Richard Mularski, MD, Kaiser Permanente, Portland, OR. Corita Grudzen, MD MSHS FACEP, NYU Langone Health, New York, NY. Jennifer Temel, MD, Massachusetts General Hospital, Boston, MA. Joseph Greer, PhD, Massachusetts General Hospital Cancer Center, Boston, MA.

Objectives

- Discuss different approaches to expanding access to home-based palliative care among diverse patient populations being evaluated in PCORI-funded clinical trials.
- Discuss challenges and examine potential solutions for successfully conducting large scale, complex, multi-site palliative care clinical trials.

Patients with advanced illnesses and their caregivers have been shown to benefit significantly from palliative care services. However, access to comprehensive palliative care remains limited and in many communities is restricted to hospital consults or end-of-life hospice settings. Patients and caregivers report a significant unmet need for receiving palliative care where they live. In response to systematic reviews and priorities identified by a large multi-stakeholder group, the Patient-Centered Outcomes Research Institute (PCORI), in fiscal year 2017, invested over $80 million to fund 9 large, multi-site clinical trials focused on the delivery of community-based palliative care.

In this session we will discuss four of these trials that are evaluating different approaches to delivering palliative care to patients in their homes. These include:

- A trial in 10 Accountable Care Organizations that is comparing the effectiveness of in-person home-based palliative care (HBPC) versus palliative care delivered in clinic by trained primary care providers.
- A trial in 15 clinical sites from an integrated healthcare system that is comparing the effectiveness of an efficient, technology-supported model versus a standard in-person model of HBPC.
- A trial enrolling patients discharged from 9 emergency departments that is comparing the effectiveness of a nurse-led, telephonic case management model of delivering HBPC versus in clinic visits with palliative care specialists.
- A trial in 20 cancer centers that is comparing the effectiveness of delivering HBPC utilizing telemedicine versus in clinic visits with palliative care specialists.

Following an overview of the four trials, we will engage in a moderated panel discussion among the PIs of the studies and with the session attendees on the opportunities for expanding access to HBPC to diverse patient populations and challenges in conducting such large and complex trials that have the potential to generate evidence needed to transform the delivery of palliative care in the US.

Straddling Fee-for-Service and Value-Based Payment: Eight Ways to Keep Your Palliative Care Program Funded and Growing (FR473)

Tom Gualtieri-Reed, MBA BA, Spragens & Associates LLC, Chapel Hill, NC. Donna Stevens, MHA, Lehigh Valley Health Network, Allentown, PA.

Objectives

- Describe common challenges and barriers to funding a palliative care program across different payment models and funding sources.
- Identify four actions that a program can take to improve the likelihood of adequate funding and growth.
- Describe the basic building blocks of the business case for palliative care programs.

Are you struggling to get adequate staffing for your palliative care program? Have you been asked to begin seeing patients in the home or expand into the cancer center? Is your organization considering reducing or eliminating your program? Building the business case for your palliative care program is a continuous process and is particularly challenging during this period of shifts in reimbursement from fee-for-service to value-based payment.

This session will provide participants with practical actions they can take to tell their "value story" and align with organizational, payer, or other funder's goals. Using a palliative care program's experience, this interactive session will walk participants through this program's recent journey in going from being at risk of having their program funding reduced to a place where their organization has recognized its value and is growing its resources.

Through large group facilitated discussion this session will encourage participants to share their own experiences in building the business case for the resources they needed to sustain and grow their program, including what worked and what did not work.

Finally, the presenters will share business planning tools and practical steps for conducting a needs assessment and aligning the program's goals with their organization's or other funders' goals.

Sojourn's Scholars Present: In the Expert's Studio (FR474)

Toby Campbell, MD MS MSC, University of Wisconsin, Madison, WI. Abraham Brody, PhD RN ACHPN FAAN FPCN, NYU Rory Meyers College of Nursing, New York, NY. Elizabeth Lindenberger, MD, Icahn School of Medicine at Mount Sinai, New York, NY. Caroline Hurd, MD, University of Washington, Seattle, WA.

Lynn Reinke, PhD ARNP, Department of Veterans Affairs, Seattle, WA.

Objectives

- Gain insight into the approach to highly skilled communication.
- Skill demonstration in order to demystify the communication process for clinicians.
- Enhanced understanding of the invisible process an expert takes when approaching a complicated situation.

Clinician/patient communication is a central skill of the palliative care and hospice professional. While a variety of training methods and approaches are used to teach communication skills, the opportunity to learn directly from a leader in the field is rare. Even rarer is the opportunity to hear about their personal and professional development. Participants will hear the expert comment on their strategies, thought processes, and development. Our presentation is based upon a "Master's Class" in which the audience learns from the demonstration of skill by an acknowledged expert and a discussion of their development and approach. We presented this session in 2018 with Dr. Ira Byock and plan to reprise our session in 2019 with another expert, ideally in a larger room with video capability so the audience can better see the expert's face and body language on screen.

The program is broken into thirds. In the first portion, the interviewer digs deeper into the expert's personal and professional development into a leader of the field. In the second portion, attendees observe our expert in an uninterrupted simulation such as a family meeting. In the final portion interviewers walk the expert through the simulation to gain insights into their thought process about the communication strategies used and alternatives they considered.

For example we may ask about how they prepare for a consult, how they cope after a difficult day, or how they balance work and family. We engage the audience in the form of submitted questions on paper. This session lends itself to being repeated annually with a different expert participant.

Our group, over time, wants to represent a diverse group of experts. If accepted this year we intend to approach Susan Block, Martha Twaddle, or Diane Meier.

Calculating Conversations About Opioid Conversions: Not Your Mama's Equianalgesic Chart! (FR475)

Mary Lynn McPherson, PharmD MA MDE BCPS, University of Maryland School of Pharmacy, Baltimore, MD. Mellar Davis, MD FCCP FAAHPM, Geisinger Medical Center, Danville, PA.

Objectives

- Describe reasons why patients need to switch from one opioid regimen to a different opioid regimen.
- Describe recent data that evaluates including switching from IV hydromorphone to oral hydromorphone, morphine or oxycodone, and other conversions.
- Describe considerations for future opioid switching best practices: equivalency vs. utility.

It is not uncommon for patients to require switching from one opioid to a different opioid to maximize pain control and minimize adverse effects. This may be due to transitions in care (between acute and chronic care), due to lack of an acceptable therapeutic response, or due to opioid-induced toxicity. Practitioners rely on equianalgesic tables to determine an equivalent dose of a different opioid regimen. Much of the data that supports these tables is from single-dose studies, not steady-state clinical trials, and seldom if ever consider patient-specific considerations. In the past 2-3 years, better evidence has emerged in opioid conversions, including data from stead-state clinical practice. In this presentation participants will learn about this emerging data that demonstrates best practices in switching between opioid and dosage formulations. Using a case-based format, the presenters will guide participants through the application of this data, and use of a "new and improved" equianalgesic table. Last, participants will leave about a new concept of "opioid utility" which may be the next concept in opioid conversions. This presentation will share cutting-edge data that provide more accurate guidance than traditional opioid equianalgesic charts have in years past.

Managing Scarce Resources: Best Practices in Using Triggers in the Hospital and in the Community (FR476)

Allison Silvers, MBA BA, Center to Advance Palliative Care, New York, NY. Dana Lustbader, MD FAAHPM, ProHEALTH, New York, NY. Rachel Adams, MD, Icahn School of Medicine at Mount Sinai, New York, NY.

Objectives

- List the key data elements used in effective patient identification algorithms, and explain the variation needed between inpatient and outpatient services.
- Describe the key steps in implementing a proactive patient identification program, including ensuring patient engagement.
- Devise strategies to achieve buy-in and support from treating providers, accounting for the needs and culture of their organization.

With limited resources and a specialized skill set, palliative care services must be delivered to the appropriate set of patients to ensure value to the organization. Unfortunately, referrals from treating providers do not always result in palliative care teams seeing the right patients at the right time. As an