Clinician Wellness, including resilience and burnout, has been gaining recognition as a critical area within health care quality in recent years. In the palliative care community, it has long been recognized that the intensity of the emotional work required in palliative care can contribute to burnout (marked by emotional exhaustion, cynicism, and decrease personal efficacy). Until recently, however, much of the efforts for clinician wellness, such as mindfulness and mind-body techniques, have been targeted at personal resilience strategies. Though important, personal strategies are only half the story. There is growing recognition that promoting clinician wellness and thriving at work requires both personal strategies and organizational support.

During this presentation, we will review five geographically and organizationally diverse programs and their innovative efforts to provide programmatic approaches clinician wellness. The multidisciplinary panel has been chosen from a variety of practice settings to demonstrate the range of programs that are possible, including a tertiary academic center, two community hospital settings with different leadership perspectives, a tertiary teaching program with strong VA affiliations, and one hospice setting. Each clinical environment presents unique challenges and opportunities for implementing programs, including resource limitations, parent institution culture, geographic challenges including rural and urban settings within one larger program, and program size with associated growth related challenges.

We will begin with a brief overview of current research in general clinician wellness, and then progress on to Palliative Care specific content. We will identify organizational, programmatic and team related challenges and strategies to overcome them when developing, implementing and sustaining wellness programs. We will host an interactive discussion to allow personalization and adaptation of strategies and tools that could be implemented in attendees' own practice environments.

New Drugs and Drug News: The 411 and Implications for Palliative Care (SA505)

Mary Lynn McPherson, PharmD MA MDE BCPS, University of Maryland School of Pharmacy, Baltimore, MD.

Objectives

- List new drugs approved by the FDA in 2018. For each drug the participant till be able to describe the approved indication, unapproved uses of the medication, common adverse effects and drug interactions.
- For each new relevant medication approved in 2018, describe the burden-to-benefit ratio and the role of the medication in caring for patients with advanced illness.
- Analyze important drug alerts and their relevance to drug therapies commonly used in hospice and palliative care patients.

Up to 100 new drugs and dosage formulations are approved every year by the Food and Drug Administration (FDA). Some of these are new molecular entities, while others are new formulations, new indications, generic drug approvals or labeling revisions. Even if a drug is a "new" molecular entity, it may not be "improved" over molecular entities already commercially available. In caring for patients with advanced illnesses, practitioners must make prudent drug therapy choices. Part of this decision-making process is a careful assessment of the burden-to-benefit ratio, including the financial burden of using each medication.

This concurrent session is a follow-up to the previous year's very popular update on new drugs. For relevant drugs approved in 2018, participants will learn about the FDA-approved indication for using the medication, unapproved uses of the medication (particularly as it applies to palliative care patients), if it is a controlled substance and the schedule (if appropriate), adverse effects, major drug interactions, dosing, and financial implications of drug procurement and monitoring if relevant.

Participants will learn what "NDA Chemical Type" (e.g., new molecular entity, formulation, manufacture, indication or OTC switch), and "Review Classification" (priority, or standard review; orphan drug status) was assigned by the FDA. If available, participants will also learn the "new drug comparison rating" (1-5, 5 highest in terms of drug importance). Most importantly, the participant will learn about the role of the new agent in caring for patients with advanced illnesses, and how this medication compares with medications already available. Public health advisories and drug-related alerts pertinent for end of life care will also be discussed, and their impact on caring for palliative care patients. Inappropriate use of medications in hospice or palliative care may result in suboptimal symptom management. This is a session that every health care professional needs to attend!

Not Just for Neonatologists Anymore—The Blueprint for the Perinatal Palliative Care Consult (SA506)

Jonathan Mullin, MD, Washington University School of Medicine, Saint Louis, MO. Christopher Collura, MD, Mayo Clinic, Rochester, MN. Joan Rosenbaum, MD FAAHPM, Division of Newborn Medicine, Saint Louis, MO.

Objectives

- Recognize trends in the growth of perinatal palliative care and the evolution in characteristics of

patients who receive perinatal palliative care consults.
- Discuss areas of expertise and challenges of perinatal palliative consultation for both non-neonatologists and non-palliative medicine trained clinicians.
- Construct a framework for perinatal palliative care consultation based on patient characteristics and background of consulting providers.

Nearly 30 percent of infant deaths in the United States result from congenital anomalies. Treatment options now exist for conditions that were once considered lethal. Parents may face challenging decisions regarding anticipated newborn care, which impact themselves and their families perinatal palliative care (PPC) supports families navigating these decisions through a family-centered, shared decision-making model of care. PPC occurs concomitantly with expectant obstetrical care, providing intensive psychosocial support during and after pregnancy, including at end-of-life.

Currently there is no standard practice for PPC. Perinatal palliative care programs differ in terms of interdisciplinary structure and training. Historically, consults were performed by neonatologists, many of whom have no formal training in palliative care. NICU survivors often have complex medical and palliative care needs that include pain and symptom management, evolving goals of care, and need for psychosocial support. Thus, many contend that PPC consults should be performed by palliative care-trained clinicians.

Challenges exist for palliative care-trained providers including unfamiliarity with delivery room care, evolving standards around resuscitation at the limits of viability, and nuanced understanding of neonatal physiology. Neonatologists may face challenges performing PPC consultations, including a nuanced understanding of options for palliative care, palliative transportation and hospice. Additionally, neonatologists are limited in their clinical capacity for long-term continuity that many children receiving PPC consults will require.

A one-size fits all model is unlikely to meet the palliative care needs every patient. In this interactive session, two neonatologists, board certified in hospice and palliative medicine, will present key considerations and education for non-neonatologists performing palliative care consultation. A palliative care physician will review the data on PPC programs, and present data and experiences from a single institution that has transitioned to having non-neonatologists perform palliative care consults including discussions of early involvement, transitions of care, and continuity.

Finding Strengths in Our Differences: How Interprofessional Training Prepares Clinicians for Collaborative Practice (SA507)

Elliot Rabinowitz, MD, Boston Children's Hospital, Boston, MA. Katharine Brock, MD MS, Emory University, Children's Healthcare of Atlanta, Atlanta, GA. Jenna Freitas, MSN RN CPNP, Boston Children's Hospital, Boston, MA. Caitlin Scanlon, MSW, Riley Hospital for Children, Indianapolis, IN. Shih-Ning Liaw, MD FAAP, Dana-Farber Cancer Institute, Boston, MA. Jane deLima Thomas, MD FAAHPM, Dana-Farber Cancer Institute, Boston, MA.

Objectives
- Describe the unique aspects of an interprofessional training model from the perspectives of fellowship directors and social work, nurse practitioner, and physician trainees.
- Identify the benefits and challenges of an interprofessional training model in providing patient care and promoting self-care.
- Devise strategies to develop interprofessional training experiences that attendees can implement in their own palliative care and hospice programs.

Clinical practice guidelines for quality palliative care highlight the interprofessional nature of palliative care, recognizing that clinicians in each discipline must understand the unique perspectives and strengths of their colleagues in order to provide comprehensive collaborative care. Despite this, finding clinicians proficient in interprofessional collaborative practice proves difficult due to the lack of interprofessional training programs. Instead, palliative care clinicians often resort to learning to work with team members of different disciplines in the course of delivering complex clinical care to seriously ill patients and their families.

One innovative solution to this problem is interprofessional palliative care training programs. Training physicians, nurses, psychosocial clinicians, and other disciplines in an interprofessional fellowship affords professionals insight into the distinct and shared roles of each discipline while allowing trainees dual roles as learner and teacher for their co-fellows. This model includes cross-training experiences, a shared didactic and experiential curriculum, and respectful appreciation of one another's value.

In this concurrent session, attendees will explore this interprofessional educational model through the lens of interprofessional trainees and fellowship directors. Presenters will summarize the literature of interprofessional education, highlight the benefits and challenges of each discipline's role through case-based clinical scenarios, and examine how this model minimizes compassion fatigue and clinician burnout.