

- Maximize interdisciplinary team communication during a WOLST procedure.

**Background.** Literature demonstrates many patients with life threatening complex chronic conditions die in the intensive care unit (ICU), with nearly half of these patients dying after withdrawal or withholding of life sustaining therapies.<sup>1-7</sup> There is considerable variation in how WOLST occurs and whether formal training is provided.<sup>2</sup> No prior research has established the best practices for this procedure.<sup>1-7</sup>

**Aim Statement.** In patients undergoing WOLST, we will use a best practice guideline and electronic medical record (EMR) templated note to increase provider confidence and quality of death by 10% in 12 months.

**Methods.** We created a best practice WOLST guideline through literature review and expert consensus. This guideline included a pre-WOLST huddle template and a templated EMR note. Care team members involved in a WOLST received a survey to assess their confidence with the process and evaluate their perception of quality of death in their patient. Participants included clinicians involved in a patient's WOLST. The setting included all ICUs at a quaternary children's hospital.

**Results.** Baseline data was collected following 35 WOLST procedures, 250 surveys were sent with 116 responses, resulting in a survey response rate of 46%. Physicians and nurses reported a mean score of 84 and 82 out of 100 respectively for confidence in preparing families for the dying process. Data revealed marked variability when evaluating clinicians perception of death, with scores ranging 0-100; mean=81. Thematic analysis identified key processes on which to focus PDSA cycles including: anticipatory guidance to team and family, provider role clarity, and earlier involvement of interdisciplinary team members.

**Conclusions and Implications.** Little has been published regarding a specific methodology for teaching the process of WOLST to care teams, thus development of a systematic approach is critical to providing the best care at the end of life. Identifying key drivers to WOLST procedures has enabled creation of a practice guideline and EMR template for continued PDSA cycles.

### **Training Nonpalliative Care Clinicians in Serious Illness Communication: Results of a Train-the-Trainer Model in Three Health Systems (SA511D)**



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#### *Objectives*

- List the steps of a structured approach to training clinicians in serious illness communication using the Serious Illness Conversation Guide.
- Evaluate clinician-reported outcomes of serious illness communication training, including self-assessment of change in skills.
- Categorize and reflect on clinician takeaways from training that they will apply in practice as well as trainer perceptions of common barriers.

**Background.** Failure to initiate discussions about values and goals in serious illness ('serious illness communication') remains a common problem. Insufficient training leaves clinicians unsure of what to say or how/when to approach these conversations. Given the shortage of palliative care clinicians, evidence is needed to guide the development and implementation of consistent high-quality communication training for all clinicians.

**Aim Statement.** Evaluate the impact of clinician training as part of an organization-wide initiative and train-the-trainer program in three health systems.

**Methods.** In partnership with the Serious Illness Care Program at Ariadne Labs (AL), 3 health systems identified champions to complete a novel train-the-trainer program. Subsequently, these trainers delivered skills-based trainings on the Serious Illness Conversation Guide (SICG) to nonpalliative-care clinicians in their own systems. After each training, clinician participants completed a survey, including self-assessment of change in skills and self-reported learnings.

**Results.** From 2016-2018, AL trained 22 trainers (18/22 were palliative care MDs) in three systems, who then trained 331 clinicians (48% MD; 32% APP; 20% RN, SW) in 53 sessions spanning subspecialties (67%); primary care (25%); other (8%). Upon completion, participants reported improvement in each of the communication tasks (e.g. assessing illness understanding, sharing prognosis, exploring goals/values); improvements between self-rating scores pre- and posttraining were all significant ( $p < 0.0001$ ). Participants rated the quality of the training highly (98% mostly/extremely effective) and shared a diverse array of personalized takeaways to apply in practice, including core skills learned (e.g. reflective listening) and the usefulness of a structure.

**Conclusions and Implications.** Serious Illness Conversation Guide training, delivered through a train-the-trainer model and system-level program, was highly acceptable and resulted in significant

measurable improvements in clinician self-reported skills. This is a viable and scalable method for health systems seeking to train their own workforce in serious illness communication.

**1:30–2:30 pm**

### *Concurrent Sessions*

#### ***Using Improv to Enhance Communication Skills Practice (SA520)***



Kathleen Neuendorf, MD, Cleveland Clinic, Cleveland, OH. Brooke Johnston, MD, Hands of Hope Comprehensive Pediatric Care, Greenville, SC. Connor Brunson, BS, University of South Carolina School of Medicine, Greenville, SC.

##### *Objectives*

- Recognize the commonalities of improvisation and healthcare communication and discuss ways these techniques are adaptable to different settings.
- Experiment with variations in tone of voice, physicality, and word choices and reflect on the impact.
- Restate frustrations as priorities and values.

Have you been asked to give grand rounds on communication skills and want to incorporate a meaningful exercise to enhance your didactic? Have you been facilitating communication skills training and feel bored with the current curriculum? Or maybe you are looking for a different perspective on the communication skills you are using. Many palliative care providers are not only relied upon for their excellent communication skills with patients, families and colleagues, they are asked to teach communication skills to others as well. Self and social awareness are valuable skills for identifying opportunities to find words that will resonate with patients in the present moment. However, as clinicians are being asked to do more with less and in shorter periods of time, opportunities for mindful, reflective practice can be harder to find. Idealized communication sessions that limit the number of participants and require hours of time are not always possible. Adapted improv techniques to practice communication skills, even in large group settings, allows for a safe and supportive environment that fosters participant spontaneity and honesty while raising awareness about what we communicate, whether it is intentional or not. In this session, presenters who are using improvisation in a variety of settings will quickly review the main tenants of improvisation and discuss how these tenants enhance clinical encounters and apply in healthcare communication. Participants will experience a selected group of

improv exercises, discuss their relevance in communication skills training and hypothesize how these activities can be adapted to a variety of audiences. If you've been looking for ways to bring meaningful communication skills training to audiences from 10-1000 participants in a short amount of time, this session is for you. We promise that "being funny" is NOT a core tenant of improv and not required to attend this session.

#### ***In With the New: Managing Acute Malignant Pain in Patients on Opioid Replacement Therapy with Buprenorphine (SA521)***



Lori Earnshaw, MD FAAHPM, University of Louisville, Louisville, KY. Zachary Sager, MD MA, BIDMC/Boston VA, Boston, MA. M. Kate Probst, PharmD BCACP BCGP, Sullivan University College of Pharmacy, Louisville, KY.

##### *Objectives*

- Compare and contrast the pharmacology of pure and partial opioid agonists.
- Describe an approach to treating acute pain in hospice patients receiving buprenorphine and naloxone therapy.
- Establish the role of buprenorphine in hospice and palliative care clinical practice.

After Dole and Nyswander introduced the role of methadone in drug rehabilitation in 1965, methadone became the standard for medication assisted therapy of opioid use disorders. Similarly, hospice and palliative care professionals have recognized the role of methadone in treating cancer-related pain. Since its release in the early 2000s, buprenorphine has become the preferred medication assisted treatment option given its ability to be prescribed in a less restrictive setting, the relative ease of dosing, and reduction in stigma. Given the popularity of buprenorphine for medication assisted treatment, hospice and palliative care practitioners must be prepared to manage patients on buprenorphine who require pain management for serious illness. We will present the case of a young hospice patient with terminal cancer whose pain was being managed with combination buprenorphine and naloxone therapy for opioid use disorder. We will describe the pharmacology of buprenorphine, how it is used in medication assisted treatment and how to transition patients on buprenorphine to a more traditional opioid agonist for acute pain management. Finally, we will discuss the possible role of buprenorphine for management of pain in the setting of an opioid use disorder.

#### ***Speed Dating for Kids 2.0 (SA522)***



Emma Jones, MD, Pediatric Advanced Care Team, Boston, MA. Mary Lynn McPherson, PharmD MA MDE BCPS, University of Maryland School of