

inpatient (GIP) level of care. The Office of Inspector General (OIG) published a report in 2016 concluding one-third of GIP stays in 2012 were inappropriate, costing Medicare \$268 million in unnecessary care. In response, CMS began tracking hospice GIP stays longer than 5 days in the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

Conversely, CMS also includes “no GIP” use as a target area in the PEPPER, which has confirmed a number of hospices do not offer any GIP care. A few mainstream media articles have lashed out at the hospice industry for not offering higher levels of care and leaving patients and families without symptom management when they need it most. Interestingly, CMS has given this issue less attention.

From the government’s perspective, it seems there is either too much or too little GIP. What is a hospice to do in this no-win situation? First, hospices that do not provide GIP need to address the obstacles that prevent them from offering this required level of care. Second, hospices that offer too much GIP need to review and better understand the Medicare regulations as well as clinical criteria and decision-making related to GIP.

This session reviews the risks and challenges hospice programs face in providing, or not providing, the GIP level of care. The discussion then takes a deeper dive into the Medicare regulations and clinical criteria, decision making, and care transitions that need to be considered when offering the GIP level of care. Through didactics, case presentations, and audience participation, learners will be able to navigate GIP care confidently and compliantly... resulting, hopefully, in their hospice programs achieving GIP and OIG harmony.

Picture My Voice: Harnessing the Power of Comics in Palliative Care (FR415)



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Objectives

- Identify ways that palliative providers can use comics to share and process powerful experiences in care.
- Cite examples of how comics can be used to support patients through illness and provide education.
- Participate in creation of a brief comic narrative demonstrating the power of graphic medium in sharing thoughts or experience.

Graphic narratives, often referred to as “comics,” are increasingly recognized as a unique and powerful platform to help both healthcare providers and patients in promote education and exchange of stories in illness

and care. For Palliative Care providers who are seeking ways to support clinicians and reduce burnout, graphic narrative can be an accessible and rapid means for processing distressing healthcare experiences, and resultant works can be used to provide support to colleagues. For patients, graphic narrative can be a moving method for sharing their illness with subtleties of emotion or experience that are not easily captured with prose, and comic educational materials may be more approachable for a variety of audiences and literacy levels than simple text. Finally, reviewing the graphic narratives of others helps patients humanize their illness and offers healthcare providers a unique window into what their patients are experiencing.

Many palliative providers may be unfamiliar with the literature that exists on comics in healthcare, unaware of graphic resources available to patients, and uncertain how to utilize graphic narrative in the care of themselves and those they treat. In this conference session, an interdisciplinary duo will open the pages of “graphic medicine” to participants with case examples and visual representations of outstanding health comics that highlight their potential uses in Palliative Care. Providers will develop a toolkit of techniques for using graphic narrative to care for themselves and their patients, and the session will close with an opportunity for participants to create their own brief comic narrative.

Navigating the Landscape of Increased Cancer Survivorship: When Malignant Pain Transitions from Acute to Chronic (FR416)



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Objectives

- Consider how immunotherapy and prolonged survival are impacting symptom management in patients with incurable malignancies.
- Describe how to assess symptom burden and likelihood of persistence in patients with cancer.
- Identify therapies and conditions which warrant consideration of prophylactic interventions to mitigate development of cancer related pain.

Recent advances in cancer therapies, especially immunotherapy, have drastically impacted cancer treatment and survival. These advances engender earlier diagnosis and longer survival. Increased survivorship and novel therapies bring new challenges including symptom clusters and pain syndromes as well as unknown long-term and late effects of both disease and

treatment. Assessment of symptoms as well as treatment are challenging as pharmacologic approaches must consider the treatment, interactions with treatment as well as long-term impact on the patient. The benefits of such advances are dramatic, so too are the challenges for palliative care providers.

Despite the increased prevalence of cancer survivors and those living with cancer, data regarding pain in this population is lacking but purported to be between 16 and 50%. Chronic pain in this population is often neuropathic; CIPN appears to be on the rise. Cancer pain is complex—due to tumor, anti-neoplastic therapies, associated nerve damage as well as local and generalized inflammation. Tumor related factors and responses such as cachexia, fatigue and nausea often reinforce pain syndromes. Cancer pain does not follow non-malignant trajectories; assessing and treating pain in survivors is similarly unique. There is limited evidence for pain treatment in this population; however, long-term use of opioids and adjuvant analgesics have both known and unknown consequences.

Cancer survivors demand surveillance—a multidisciplinary team and partnerships amongst oncology, palliative care, pain management and rehabilitation specialists are ideal—pain and other symptoms often signal recurrent disease, second malignancy or late onset treatment effects that warrant evaluation, treatment and monitoring. Developing and implementing assessment tools, considering prophylactic therapies prior to treatment and nurturing relationships amongst specialists as well as investigating and utilizing adjuvant, non-opioid therapies is essential in this era of increasing survival.

Substance Use as a Family Disease: Shepherding the Flock Safely Through the End of Life (FR417)



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Objectives

- Identify the importance of creating structure and a 'holding environment' for individuals with substance use disorders (SUDs), in particular during the transition to home hospice.
- Describe how family systems theory can be used to conceptualize and assess the family containing someone with a substance use disorder.
- Describe safety measures used by the hospice team to limit substance misuse and diversion in the home setting.

Opioids have long been a mainstay of symptom management in hospice care, allowing patients with

terminal illnesses to have an improved quality of life in the final part of their journeys. Unfortunately, these same medications have contributed to the explosion of the opioid epidemic. As patients with substance use disorders (SUDs) age and develop other life-limiting illnesses, many will be referred to hospice care. For these individuals, opioids used for symptom management can increase suffering due to misuse of medications and addiction. Individuals with SUDs are often dealing with concomitant psychiatric illnesses, coupled with the challenges all individuals face at the end of life, making them particularly vulnerable to chemical coping, escalating misuse, or relapse. Bringing principles of addiction psychiatry and family systems into the home environment can help us safely shepherd individuals through the final part of their lives.

Through case presentations, a review of the literature, and personal experience, we will share with those in the hospice community how individuals and families with substance misuse can be transitioned to home hospice as safely as possible. We will demonstrate screening techniques and language used at initial visits to build trust with patients and families. We will show how the hospice team can set expectations and boundaries for those within their care. We will also describe measures taken to improve the safety of patients, families, and the hospice team while balancing the mission of hospice medicine, addressing total pain at the end of life. Woven into each section will be common ethical challenges encountered by hospice team members during the care of individuals with SUDs.

Beyond Charlie Gard: Rights, Responsibilities and Rational Response in the Realm of Parental Requests for Potentially Non-Beneficial Treatment (FR418)



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Objectives

- Discuss the ethical issues raised by the high-profile case of Charlie Gard, as well as, parental requests for potentially non-beneficial treatment in a broader historical and practical context.
- Discuss multiple perspectives on the complex issues of parental requests for potentially non-beneficial treatment.
- Discuss the potential influence of public opinion and modern media in such cases.

The much-publicized case of Charlie Gard brought the issue of parental requests for potentially non-beneficial treatment (NBT) into the public eye. It is not