medicine, Durham, NC. Sean O'Mahony, MD MS FAAHPM, Rush University Medical Center, Chicago, IL. Helen Chen, MD, Hebrew SeniorLife/Harvard Medical School, Boston, MA. Susan Hingle, MD, SIU School of Medicine, Springfield, IL. Darilyn Moyer, MD, American College of Physicians, Philadelphia, PA.

Objectives

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

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

Finding Your Highest and Best Use as a Palliative Nursing Leader (TH354)

Abraham A. Brody, PhD RN FAAN FPCN, Hartford Institute for Geriatric Nursing and New York University, New York, NY.

Objectives

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

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

4:30—5:30 pm

Concurrent Sessions

Clinical Practice Guidelines for Quality Palliative Care: The 4th Edition of the NCP Guidelines (TH360)

Gwynn Sullivan, MSN, National Coalition for Hospice, Richmond, VA. Betty Ferrell, MA CHPN FAAN FPCN,