Lynn Reinke, PhD ARNP, Department of Veterans Affairs, Seattle, WA.

Objectives

- Gain insight into the approach to highly skilled communication.
- Skill demonstration in order to demystify the communication process for clinicians.
- Enhanced understanding of the invisible process an expert takes when approaching a complicated situation.

Clinician/patient communication is a central skill of the palliative care and hospice professional. While a variety of training methods and approaches are used to teach communication skills, the opportunity to learn directly from a leader in the field is rare. Even rarer is the opportunity to hear about their personal and professional development. Participants will hear the expert comment on their strategies, thought processes, and development. Our presentation is based upon a “Master’s Class” in which the audience learns from the demonstration of skill by an acknowledged expert and a discussion of their development and approach. We presented this session in 2018 with Dr. Ira Byock and plan to reprise our session in 2019 with another expert, ideally in a larger room with video capability so the audience can better see the expert’s face and body language on screen.

The program is broken into thirds. In the first portion, the interviewer digs deeper into the expert’s personal and professional development into a leader of the field. In the second portion, attendees observe our expert in an uninterrupted simulation such as a family meeting. In the final portion interviewers walk the expert through the simulation to gain insights into their thought process about the communication strategies used and alternatives they considered.

For example we may ask about how they prepare for a consult, how they cope after a difficult day, or how they balance work and family. We engage the audience in the form of submitted questions on paper. This session lends itself to being repeated annually with a different expert participant.

Our group, over time, wants to represent a diverse group of experts. If accepted this year we intend to approach Susan Block, Martha Twaddle, or Diane Meier.

Calculating Conversations About Opioid Conversions: Not Your Mama’s Equianalgesic Chart! (FR475)

Mary Lynn McPherson, PharmD MA MDE BCPS, University of Maryland School of Pharmacy, Baltimore, MD. Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA.

Objectives

- Describe reasons why patients need to switch from one opioid regimen to a different opioid regimen.
- Describe recent data that evaluates including switching from IV hydromorphone to oral hydromorphone, morphine or oxycodone, and other conversions.
- Describe considerations for future opioid switching best practices: equivalency vs. utility.

It is not uncommon for patients to require switching from one opioid to a different opioid to maximize pain control and minimize adverse effects. This may be due to transitions in care (between acute and chronic care), due to lack of an acceptable therapeutic response, or due to opioid-induced toxicity. Practitioners rely on equianalgesic tables to determine an equivalent dose of a different opioid regimen. Much of the data that supports these tables is from single-dose studies, not steady-state clinical trials, and seldom if ever consider patient-specific considerations. In the past 2-3 years, better evidence has emerged in opioid conversions, including data from stead-state clinical practice. In this presentation participants will learn about this emerging data that demonstrates best practices in switching between opioid and dosage formulations. Using a case-based format, the presenters will guide participants through the application of this data, and use of a "new and improved” equianalgesic table. Last, participants will leave about a new concept of "opioid utility” which may be the next concept in opioid conversions. This presentation will share cutting-edge data that provide more accurate guidance than traditional opioid equianalgesic charts have in years past.

Managing Scarce Resources: Best Practices in Using Triggers in the Hospital and in the Community (FR476)

Allison Silvers, MBA BA, Center to Advance Palliative Care, New York, NY. Dana Lustbader, MD FAAHPM, ProHEALTH, New York, NY. Rachel Adams, MD, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- List the key data elements used in effective patient identification algorithms, and explain the variation needed between inpatient and outpatient services.
- Describe the key steps in implementing a proactive patient identification program, including ensuring patient engagement.
- Devise strategies to achieve buy-in and support from treating providers, accounting for the needs and culture of their organization.

With limited resources and a specialized skill set, palliative care services must be delivered to the appropriate set of patients to ensure value to the organization. Unfortunately, referrals from treating providers do not always result in palliative care teams seeing the right patients at the right time. As an 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.