

seeking emergent care; 3) ensuring family members have a common understanding of the patient's plan of care; 4) initiating and facilitating conversations with patients about coping, values, beliefs, and "what if" scenarios about current and potential future health states and treatments; 5) implementing choices (e.g., providing transportation) and addressing "spillover" decisions (e.g., work arrangements) resulting from medical treatment choices; and 6) making upstream healthcare decisions on behalf of patients who preferred to have decisions made by their family caregivers.

Conclusion. These data highlight a previously unreported and understudied set of critical decision partnering roles that cancer family caregivers play in patient healthcare decision-making.

Implications for Research, Policy, or Practice. Optimizing these roles may represent novel targets for early palliative care decision support interventions for family caregivers.

A Codified Process for Multidisciplinary Team Consensus Around the Termination of Life Sustaining Treatments (LST) in France: An Interview Study (S822)



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Objectives

1. Describe three ways that the LAT process used at the Paris hospitals in this study enabled nurses and other allied health professionals to feel empowered to co-create consensus surrounding LST decision-making.
2. Demonstrate how a LAT-type process might be applied to an American context to improve consensus, ethical decision-making, and nurse/staff empowerment.

Original Research Background. In 2005, French lawmakers passed the Claeys-Leonetti (C-L) Law, which prohibits futile care and authorized withholding or withdrawing (WD/WH) of futile treatments. This law allowed patients to refuse futile treatments and physicians to WD/WH LST where appropriate, and provided a framework for mandatory multidisciplinary team consensus around LST.

Research Objectives. The objective of this study was to understand how the C-L law influences multidisciplinary team dynamics, clinician empowerment, and the intensity of end-of-life care.

Methods. Semi-structured in-depth interviews were conducted with 13 physicians and 6 nurses (with

additional interviews underway) at two hospitals in Paris. Participants were purposively sampled by seniority and profession/specialty to provide a range of perspectives and contribute to understanding emerging patterns and themes. Transcripts were analyzed using thematic analysis.

Results. Decisions to WH/WD LST are achieved through consensus of the entire multidisciplinary team including physicians, nurses, and at times other allied health professionals. Meetings to decide upon termination of LSTs (réunion de Limitation et Arrêt des Thérapeutiques Actives (LAT)) are an important part of the process and can be called by any team member. Treatment decisions generally do not proceed until every team member is in agreement. This procedure improved nurse and junior physician empowerment, although the degree to which individuals felt comfortable/empowered to speak up was variable.

Conclusion. Since the passage of the C-L Law, decision-making practices at two Parisian hospitals have adapted procedures that provide time and space to achieve consensus amongst the entire interdisciplinary team. These procedures encourage consensus and ethical decision-making around WD/WH of LSTs. More research is needed to determine how best to implement interdisciplinary consensus and the impact on quality of decision-making.

Implications for Research, Policy, or Practice. An intervention using the LAT procedures could improve multidisciplinary team consensus and improve nurse and junior physician empowerment around end-of-life decision-making in the United States.

Defining Palliative Opportunities in Pediatric Patients with Bone and Soft Tissue Tumors (S823)



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Objectives

1. Define and recognize palliative opportunities that occur during a patient's disease course, including how many and when these occur in a patient's course with a bone/soft tissue tumor.
2. Describe the palliative opportunities that preceded a palliative care consultation and the timing of palliative care consultation during these patients' illness.

Original Research Background. Pediatric patients with solid tumors have many opportunities for increased primary or specialty palliative care (PC).

However, how many, when they occur, and if they are correlated with other factors are unknown.

Research Objectives. To define palliative opportunities within pediatric cancer, and explore how these occur in patients with solid tumor.

Methods. A priori, nine palliative opportunity categories were defined (disease progression and relapse, hospital admission for symptoms or social concerns, intensive care or marrow transplant admission, phase 1 trial or hospice enrollment, DNR status). A single-center retrospective review was conducted on patients aged 0-17 years at diagnosis with bone/soft tissue tumors who died from 1/1/12-11/30/17. Demographic, disease, and treatment data was collected, and descriptive statistics were performed. Timing of opportunities was evaluated over quartiles from diagnosis to death.

Results. Patients ($n=60$) had a mean of 9 ($SD=4$) palliative opportunities. Number or type of opportunities did not differ by demographics or diagnosis. PC consulted on 18 patients (30%) a median of 14.0 months (IQR 25.0) after diagnosis, and 2.6 months (IQR 11.5) prior to death. Likelihood of PC consult did not differ by diagnosis or total opportunities. The opportunities that preceded PC consult were progression/relapse (9/18), escalated hospital level of care (4/18), symptom admission (3/18), and end-of-life (EOL) concerns (2/18). Hospice was involved for 72% of patients. The majority of opportunities occurred in the last quartile of the disease course (median 5.0, IQR 5.0).

Conclusion. Patients with solid tumors incur many events warranting psychosocial or palliative support, which increase toward the EOL. Mean reported opportunities is likely a minimum due to stringent collection methods. No palliative opportunity or demographic variable was associated with PC consultation.

Implications for Research, Policy, or Practice. Additional work is needed to further refine what qualifies as a palliative opportunity, how to fully capture opportunities, and how those may differ across different cancers.

Identifying Late-Stage Cancer and Chronic Kidney Disease Patients for Palliative Care Research and Practice: Computable Phenotypes and Natural Language Processing (S824)



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Objectives

1. Describe the utility of computable phenotypes and natural language processing in a palliative care population.
2. Describe the research and practice implications of systematic identification of palliative care patients.

Original Research Background. Systematic identification of seriously-ill patients allows palliative care researchers and clinicians to test new models of care delivery. Algorithms based on clinical indicators—including natural language processing—can aid in such identification.

Research Objectives. To develop electronic health record (EHR) phenotypes to identify patients with Stage 4 solid-tumor cancer (CA) or Stages 4-5 chronic kidney disease (CKD).

Methods. We developed two computable EHR phenotypes to retrospectively identify decedents who had been admitted to an academic medical center in the last six months of life with CA or CKD, respectively. Each search included International Classification of Diseases (ICD) 9 and 10 codes and a date of death 11/07/17-12/31/17 (CA) or 11/26/17-12/31/17 (CKD). Additionally, the cancer search included natural language processing (NLP) searches of notes for indicators of stage 4 CA (e.g., “stage IV,” “metastatic”); the CKD search included glomerular filtration rate (GFR) <30 . For each EHR phenotype, we calculated the sensitivity, positive predictive value (PPV), and false discovery rate (FDR). Results of the phenotypes were compared to manual chart review for indicators of late-stage disease among patients admitted to the Oncology and Nephrology inpatient services, respectively.

Results. The EHR phenotype identified 116 CA patients, of whom 84 had Stage 4 CA, and 65 CKD patients, of whom 23 had Stage 4-5 CKD. The EHR phenotype for Stage 4 cancer had a sensitivity of 98.8%, PPV of 79.2%, and a FDR of 20.8% when compared to the assessment of the primary oncology services. The EHR phenotype for Stage 4-5 CKD had a sensitivity of 100%, PPV of 47.9%, and a FDR of 52.1% when compared to the assessment of the primary nephrology service.

Conclusion. EHR phenotypes can efficiently identify patients with late-stage disease for palliative care.