alternative, data-driven proactive patient identification (aka "trigger programs") for palliative care services have been credited with strong improvements in quality, satisfaction, and utilization. In fact, there is a growing industry of vendors creating proprietary data-driven algorithms to identify different subsets of patients, including those most likely to benefit from palliative care.

While some organizations report huge successes with trigger programs, others find that triggers are underutilized, ineffective in achieving targeted outcomes, or generate patient volumes beyond the capacity of the palliative care team. Still others struggle with implementing trigger programs in the first place, due to concerns about HIPAA compliance or objections from other departments and specialties.

This session will walk attendees through the details of implementing a data-driven patient identification program. The session first covers the common core data elements in identification algorithms and how they vary from an inpatient to a community-based setting. Next, the session will review the key steps in the process of implementing a proactive patient identification program. Lastly, triggers create a very different relationship with treating clinicians, and will likely identify patients that some may not think to refer. Thus, the session ends with an exploration of how successful trigger programs incorporate treating clinicians, securing buy-in and sustaining those relationships over time.

Lessons Learned from Engaging Latinos in a Palliative Oncology Research Program (FR477)

Richard Leiter, MD, Dana-Farber Cancer Institute, Boston, MA. Maria Teresa Bejarano Varas, MD, Boston Medical Center and Boston University, Boston, MA. Yudy Muneton, LCSW, Dana-Farber Cancer Institute, Boston, MA. Laura Hayman, PhD MSN, University of Massachusetts Boston, Boston, MA. Ana Lindsay, DDS MPH DrPH, University of Massachusetts, Boston, MA. Andrea Enzinger, MD, Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Recognize disparities in end-of-life care for Latinos with advanced cancer.
- Appraise the existing literature describing the psychosocial, cultural, and communication factors that influence illness understanding, decision-making, and end-of-life care among Latinos with cancer.
- Describe methods for engaging and collaborating with stakeholders and interdisciplinary team members from palliative care and oncology in a research program on minority patients with serious illness.

Latinos with incurable cancer often receive palliative chemotherapy without understanding that it is unlikely to cure. Such misconceptions are more prevalent among Latinos than Whites, and may contribute to Latino/non-Latino disparities in end-of-life (EOL) care, such as lower rates of advance care planning, underutilization of hospice, and high rates of hospital and ICU death. Latino advanced cancer patients face formidable cultural, linguistic, and structural barriers to accessing critical information about their disease and treatment options. Nevertheless, interventions to enhance Latinos' understanding and engagement in treatment decision-making are few and underdeveloped. Bolstering communication between oncologists, Latino patients, and caregivers holds promise to improve understanding and quality in advanced cancer and palliative care.

In partnership with Latino community members, investigators, and students, we have developed a multimedia, patient-centered intervention supporting palliative chemotherapy education, tailored to the needs of Latino patients with advanced gastrointestinal malignancies and their caregivers. In an NCI-funded randomized controlled trial (RCT) we seek to determine its impact on Latino patients' and caregivers' understanding of chemotherapy risks and benefits, communication satisfaction, treatment choices, and EOL planning.

In this concurrent session we will present our systematic literature reviews and focus groups with Latino patients and caregivers to contextualize disparities in end-of-life outcomes for Latinos with advanced cancers. Audience members will be asked to list challenges they face performing cross-cultural palliative oncology research. We will then present our work on this project as an example of how to overcome these barriers. Focusing on the creation of our intervention, the development of tools to measure outcomes, and the design of an RCT, we will review critical topics, challenges, and lessons learned in research involving minority patients with advanced illness: the engagement of stakeholders, the translation of educational and research materials into another language, and the exploration of explanatory models and decision-making frameworks.

Integrative Pain Management for Hospice and Palliative Care (FR478)

Ann Marie Chiasson, MD DC HMDC, University of Arizona, Tucson, AZ. Lucille Marchand, MD BSN FAAHPM, University of Washington, Seattle, WA.

Objectives

- Discuss the role of Integrative Therapies in the management of pain in palliative care and hospice patients.
- Understand the evidence for acupuncture in pain for palliative care and hospice patients.

- Understand the evidence for dietary supplements in pain management for palliative care and hospice patients.

Pain is a complex multidimensional issue compromised of physical, biochemical, neurological, nutritional, and psychosocial-spiritual components. Primary medical treatments to date habitually treat pain with pharmacologic management as first line of care, yet chronic pain management metrics have not improved. As opioid medications have recently come under intense scrutiny, certain integrative therapies such as acupuncture are now being recognized as effective for many chronic non-malignant pain syndromes, such as chronic headache and chronic low back pain. Palliative and hospice patients often have co-morbid chronic non-malignant pain secondary their palliative diagnosis. Further, as up to half of cancer patients report under-treated pain, an integrative comprehensive pain strategy can provide superior pain management in cancer patients. This presentation will address the evidence and role for integrative therapies, including acupuncture, dietary supplements, mind-body therapies, massage, music, and cannabinoids in the management of chronic and cancer pain.

Vigil Volunteers—The Power of Presence at the Bedside (FR479)

Rebecca Hixson Vanderbilt University Medical Center, Nashville, TN. Mohana Karlekar, MD, Vanderbilt University Medical Center, Nashville, TN. Andrew Peterson, MDiv MMHC, Vanderbilt University Medical Center, Nashville, TN. Cody Case, MDIV, Vanderbilt Medical Center, Nashville, TN.

Objectives

- Outline the key steps in developing a self-sustaining Vigil Volunteer Program from inception to institution-wide roll out.
- Describe a framework to recruit, orient and provide ongoing training for volunteers with little to no experience in caring for patients at the end of life that is both that time and cost efficient.
- List both the benefits and barriers in establishing a model a Vigil Volunteer Program to patients, families and clinical staff.

Many of us have imagined what we want at the end of life (EOL). Most all of us wish to be surrounded by loved ones. Studies show that patients fear abandonment. The reality, however, is that a significant portion of patients die alone. Death creates angst. Dying alone exacerbates this angst.

In our institution, a quaternary care center that routinely accepts patients from hundreds of miles away, a great many patients find themselves alone at the EOL despite having family. The moral distress of dying alone is unimaginable. To address this concern, we developed a Vigil Volunteer program available to *any* patient who finds themselves alone at the EOL regardless of whether they had family.

In this session, we will describe the structure and operations of our Vigil Volunteer Program including the iterative process that led to this self-sustaining program. We will use our experience as an example to show how other institutions can develop their own vigil program to suit their individual needs without adding additional staffing.

We will describe the impetus in developing our program, and how we scaled our pilot from a single inpatient unit to the entirety of the institution.

We will discuss the nuts and bolts of the program emphasizing staffing, specifically volunteer recruitment, orientation, and ongoing training and resilience. Finally, we will highlight the benefits to patients, families and health care providers, as well as share the perspective of an actual volunteer's personal experience.

Each member of our team will discuss how our institution has created a therapeutic presence for our hospitalized patients nearing the end of life. We will describe and account for the effect of human, mindful presence positively impacts the care and comfort of those individuals who would otherwise have gone through the journey alone.

The Evolution from Futility to Non-Beneficial Treatment: Updates for the Palliative Care Clinician (FR480)

Adam Marks, MD, University of Michigan, Ann Arbor, MI. Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI. Gregg VandeKieft, MD MA FAAHPM, Providence Health and Services, Olympia, WA. Denise Hess, MDIV, Providence St. Joseph Health, Hillsboro, OR. Steven Radwany, MD FACP FAAHPM, Summa Health System, Akron, OH.

Objectives

- Understand the definition and history of the ethical concepts of medical futility and non-beneficial treatment as it pertains to hospice and palliative medicine.
- Discuss the ethical and legal scope and limitations of these concepts in withdrawing/withholding life-sustaining therapies.
- Review the experiences of three hospital systems' implementation of non-beneficial treatment policies, including impact on ethics consults.

Not infrequently, palliative medicine clinicians encounter a patient or family who requests treatment at the end of life that is of little or no clinical benefit. In the majority of instances, these cases can be resolved with thoughtful, value-based communication and shared decision making. However, in some cases, conflict can arise when the patient or family insists on