

ACO-type model just for dialysis patients). The Pathways Project developed a change package which consists of 14 evidence-based practices which the Collaborative teams are to test, implement, and evaluate. Examples of these best practices are identifying seriously ill patients, implementing advance care planning and shared decision-making, providing medical management without dialysis as an alternative to dialysis, and offering palliative dialysis and systematic dialysis withdrawal for appropriate patients. The Pathways Project developed the change package and associated tools and resources with input from the Pathways' interdisciplinary Technical Expert Panel (TEP), which included patient subject matter experts. This session will introduce these best practices and describe successes and roadblocks encountered in implementing them within nephrology and dialysis settings. The session will also describe the latest results from the CMMI ESCO demonstration and discuss how palliative care aligns with the ESCO goals. Speakers will guide participants in assessing the readiness of their palliative care service to build bridges with ESCO models and dialysis centers in their community to strengthen nephrology/palliative care collaboration.

Implementing a Bereaved Family Survey to Improve Palliative and End of Life Care at Academic Medical Centers (FR406)



Jessica Kaltman, MD MSHS, UCLA David Geffen School of Medicine, Los Angeles, CA. Anne Walling, MD, UCLA, Los Angeles, CA. Karl Lorenz, MD MS MSHS, Stanford-VAPAHCS, Palo Alto, CA. David Casarett, MD MA FAAHPM, Duke University, Durham, NC. Stephanie Harman, MD, Stanford University School of Medicine, Stanford, CA.

Objectives

- Describe the process needed to implement the Bereaved Family Survey (BFS) at academic health systems.
- Explain the importance of the BFS and how it can be used to improve the quality of palliative and end of life care provided by medical systems.

With the growth of value-based payment and alternative payment models, health systems have an interest in addressing the significant deficiencies in the care of serious illness including the quality of palliative and end of life care (PEOLC). A key obstacle to improvement is difficulty in measuring care processes and outcomes at the end of life. The patient and caregiver's experience with PEOLC is an important domain of quality inaccessible using administrative data and requires direct patient and family feedback. The Bereaved Family Survey (BFS) is endorsed by the National Quality Forum and has been used

nationally by the Department of Veteran's Affairs (VA) since 2010 to assess PEOLC at inpatient facilities. However, it has not been broadly used outside the VA or in the outpatient setting. BFS results can identify systematic problems in relation to communication, pain and symptom management, and care of the dying patient as well as patient characteristics associated with a poor end-of-life experience.

This concurrent session will help participants to assess whether the BFS is appropriate for their institutions and will provide guidance about implementation in the inpatient and ambulatory care setting. We will discuss the steps needed to execute the BFS in a large health system as well as strategies for automating the process. The presentation will review research and experiences with the BFS, address challenges in the implementation process including recent efforts in our own health systems, and provide potential solutions to these barriers, and discuss opportunities for collaboration in using it for quality improvement. The BFS collects valuable information regarding gaps in care quality vital to improve the quality of PEOLC.

Transcending Emotional Labor in Palliative Care: How Best Practices from Organizational Psychology Can Enhance Workplace Well-Being (FR407)



Erin Stevens, DO, Massachusetts General Hospital, Boston, MA. Keri Brenner, MD MPA, Stanford University, Palo Alto, CA. Gregory Stevens, PhD, WorkHuman Research Institute, Globoforce, Framingham, MA.

Objectives

- Describe emotional labor and understand its significance within palliative care.
- Demonstrate best practices for emotion management from research within service industries and discuss the relevance within palliative care.
- Outline tips that palliative care providers can use to strategize their day to mitigate emotional labor at work.

Emotional labor, often referred to as emotional management, is an underrecognized area of research within palliative care. Emotional labor is the process by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions. Given the highly emotional nature of this work, palliative care providers are frequently attending to others' emotions as well as those within oneself. Often, providers are able to display their true emotions, but at other times may experience emotional discrepancy and engage in emotional management. It is this emotional labor

within palliative care that can make one especially vulnerable to feelings of inauthenticity. Studies have shown that emotional labor influences job satisfaction, burnout, and organizational well-being. In this case-based discussion led by an industrial organizational psychologist and dual trained palliative care-psychiatry and palliative care-geriatric clinicians, we will discuss emotional labor, highlighting the many areas from clinical interaction to collegial engagement where there is the potential to experience emotional labor. We will review literature from business management and organizational psychology, illustrating strategies at the organizational, team, and individual level that may help mitigate the long-term consequences of emotional labor and draw from the most recent research of the employee experience to emphasize the importance of bringing the “whole self” to work.

Pediatric Concurrent Care: Where Are We Today? (FR408)



Khaliyah Johnson, MD HMDC, Children’s Healthcare of Atlanta, Atlanta, GA. Nancy Hutton, MD FAAP FAAHPM, Johns Hopkins School of Medicine, Baltimore, MD. Kimberly Bower, MD DC HMDC FAAHPM, Rady Children’s Hospital, San Diego, CA. Mary Tiso, RN, Gilchrist, Baltimore, MD. Judi Lund Person, MPH CHC, National Hospice & Palliative Care Organization, Alexandria, VA.

Objectives

- Describe the CCCR legislation and options available for its implementation.
- Identify barriers to implementing concurrent care in one’s state and strategic approaches to overcoming these barriers.
- Cite additional steps that may be taken to advocate for improved access to pediatric palliative care for Medicaid patients.

In 2010, the concurrent care for children requirement (CCCR, Section 2302) was signed into effect as part of the Patient Protection and Affordable Care Act, in order to improve pediatric patients’ access to hospice care while simultaneously receiving disease modifying treatments. This talk will provide an overview of the progress that has been made in nearly ten years since the implementation of CCCR, highlighting successes and common challenges experienced across states. Georgia, Maryland, and California will be used as case examples to demonstrate how local pediatric clinicians and stake-holders worked with state-based Medicaid programs to identify barriers to CCCR implantation and formulate a strategic plan for addressing those barriers. Finally, we will engage the audience in discussion on the impact of section 2302 on improving care for children with life-limiting illnesses,

and what additional advocacy efforts can be taken to optimize its impact.

Standing Tall: Advancing Your Career as an Academic Clinician and Educator in Hospice and Palliative Medicine (FR410)



Sangeeta Lamba, MD FAAHPM, Rutgers New Jersey Medical School, Newark, NJ. Jane deLima Thomas, MD FAAHPM, Harvard Medical School, Harvard Interprofessional Palliative Care, Fellowship, Dana-Farber Cancer Institute/Brigham and Women’s Hospital, Boston, MA. Vicki A. Jackson, MD MPH FAAHPM, Massachusetts General Hospital, Boston, MA. Steven M. Radwany, MD FACP FAAHPM, Ohio State University Wexner Medical Center, Akron, OH.

Objectives

- Identify and engage in steps to start a professional development plan for academic advancement and success.
- Define the broadened scope of scholarship for academic advancement to include education, clinical practice, and leadership.
- List strategies for building a clinical and/or educational portfolio from work that you already do.

The majority of academic interdisciplinary clinicians in hospice and palliative medicine such as the physicians, nurses and social work faculty spend a large proportion of their time in clinical practice and teaching, and therefore may face unique struggles related to academic/career advancement. Faculty working in the areas of clinical innovation and education have important scholarly contributions that should be shared with the field to advance our knowledge. Many faculty erroneously believe that only rigorously designed research projects are worthy of dissemination or feel unsure about how to share their clinical innovation, quality improvement, and education work in a scholarly way. Building a portfolio of scholarly work is important when seeking advancement and/or promotion. There exists a lack of local mentors who can guide clinicians and educators on how to develop and successfully submit a portfolio since senior leadership such as Chairs have traditionally advanced on research tracks themselves. We plan to use a panel with expertise both in academic palliative medicine and faculty affairs to assist attendees in identifying how to develop a professional development plan including options for scholarship such as case reports, thought pieces, quality improvement, clinical innovation, and education projects. The goal will be for faculty to identify and document their work with a broadened scope of scholarship as contributions to the field and for their academic advancement.