

City of Hope National Medical Center, Duarte, CA. Martha Twaddle, MD FACP FAAHPM HMDC, Northwestern Feinberg School of Medicine, Lake Forest, IL.

Objectives

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

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

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

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



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

Objectives

- List the advantages and challenges to teaching with drills and the evidence for use in health professions education.

- Appreciate and apply drill based practice to teaching palliative care skills.
- Describe the educational and behavioral theories of drill design; this includes the components and structure of a successful drill.

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

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



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

Objectives

- Describe recent payment reform efforts that affect hospice and palliative care delivery.
- Identify the opportunities and challenges of recent payment reforms for hospice and palliative care delivery.

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

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

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

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



Lara Skarf, MD, VA Boston Healthcare System, Boston, MA. Sohera Syeda, MD, Boston VA Healthcare, West Roxbury, MA. Zachary Sager, MD MA, BIDMC/Boston VA, Boston, MA. Elizabeth Bowers, ACHPN, Hospice of the North Shore, West Roxbury, MA. Marilyn Moy, MD, VA Boston Healthcare System, Boston,

MA. Tekkil Mekuria, PharmD, VA Boston Health Care, West Roxbury, MA. Barbara Hayes, MSN GCNS, VA Boston Healthcare System, Boston, MA. Marina Khait, FNP, US Department of Veterans Affairs, West Roxbury, MA.

Objectives

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

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

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

In this concurrent session, clinicians from a multidisciplinary Palliative Care-Pulmonary clinic will use case studies, clinical literature, and pilot data from this institution's experience to share challenges and solutions supporting patients with advanced pulmonary disease and building strong collaborative ties to a pulmonary program. We will share our experiences with advance care planning, POLSTs, symptom