Palliative care continues to be a rapidly growing field aimed at improving quality of life for patients and their caregivers. As our understanding of what works in palliative care is growing, there is a need to usefully synthesize evidence across key areas about which interventions work, for whom, and under what conditions, to more directly guide clinical practice, quality measurement, and to help make evidence-based policy decisions. The purpose of this educational session is to provide a synthesized overview of the current evidence in palliative care that was used to inform the Clinical Practice Guidelines for Quality Palliative Care, 4th edition.

Ten key review questions addressing eight domains guided a systematic review focused on palliative care interventions. The review was supported by a technical expert panel. We searched eight databases for systematic reviews published in English from 2013, after the last edition of NCP guidelines were published, to present. We identified 139 systematic reviews meeting inclusion criteria. Most promising areas in terms of structure and process of care are home-based palliative care, interdisciplinary team care, and telehealth approaches. There is documented evidence for comprehensive palliative care and music/art therapy addressing physical and psychological aspects of care, and for life review/dignity therapy in the area of spiritual assessment approaches. The existing evidence base for social needs assessments and culturally sensitive care remains very limited. Grief/bereavement support services appear to improve key outcomes for caregivers. Evidence for ethics consults and advance directive/physician order interventions show the strongest evidence in the ethical and legal aspects of care domain.

A substantial body of evidence exists to support clinical practice guidelines for quality palliative care but the quality of evidence is limited. This comprehensive review underscores the importance of targeting future research toward building high-quality evidence in key areas of clinical practice and patient/caregiver needs.

Leveraging Global Partnerships to Expand Human Resources in Palliative Care: The Development of Regional Training Centers in Chile and Jamaica (SA526)

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Objectives

- Recognize the immense need for standardized, high-quality palliative care training programs in low and middle-income countries.
- Identify how training programs need to be carefully contextualized into the available local resources and needs of the local population.
- Explain strategies and best-practices to foster and maintain successful academic partnerships between different countries.

As recently highlighted by the Lancet Commission on Palliative Care and Pain Relief, there remains a morally unacceptable lack of access to palliative care services around the world. This access abyss is especially pronounced within low and middle income countries (LMICs), where despite having 81% of the world's population, only two LMICs (Uganda and Romania) have advanced palliative care services that are integrated into the health system. As suggested by the WHO public health strategy for palliative care, the growth of available services requires appropriate public policies, adequate drug availability, and effective education and training programs.

With a direct focus on this 3rd strategy of providing education opportunities, The Program in Global Palliative Care at Harvard Medical School has sought to foster academic partnerships with palliative care leaders in LMICs to create and implement high-quality, standardized training programs. This session will focus on the partnerships formed between Harvard and two specific sites: the Pontificia Universidad de Catolica in Santiago, Chile and Hope Institute Hospital in Kingston, Jamaica. Through these academic partnerships, both sites are now offering various levels of formal training in palliative care across their own respective countries, and both are also considering strategies to offer training beyond their borders to the rest of Latin American and the Caribbean in the coming months.

In this session, colleagues from Chile, Jamaica, and Boston, will highlight our experience of forming these partnerships, with a focus on how training structures and educational content were contextualized for each site, as well as the lessons learned and best practices that were identified.

An Integrative Medicine Approach to the Utilization of Cannabis and Cannabinoids for Palliation in Advanced Cancer Patients: Canadian/US Perspectives and Practical Recommendations (SA527)

Sunil Aggarwal, MD PhD, SageMED, UW School of Medicine, MultiCare, Seattle, WA. Maria-Fernanda Arboleda, MD, McGill University, Montreal, Canada. Claude Cyr, MD, Clinique La Cité Médicale, Montreal, Canada. Antonio Vigano, MD MSC, McGill University, Montreal, Canada. Paul Daeninck, MD MSC FRCPC, University of Manitoba, Winnipeg, Canada. Lynda Balneaves, PhD, University of Manitoba, Winnipeg, Canada. Andree Neron Montreal, Canada. Erin Prosk, MSC, Santé Cannabis, Montreal, Canada.

Objectives

- Describe current and future examples of research on medical cannabis for palliation in advanced cancer patients.
- Understand the various challenges to providing access and monitoring to medical cannabis in community-based, tertiary care and long-term care residences.
- Review key practical recommendations on the integration of cannabinoids for symptom management in palliative care patients.

Integration of cannabinoids into palliative care has been delayed by many obstacles, such as paucity of clinical research data, poor clinical knowledge on how to initiate and monitor cannabinoid treatments and conflicting or unsupportive regulatory frameworks. Cancer patients, on the other hand, are known to have high rates of cannabis use and desire but are not receiving information about cannabis from oncology providers. This session proposes to illustrate the different clinical settings where the use of the traditional plant botanical cannabis and its derivatives could be considered, as well as provide an overview regarding their appropriate use from an integrative medicine perspective –cannabinoid integrative medicine. The discussion will primarily be focused on the palliative care needs of patients with advanced cancer. The group of authors include both US and Canadian-based clinician-scientist/scholars who have developed a practical approach for the integration of cannabis into oncologic palliative care, including guidance on choice of chemovars (strains), titration and monitoring as well as development of clinical pearls based on their clinical experience and the published literature. Areas covered include symptom management, palliation of existential distress, and experimental use of cannabinoids in disease modification.

Shared Decision Making for Long-Term Opioid Therapy for Cancer Pain (SA528A)

Karleen Giannitrapani, PhD, VA Health Services Research and Development Service/Stanford, Palo Alto, CA. Azin Azarfar, MD, University of Central Florida, Orlando, FL. Maria Silveira, MA MD MPH FAAHPM, University of Michigan, Ann Arbor, MI. Amanda Midboe, PhD, Veterans Affairs, Palo Alto, CA. Peter Glassman, MBBS, VA Greater Los Angeles Healthcare System, Los Angeles, CA. William Becker, MD, VA Connecticut Healthcare System, West Haven, CT. Karl Lorenz, MD MS MSHS, Stanford—VA Palo Alto Health Care System, Palo Alto, CA.

Objectives

- Describe provider and patients' process of weighing the risks and benefits of chronic opioid therapy for patients with cancer and pain.
- Identify strategies that support shared decision making between providers and patients about the appropriate use of opioids for goal concordant pain care.

Original Research Background. Simultaneously, opioids pose potential risks and many patients with cancer pain are appropriately managed on long-term opioid therapy (LTOT).

Research Objectives. To compare patient and provider perspectives on weighing the risks and benefits of LTOT and strategies to support shared decision making for cancer pain.

Methods. Semi-structured interviews with 20 patients and 20 providers (Palliative care, oncology, and primary care based advanced practice nurses (APRNs) and physicians) from 2 VA medical centers. Transcripts were analyzed with constant comparison.

Results. *Provider Results* providers use stage, state, prognosis ("*given the amount of time a person with terminal cancer is going to live, the risk is relatively small compared to the benefit*"), mental health concerns, and history of substance use disorders to continuously weigh the appropriateness of LTOT for cancer pain. Given the dynamic nature of weighing the above, they also highlight the need for frequent touch points with patients and increasing provider time burden associated with prescribing opioids. *Patient Results:* patients report that current cancer prognosis/symptoms/related fears ("*There are side effects [e.g. chemotherapy] that scare me a lot more than the opioids' side effects*"), personal experiences with substances (opioids, cannabis, previous addictions) witnessing opioid use and addiction experiences of family and close friends, and not being able to "*afford being functionally impaired*" by pain impact perceptions of the risks and benefits of opioids for their circumstance. Patients prefer to focus oncology visits on discussing cancer treatment rather than opioids. In lieu of using physician visit time, patients feel able to navigate dosing and tapering decisions with palliative care advanced practice nurses (APRNs) and clinical pharmacists.

Conclusion. Providers and patients have diverse and sometimes competing priorities when weighing LTOT risks; frequent patient-provider communication is necessary for dynamic shared decision making.

Implications for Research, Policy, or Practice. Further developing opioid prescribing roles