medical treatment, **often for religious reasons**, that is felt by the clinician to be either of little benefit or carries significant risk without expectation of improvement.

In the past, the concept of “futility” has been used to discuss such cases, and many hospitals have crafted policies defending the clinicians right to not provide care deemed medically futile. However, as an ethical construct the concept of futility has long been known to be difficult to invoke in individual circumstances and thus can be unevenly or inappropriately applied. Recently, increased attention has been paid to the concept of "non-beneficial treatment” (NBT) as a term that more accurately captures medical treatments that either have little or no chance of benefit or for which the risks outweigh the benefits.

This concurrent session will provide a review of these terms, the impact they have on clinical care, their scope and limitations, and provide perspectives from three institutions that have implemented a hospital policy on non-beneficial treatment. Participants will be engaged to share their own experiences with futility and/or NBT policy development, implementation, and application in practice, in service of identifying best practices and strategies for success.

Palliative Care for Inmates in the Hospital Setting (FR481A)

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Objectives

- Identify illness and symptom burdens unique to the inmate population.
- Describe the need for palliative care in the hospitalized prison population.

Original Research Background. The US population of inmates is growing at a rate 11 times faster than the general population. Along with this growth there is rapid increase in the number of elderly prisoners with an accelerated ageing phenomenon. Previous studies have demonstrated multiple barriers to providing palliative care for seriously ill inmates.

Research Objectives. The aim of this study was to assess the frequency of palliative care consultation and nature of consultation requests for inmates who died while hospitalized at a large tertiary care hospital.

Methods. A retrospective chart review of all inmate decedents over a 10-year time period was conducted. The reason and timing of consultation was noted in addition to symptoms identified and interventions recommended by the palliative care team. Characteristics of patients who were transferred to the inpatient palliative care unit were also recorded.

Results. Two hundred ninety-nine inmates died over the 10 years, with 45% of inmate decedents being seen by palliative care. Timing of consultations was short, with median time of consultation being 3 days prior to death. Inmates with cancer were significantly more likely to have a palliative care consultation prior to death ($p<0.000$). Older inmates were also significantly more likely to have palliative care consultations ($p<0.026$). The most frequent intervention recommended, in 82% of patients, was opiates for pain or dyspnea. Delirium was often missed by the primary team but was identified by the palliative care team in 37% of patients.

Conclusion. The inmate population has both a high rate of comorbid conditions with associated symptom distress. There is a demonstrated need for palliative care interventions, much like free-living patients.

Implications for Research, Policy, or Practice. Nearly 5,000 prisoners die each year, most in community hospitals. There is a need for inmates to have access to palliative care and further research should be done to determine how to best deliver care for this underserved population.

Shifts in the Adoption of Hospital-Based Palliative Care Programs (FR481B)

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Objectives

- Explain the prevalence of palliative care programs in US hospitals and how this has changed over time.
- Discuss the characteristics of hospitals that implemented palliative care programs during the period and the characteristics of those that closed programs during the period.

Original Research Background. Cross-sectional studies have identified hospital size, tax status, and region as predictors of palliative care presence in hospitals. However, little is known regarding longitudinal changes in palliative care program adoption and closure and whether characteristics of hospitals newly establishing palliative care programs differ from historical adopters.

Research Objectives. Identify the organizational and regional characteristics associated with hospitals with newly established palliative care programs and those that closed programs between 2013 and 2016.

Methods. We linked the American Hospital Association Annual Survey to the National Palliative Care Registry for 2013 and 2016. We categorized hospitals as newly establishing a palliative care program, closing a program, or no change. We used 3 multivariate logistic regressions to identify factors associated with each category.

Results. Nationally, the proportion of hospitals with 50 or more beds with a palliative care program increased from 67% in 2013 to 78% in 2016. A total of 278 hospitals established palliative care programs and 61 hospitals closed programs during this period. The proportion of for-profit hospitals with palliative care increased from 23% to 45% compared with nonprofit hospital increase from 78% to 88%. Hospitals with new vs established programs were more likely to be smaller (AOR 8.41, 95% CI 5.49-12.89 for 50-149 vs >300 beds; AOR 3.75, 95% CI 2.43-5.79 for 150-300 vs >300 beds), for-profit (AOR 7.45, 95% CI 4.95-11.19), sole community providers (AOR 3.36, 95% CI 1.97-5.73), and in the South Atlantic. Hospitals that closed palliative care programs had similar characteristics to hospitals that newly established programs.

Conclusion. Palliative care program implementation is volatile among for-profit and smaller hospitals and varies by region. The impact of these changes on access to palliative care remains a critical area for future research.

Implications for Research, Policy, or Practice. Understanding longitudinal patterns in palliative care program implementation and closure will enable development of technical assistance and resources to maximize access to palliative care.

Development of a Social Work-Led Primary Palliative Care Model in Hospital Medicine (FR481C)

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Objectives

- Describe what is involved in an embedded primary palliative care program.
- Describe how an embedded primary palliative care program model can improve patient outcomes.

Original Research Background. Due to palliative clinician workforce shortages and the growing number of patients with serious illness in need of palliative care, innovative primary palliative care models are essential to meet this population's needs using the existing resources.

Research Objectives. To increase palliative care delivery, enhance appropriate hospice referral and decrease readmissions of seriously ill patients admitted to the hospitalist service.

Methods. To meet unmet palliative care needs of patients admitted to the hospitalist service at Mount Sinai Medical Center, a social worker-led embedded primary palliative care model was developed. The social worker facilitated goals of care discussions, delivery of prognosis, discharge planning, and completion of advance directive documentation.

Results. In 2017, 184 patients received a primary palliative care consultation; those patients seen had an average age of 70 years, 43% were female and the median Karnofsky performance status of 40%, as compared to 20% for those seen by specialty palliative care. Overall, 51% of the patients seen met palliative care solid tumor oncology trigger criteria, 20% were triaged from the specialty palliative care team and 15% were direct referrals from hospitalists. Of those evaluated, 5% had documented goals of care in the electronic medical record before the consultation and 92% after the consultation. The hospice referral rate was 25% and the specialty palliative care referral rate was 25%. Reasons for referral to specialty palliative care were transfer to the palliative care unit (51%) and complex symptom management (49%). Of those who received the consultation, 30-day readmission rate was 5.3%, as compared to those who did not (16%).

Conclusion. Patients seen by the social worker-led primary palliative care team were more functional, suggesting they were seen earlier in their disease course, and had fewer readmissions.

Implications for Research, Policy, or Practice. Primary Palliative Care Models broaden the reach of Palliative Care to patients who are seriously ill.

Promoting Resilience in Stress Management (PRISM): A Prevention Model for Palliative Care (FR481D)

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