- Understand the evidence for dietary supplements in pain management for palliative care and hospice patients.

Pain is a complex multidimensional issue compromised of physical, biochemical, neurological, nutritional, and psychosocial-spiritual components. Primary medical treatments to date habitually treat pain with pharmacologic management as first line of care, yet chronic pain management metrics have not improved. As opioid medications have recently come under intense scrutiny, certain integrative therapies such as acupuncture are now being recognized as effective for many chronic non-malignant pain syndromes, such as chronic headache and chronic low back pain. Palliative and hospice patients often have co-morbid chronic non-malignant pain secondary their palliative diagnosis. Further, as up to half of cancer patients report under-treated pain, an integrative comprehensive pain strategy can provide superior pain management in cancer patients. This presentation will address the evidence and role for integrative therapies, including acupuncture, dietary supplements, mind-body therapies, massage, music, and cannabinoids in the management of chronic and cancer pain.

Vigil Volunteers—The Power of Presence at the Bedside (FR479)

Rebecca Hixson Vanderbilt University Medical Center, Nashville, TN. Mohana Karlekar, MD, Vanderbilt University Medical Center, Nashville, TN. Andrew Peterson, MDiv MMHC, Vanderbilt University Medical Center, Nashville, TN. Cody Case, MDIV, Vanderbilt Medical Center, Nashville, TN.

Objectives

- Outline the key steps in developing a self-sustaining Vigil Volunteer Program from inception to institution-wide roll out.
- Describe a framework to recruit, orient and provide ongoing training for volunteers with little to no experience in caring for patients at the end of life that is both that time and cost efficient.
- List both the benefits and barriers in establishing a model a Vigil Volunteer Program to patients, families and clinical staff.

Many of us have imagined what we want at the end of life (EOL). Most all of us wish to be surrounded by loved ones. Studies show that patients fear abandonment. The reality, however, is that a significant portion of patients die alone. Death creates angst. Dying alone exacerbates this angst.

In our institution, a quaternary care center that routinely accepts patients from hundreds of miles away, a great many patients find themselves alone at the EOL despite having family. The moral distress of dying alone is unimaginable. To address this concern, we developed a Vigil Volunteer program available to *any* patient who finds themselves alone at the EOL regardless of whether they had family.

In this session, we will describe the structure and operations of our Vigil Volunteer Program including the iterative process that led to this self-sustaining program. We will use our experience as an example to show how other institutions can develop their own vigil program to suit their individual needs without adding additional staffing.

We will describe the impetus in developing our program, and how we scaled our pilot from a single inpatient unit to the entirety of the institution.

We will discuss the nuts and bolts of the program emphasizing staffing, specifically volunteer recruitment, orientation, and ongoing training and resilience. Finally, we will highlight the benefits to patients, families and health care providers, as well as share the perspective of an actual volunteer's personal experience.

Each member of our team will discuss how our institution has created a therapeutic presence for our hospitalized patients nearing the end of life. We will describe and account for the effect of human, mindful presence positively impacts the care and comfort of those individuals who would otherwise have gone through the journey alone.

The Evolution from Futility to Non-Beneficial Treatment: Updates for the Palliative Care Clinician (FR480)

Adam Marks, MD, University of Michigan, Ann Arbor, MI. Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI. Gregg VandeKieft, MD MA FAAHPM, Providence Health and Services, Olympia, WA. Denise Hess, MDIV, Providence St. Joseph Health, Hillsboro, OR. Steven Radwany, MD FACP FAAHPM, Summa Health System, Akron, OH.

Objectives

- Understand the definition and history of the ethical concepts of medical futility and non-beneficial treatment as it pertains to hospice and palliative medicine.
- Discuss the ethical and legal scope and limitations of these concepts in withdrawing/withholding life-sustaining therapies.
- Review the experiences of three hospital systems' implementation of non-beneficial treatment policies, including impact on ethics consults.

Not infrequently, palliative medicine clinicians encounter a patient or family who requests treatment at the end of life that is of little or no clinical benefit. In the majority of instances, these cases can be resolved with thoughtful, value-based communication and shared decision making. However, in some cases, conflict can arise when the patient or family insists on

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)

Stephanie Stephens, DO, Virginia Commonwealth University Health, Richmond, VA. Brian Cassel, PhD, Virginia Commonwealth University, Richmond, VA. Danielle Noreika, MD, Stephens Medical Center, Richmond, VA. Egidio Del Fabbro, MD, Richmond, Richmond, VA.

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)

Maggie Rogers, MPH, Center to Advance Palliative Care, New York, NY. R. Sean Morrison, MD FAAHPM, Icahn School of Medicine Mount Sinai, New York, NY. Amy Kelley, MD MSHS, Icahn School of Medicine at Mount Sinai, New York, NY. Diane Meier, MD FACP FAAHPM, Icahn School of Medicine at Mount Sinai, New York, NY. Melissa Aldridge, PhD MBA BA, Icahn School of Medicine at Mount Sinai, New York, NY.

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