usability and acceptance of existing ACP tools and develop a culturally acceptable ACP toolkit for use in the community; 3) host annual events to increase awareness of ACP on or around National Health Care Decision Day and to recognize the important role of caregivers; 4) train pastors and care navigators to support ACP in the community; and 5) assess annually completion of ACP milestones among church congregations and associated community centers.

Over the last 2 years, ACCA has helped over 2,200 persons needing care and caregivers. In the first year, care navigators identified and made more than 1000 referrals to local resources, successfully addressing 80% of participants' stated needs. Through discussion, use of case examples, findings from community events, and ACP evaluation data, this workshop will present practical information on how to effectively engage the faith-based African-American community in ACP, inform ACP communications preferences, and better understand attitudes and values around lifesaving treatment options and ACP activities.

A Personal Exploration Through Expressive Art (FR434)

Joanna Lyman, MA CCLS, Le Bonheur Children's Hospital, Memphis, TN. Melody Cunningham, MD FAAHPM, Le Bonheur Children's Hospital, Memphis, TN.

Objectives

- Recognize the primary therapeutic principles of expressive therapies and learn how they may be used to deepen the meaning and value of interactions with pediatric and adult populations.
- Describe the evidence supporting the clinical application of therapeutic art for the grieving and bereaved.
- Determine how to facilitate a replicable art based therapeutic intervention for use with all disciplines working within palliative and hospice care, and for use with patients as appropriate through personal exploration and experience.

As hospice and palliative medicine evolve, an intensified focus emerges on the human experience of death and dying. Meaning making, identity reconstruction, managing negative grief symptoms and facilitating continuing bonds with the deceased are now core competencies in palliative care. Expressive modalities in clinical practice offer a bridge between the medical and the emotional as we strive as a community to meet the psychosocial needs of our patients and their families. The clinical application of therapeutic art with the grieving and bereaved has been widely documented.

In contrast to talk therapy where unresolved issues and interpersonal dilemmas are explored with words, expressive activities such as therapeutic art and play ask participants to use their imagination, and thus subconscious, as a form of communication. For example, an individual may be asked to draw an image of an idea or feeling. In this way, participants may quickly communicate relevant issues in ways talk therapy simply cannot achieve. When these techniques are applied in the hospice and palliative care setting, clinicians can more fully enhance their patients (or colleagues) ability to communicate effectively and authentically.

This session would afford participants the opportunity to engage in a therapeutic art activity frequently utilized with both patients and trainees, designed to facilitate the emotional exploration of their experience with significant loss. Once complete, members of the group will be invited to share the feelings and insights elucidated by the activity. Facilitators will guide and support as insights into the events that surround personal losses are discovered.

Respecting Patient's Wishes—How an Electronic POLST Tool Can Drive Goal-aligned Care (FR435)

Matthew Gonzales, MD, Providence St. Joseph Health, Torrance, CA. Maulin Shah, MD, Providence St. Joseph Health, Portland, OR. Jennifer Lui, MSW LCSW, Providence St Joseph Health, Portland, OR. Chris Murphy, PT, Providence St Joseph Health, Portland, OR. Ira Byock, MD FAAHPM, Providence Institute for Human Caring, Torrance, CA.

Objectives

- Describe the key principles to work effectively with your system's Information Technology specialists to design an electronic POLST tool.
- Discuss applying lessons from the experience of deploying an electronic POLST tool across multiple states.
- Discuss how clinical decision support can help avoid administering unwanted treatments and aid delivery of goal-aligned care.

Honoring a patient's treatment preferences and priorities are key features of providing goal-aligned care. Having a clear record of a person's choices related to life-sustaining treatments is particularly valuable. Forty-seven states have developed or are developing a Physician Orders for Life-Sustaining Treatments (POLST) form to unambiguously convey treatment plans that reflect a patient's wishes to either receive or decline critical interventions. While conceptually straightforward, access to POLST forms and their utility are challenged by the information being static, a "snapshot" of a patient's preferences, and the lack of interface to the rest of the EHR.

In 2012, we created ePOLST, an integrated EHR-based tool for the electronic completion of POLST forms. In

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)

Kira Skavinski, DO, University of California at San Diego, La Jolla, CA. Solomon Liao, MD FAAHPM, University of California at Irvine Medical Center, Orange, CA. Jamie Fertal, DO, St. Joseph's Hospital, Orange, CA. Rosene Pirrello, RPH, University of California UC Irvine Health, Orange, CA.

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)

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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