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. Tekikil 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

management and hospice referral. Additionally, clinicians will share experiences and data from implementation of an opioid assessment tool and an opioid management protocol in this population.

Image-Guided Palliative Care (TH364)

Jay Requarth, MD FACS, Catawba Regional Hospice, Newton, NC.

Objectives

- Develop a treatment plan that differentiates between those with a fully expanding lung and those with a fibrinothorax.
- Determine different diagnostic tests and maintenance options that would be realistic and effective for that clinical setting.
- List the 3 therapeutic options for celiac plexus blocks and their relative effectiveness areas of planning for physical therapy services.

Image-guided palliative care is an underused therapy that can provide pain and symptom relief. These treatments can be provided by any physician with access to quality ultrasound, fluoroscopy, and computed tomography (CT) equipment. However, the efficacies and risks of the therapies may be different based on the technique and equipment used for the image-guided treatment and the timing of these treatments.

This session will describe commonly encountered palliative problems that can be mitigated with image-guided and percutaneous therapies. A continuance of the 2018 interventional radiology presentation, this discussion will address different topics and will include efficacy, options, and risk data on each of the image-guided treatment options. Celiac plexus neurolysis will be reviewed again this year because of its importance in pain management, but we will concentrate on non-radiology based options (endoscopic ultrasound directed versus percutaneous CT-guided) and optimal timing of these 2 treatment options.

The following topics will be discussed: the decision-making process and treatment of recurrent benign and malignant pleural effusions with special emphasis on the diagnosis and treatment of fibrinothorax (trapped lung), celiac plexus neurolysis for upper abdominal cancer pain, treatment options for recurrent cirrhotic and malignant ascites, gastrostomy tube insertion options and risks as well as recognition and treatment of late complications such as skin burns and intussusception, and catheter-based palliation of obstructive jaundice and cholecystitis.

Finally, the presenters will review the efficacy and risks of intercostal neurolysis (rib blocks) for chest wall pain as well as how any physician can master this simple technique which can be performed without any image-guidance.

The Untold Story of the Opioid Crisis: An Interdisciplinary Approach to Patients with Life-Limiting Complications of Opioid Addiction (TH365)

Britni Lookabaugh, MD, OhioHealth, Columbus, OH. Jessica Geiger-Hayes, PharmD, OhioHealth Riverside Methodist Hospital, Columbus, OH. Jill Yahner, MED LSW, OhioHealth, Columbus, OH. Wendy Ungar Rabbi, OhioHealth, Columbus, OH. Alan Murphy, PhD, OhioHealth, Columbus, OH.

Objectives

- Collaborate with interdisciplinary team members to navigate the complex biopsychosocial care of patients suffering from the complications of opioid use disorder.
- Negotiate the ethical considerations of recurrent cardiac surgery for infective endocarditis related to ongoing intravenous opioid use.

According to the CDC, in 2016, 62,632 Americans died from drug overdose, with 66% of these deaths related to opioid use. Even with the media's increased attention to the opioid crisis, the stories of patients with recurrent medical complications of addiction remain untold. Medically, these patients are at high risk for recurrent, life-threatening infections, such as endocarditis. Potential survival may entail multiple major surgeries. Surgeons may be reluctant to provide these surgeries, and when surgery is provided, patients suffer post-operative pain that is challenging to control because of patients' opioid tolerance, a challenge compounded when the time comes to transition to outpatient plans for pain management. Patients dying of medical complications of opioid use disorder can suffer from severe symptoms that are similarly difficult to manage. Socially, opioid use disorder may complicate relationships between patients and their families, with the result that surrogate decision making may be vexed by estrangement or codependence. Spiritually, patients struggle with distress due to loss of function and identity; younger patients, disproportionately affected by opioid use disorder, struggle with the threat to, or impending loss of, what they expected to be a longer life. Organizationally, the palliative care team may also assist in palliating the moral distress that bedside staff may feel in caring for these young and complex patients. The myriad challenges that arise in providing palliative care to patients with opioid use disorder necessitates a robust interdisciplinary approach; to that end, this session will include a physician, social worker, chaplain, pharmacist and clinical ethicist who will discuss the difficulties presented by opioid use disorder in their respective fields and suggest interventions to address them.