Describe the interprofessional educational experience of fellows in an interprofessional fellowship prior to the inclusion of a pharmacy resident.
Describe fellowship faculty experience with teaching an interprofessional fellowship.

Methods. Surveys were administer to 3 cohorts of fellowship participants, fellows from the 2017 AY (inclusive of a pharmacist), fellows from 2012-2016 AY, and fellowship faculty. The 2017 fellows were administered a survey assessing interprofessional education competencies in a post-then-pre fashion. Past fellows were administered a survey in a post fellowship fashion. Faculty were asked about their subjective experience in administering the fellowship. The online survey was completed over 12 weeks from December 2017-March 2018.

Results. 2017 fellows assessed a significant improvement in 3 out of 4 interprofessional education domains; Values and Ethics, Roles and Responsibilities and, Communication (+0.592 p=0.006, +0.935 p=0.011, +0.932 p=0.039, respectively). All four domains trended toward improvement in self assessed competencies. Past fellows similarly showed high levels of self-assessed competency after completion of their fellowships.

Conclusion. The Harvard Interprofessional Palliative Care Fellowship is a unique post-graduate education opportunity nationwide. The four professions who have the opportunity to participate receive a valuable interprofessional educational experience in addition to a robust clinical curriculum.

Implications for Research, Policy, or Practice. As more fellowships move to an interprofessional education model, data regarding interprofessional education is warranted.

Improving Conversations About ICD Management: A Training Session for Advanced Heart Failure Clinicians (S842)

Ian Kwok, MD, Icahn School of Medicine at Mount Sinai, New York, NY. Harriet Mather, MD MSc, Icahn School of Medicine at Mount Sinai, New York, NY. Karen McKendrick, MPH, Icahn School of Medicine at Mount Sinai, New York, NY. Laura Gelfman, MD MPH, Icahn School of Medicine at Mount Sinai, New York, NY. Nathan Goldstein, MD FAAHPM, Mount Sinai Hospital, New York, NY.

Objectives

1. Describe how patients and clinicians conceptualize the role of ICD deactivation in the setting of advance heart failure.
2. Practice and demonstrate specific examples of effective communication techniques related to ICD management and goals of care in the setting of advanced heart failure.

Original Research Background. Implantable cardioverter-defibrillator (ICD) devices reduce the incidence of sudden cardiac death for high-risk patients, but can also cause pain and anxiety at the end of life. However, conversations about ICD deactivation are difficult and occur infrequently.

Research Objectives. The study is a sub analysis of data from educational sessions for clinicians who care for patients with advanced heart failure as part of a 6-center, randomized-controlled trial. Primary outcomes compared pre- and post-workshop scores assessing confidence and skill in communication about advance care planning, ICD deactivation discussions, and use of empathy in conversations with patients.

Methods. Clinicians at intervention sites participated in a 90-minute communication training workshop focusing on goals of care communication including ICD deactivation, while clinicians at control sites received a lecture introducing the study. We first compared pre-workshop scores between control and intervention groups, then compared pre- and post-workshop scores for the intervention group, based on self-ratings on a 5-point Likert scale.

Results. 82 heart failure clinicians were enrolled. Pre-workshop scores showed high levels of confidence (4.22, SD=0.76) and skill (3.96, SD 0.76) in advance care planning in the setting of ICD management in both control and intervention groups, while comparisons of pre- and post-workshop scores in the intervention group showed decreases in confidence (-1.10) and skill (-0.12). None of these results reached statistical significance.

Conclusion. Heart failure clinicians had high baseline self-perceptions of confidence and skill in advance care planning in the setting of ICD management, with no differences between intervention and control sites. There were no significant changes seen immediately after the communication training intervention.

Implications for Research, Policy, or Practice. The results suggest that heart failure clinicians may overestimate their ability to engage in advance care planning discussions involving ICD deactivation, which may act as a barrier to the propagation of primary palliative care in this setting. Further research is needed to improve conversations about ICD management.

ICU Bereaved Family Members' Adjustment During the First Year (S843)

In Seo La, MSN RN, University of Maryland School of Nursing, Baltimore, MD. Debra Wiegand, PhD RN

CHPN FAAN FPCN, University of Maryland, Baltimore, MD.

Objectives

1. Identify how bereavement outcomes of family members change during the first year after a patient dies in the ICU setting.
2. Identify factors influencing prolonged grief symptoms over time.

Research Background. Nearly one in five deaths occurs in the ICU. Family members participate in the end-of-life decision making process for their critically ill family member and are considered to be at risk for psychological problems. However, little is known about how they adjust over time.

Research Objectives. Based on the Double ABCX model of family adaptation, the purpose of this study was to examine the prevalence and changes in symptoms of prolonged grief, post-traumatic stress, depression, stress, and anxiety.

Methods. A longitudinal design was used to conduct the investigation using three time points (1 to 3, 6, and 12 months after death). Family members were surveyed using validated instruments. Data were analyzed using descriptive statistics and linear mixed modeling.

Results. Participants ($n = 30$) were 60% female, 60% Caucasian, and 57% spouses. At 1-3 months after loss, 60% had symptoms of post-traumatic stress disorder and then 30.4% had symptoms 6 months after loss. At 1-3 months after loss, symptoms of depression, anxiety, and stress were found in 40%, 30%, and 26.7% of family members, respectively. At 6 months, symptoms of depression (17.4%), anxiety (13.3%), and stress (13%) were observed. In linear mixed models, symptoms of prolonged grief and post-traumatic stress, depression, and anxiety improved over time. However, they did not report a significant reduction of stress over time. There was also a negative association between social support and prolonged grief symptoms over time, indicating that the association decreased as time increased.

Conclusion. Bereavement outcomes reduced over the first year after loss, but family members tend to be at risk for psychological problems in the early months after bereavement. They may be best helped if early support can be provided by relatives, friends, and health care providers.

Implications. Further larger longitudinal studies and early supportive intervention studies need to be conducted to prevent the negative impacts of bereavement on family members' psychological outcomes.

Agreement Between Two Brief Tools to Assess Pain in the Palliative Care Setting (S844)

Maya Ladenheim, BA, University of California, San Francisco School of Medicine, San Francisco, CA. David O'Riordan, PhD MPH, University of California, San Francisco, San Francisco, CA. Giovanni Elia, MD FAAHPM, University of California, San Francisco, San Francisco, CA. Steven Pantilat, MD FACP FAAHPM, University of California, San Francisco, San Francisco, CA.

Objectives

1. Describe the most frequently used single-item tools to assess pain severity, their strengths and limitations.
2. Examine the agreement between two single-item pain assessment tools commonly used during a palliative care consultation.
3. Demonstrate the agreement between patient report of pain improvement.

Original Research Background. The numeric rating scale (NRS) and the verbal rating scale (VRS) are commonly used, unidimensional tools for assessing pain among patients referred for palliative care (PC).

Research Objectives. Examine the agreement between the NRS and VRS for the assessment of pain among seriously ill patients, and assess change in pain scores from initial assessment to follow-up 24-hours later.

Methods. Patients receiving inpatient PC who reported pain 'right now' were assessed using the NRS (0='no pain' to 10='worst') and the VRS (none, mild, moderate, severe), and had a follow-up assessment 24-hours later. Patients were also asked if their pain had improved over the past 24-hours. Improvement was defined as change of 2+ points for the NRS and 1+ category for the VRS.

Results. Thirty-four patients provided baseline and follow-up pain assessments. At baseline, the mean NRS pain level was 4.3/10. Using the VRS, 40.6% reported mild pain, 34.4% moderate, and 25.0% severe. There was excellent agreement ($r=0.8,p<0.0001$) between these measures. At follow-up, the mean NRS score was 4.4/10. Using the VRS, 6.2% reported no pain, 39.3% mild, 33.3% moderate, and 21.2% severe. There was also excellent agreement between the two measures at follow up ($r=0.7,p<0.0001$).

Patient report of pain improvement at follow-up, identified that 42.8% improved. Using the NRS, 18.2% improved, and 34.4% improved with the VRS. The agreement between patient-reported improvement and the NRS change score was slight ($k=0.09,p=0.5$), and the VRS change score was fair ($k=0.3,p=0.03$).

Conclusion. There was excellent agreement between the NRS and VRS. However, perceptions of improvement did not align with those identified using the NRS or VRS.