2016, we improved upon the ePOLST tool leveraging EHR clinical decision support to alert acute care clinicians of potential discrepancies between orders on a patient's POLST form and inpatient orders. Specifically, we developed a real-time clinical alert for providers of patients with POLST-prescribed 'Do not attempt CPR' (DNAR) status. In a Providence-affiliated ED or hospital, if a provider attempts to write a 'Full Code' order for a patient with an ePOLST order of DNAR, the provider is alerted to the discrepancy prior to signing the order.

In the first 18 months, 16,570 ePOLST forms were generated across five states; 52% (8,548) included DNAR status, and 14% (2,311) also opted for comfort measures only. In patients with an ePOLST indicating DNAR, the alert was triggered approximately 200 times per month. Fifteen percent of the time, the ordering provider removed the apparently conflicting 'Full Code' status order and wrote an alternative code status order instead.

This session will explore the principles and resources necessary to design and implement an ePOLST system. Updated data and detailed outcome analyses of the ePOLST clinical alert will be presented.

If Ketamine Is So Great, Why Won't My Institution Let Me Use it? (FR436)

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Objectives

- Implement and titrate ketamine in its various forms (topical, oral, IV, PCA) for pain and depression.
- Weigh the risks and benefits of prescribing ketamine.
- Overcome institutional barriers to prescribing ketamine.

In our current context of a national opioid shortage, Palliative Care teams need to look at alternative options that can provide equal or better analgesia. While there is an emerging evidence base for the use of ketamine in the treatment of refractory depression[1], the evidence base for the use of ketamine for palliation of pain remains thin, though primarily positive.[2, 3] Ketamine has been used topically, orally and intravenously for the palliation of pain, and orally and intravenously for the treatment of refractory depression, though it is FDA approved only as an anesthetic. For these reasons, many Palliative Care teams wish to add ketamine to their armamentarium. Many, however, encounter institutional barriers in implementing its use.

In this session we will briefly review the available literature regarding the risks, benefits, and questions on ketamine use for palliation of pain and depression. Using case examples, we will examine prescribing and titrating ketamine in various forms including topical, oral, and intravenous (drip, IV push and PCA). We will discuss when ketamine is the most effective and appropriate and discuss practical management of side effects seen. Finally we will explore institutional barriers and engage the audience on how to gain buy-in on various levels to implement ketamine, including sharing our hospital protocols and policies.

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2. Michelet, D, et. al. Ketamine for chronic non-cancer pain: A meta-analysis and trial sequential analysis of randomized control trials. Eur J Pain. 2018 Apr;22(4):632-646.
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Neither Pediatric nor Adult—Unique Care Considerations in the Adolescent and Young Adult (AYA) Patient Population (FR437)

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Objectives

- Discuss defining characteristics of the adolescent and young adult (AYA) population
- Outline unique palliative care considerations for the AYA population
- Delineate proposed palliative care models for AYA patients

Caring for adolescents and young adults (AYA)—patients aged 16-25—who are nearing end-of-life offers unique challenges for both the patients and providers. The young adult population has recently moved out of the pediatric care model but may not yet be a good fit for the adult care model. Existing literature highlights hypotheses that the AYA population is a unique group with special care needs, as these patients are not only entering early phases of independence as adults with ongoing exploration of identity and social and intimate relationships, but they are doing these things