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.

1. Kim J, Mierzwinski-Urban M. Ketamine for Treatment-Resistant Depression or Post-Traumatic Stress Disorder in Various Settings: A Review of Clinical Effectiveness, Safety, and Guidelines. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2017 Mar 1.
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.
3. Bell RF1, Eccleston C, Kalso EA. Ketamine as an Adjuvant to Opioids for Cancer Pain. Cochrane Database Syst Rev. 2017 Jun 28;6:CD003351

Neither Pediatric nor Adult—Unique Care Considerations in the Adolescent and Young Adult (AYA) Patient Population (FR437)

Alexandria Bear, MD, Medical College of Wisconsin, Milwaukee, WI. Melissa Atwood, DO MA, Medical College of Wisconsin, Milwaukee, WI. Suzanne Berg, BS CCLS, Froedtert Hospital, Milwaukee, WI. Heidi Miranda, BS MS CCLS, Froedtert Hospital, Milwaukee, WI. Catherine Van Schyndle, MS MSN RN ACHPN NP, Marquette University, Milwaukee, WI.

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 in the setting of a potentially life-limiting illness. Therefore, a dichotomy exists between this setting of growth and ongoing concerns for loss of self and control. It is important to gain the trust of the AYA patient through the use of appropriate language, encouraging the patient to maintain some control, while offering the AYA time to address “the tough stuff.”

This population creates unique challenges for palliative care providers. As the field of palliative care is rapidly growing, many providers are early in their careers and potentially closer to similar developmental stages as these patients, at times making care emotionally taxing for the provider.

This presentation will define the AYA population and outline both unique palliative care considerations and proposed care models for this patient population utilizing exemplary real-life cases. Distinctive provider challenges relating to care for this patient population will also be discussed.

Where Do We Draw the Line? Navigating Personal and Professional Boundary Challenges in Palliative Care (FR438)

Christopher Lawton, MD, Paulist Fathers, Washington, DC. Andrew Lawton, MD, Dana-Farber Cancer Institute, Boston, MA. Erin Stevens, DO, Massachusetts General Hospital, Boston, MA. Sarah Scott Dietz, MD MajUSAF MC, Wright-Patterson AFB Medical center, Dayton, OH. Jo Weis, PhD, Medical College of Wisconsin Palliative Care Center, Milwaukee, WI.

Objectives

- Define the concept of boundaries in the realm of the clinical encounter and describe its importance to medical practice.
- Explain how maintenance of healthy boundaries may be uniquely challenging in palliative care, particularly for those early in their career.
- Identify specific strategies that palliative care professionals can use to maintain healthy boundaries in their work.

Boundaries in clinical medicine are the limitations we place around the emotional and physical relationships between patients and providers and between medical colleagues. Healthy boundaries are critical in fostering a trusting provider-patient relationship, ensuring dignity and equity in care, and maintaining appropriate roles among members of the care team. Despite the importance of this topic, within medical training there has historically been inadequate attention given to boundary setting and maintenance. Palliative care providers are commonly faced with emotionally charged situations while working in a team-based system where appropriate boundaries between the patient and provider or between members of the care team can easily be compromised. Am I spending the appropriate amount of time with this patient? What’s the right balance between emotional availability and professional distance? Does the work I’m doing fall within my role on the team? Boundaries may also become blurred as the provider strives to preserve personal time and relationships in the context of demanding professional work. Palliative care clinicians, especially those early in their practice, may be uniquely vulnerable to such boundary challenges. Not maintaining healthy boundaries may lead to a lack of sustainability and ultimately to burnout. In this session, a panel of early career palliative care professionals and a palliative care psychologist will use case examples to explore the boundary challenges that arise in our field, explain their importance to patient care and provider well-being, and identify specific strategies to address and prevent them. This session seeks to empower attendees with tools for maintaining healthy boundaries with their patients, their colleagues as well as among the various roles the provider plays in their professional and personal life so as to promote greater resilience and sustainability in our work.

Inviting Ourselves to the Party: Cystic Fibrosis as a Model for Implementing Palliative Care Practice, Research, and Policy in "New Diseases” (FR439)

Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Laura Moreines, RN NP CRNP, Yale, New Haven, CT. Elaine Chen, MD, Rush University Medical Center, Chicago, IL. Elisabeth Potts Dellon, MD, UNC School of Medicine, Chapel Hill, NC.

Objectives

- Describe the opportunities and challenges involved in developing an outpatient palliative care clinic for patients with cystic fibrosis.
- Describe a patient-centered model for developing a palliative care intervention in a disease population without much palliative care evidence, as well as the challenges in conducting clinical research in CF palliative care.

Cystic fibrosis is a chronic, progressive, and fatal disease. Individuals living with CF suffer from myriad physical and psychosocial burdens that dramatically degrade patient and caregiver quality of life.

Although the evidence base for palliative care in CF is scant, patients living with CF and their caregivers undoubtedly possess palliative needs. Yet, no established model of PC exists for this population of high-need patients. Distinctive characteristics of CF, such as its lifelong nature, unpredictable trajectory, advancing therapies that may alter the course of illness dramatically for some, and the complexities of lung transplantation merit evaluation of how PC should be designed for CF. CF is one of many underrepresented disease