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daughter’s saga with their husband/father, her father-in-law’s case, and the account of an HD patient’s mother who cared for her adult son until his acute quadriplegia from a fall. Participants will use their narrative medicine skills by listening to, absorbing, interpreting, and acting on her story. Interactive dialogue sessions will help presenters and participants alike identify and clarify challenges and opportunities to integrating expert hospice/palliative support of HD family caregivers. A palliative care physician with a Master of Divinity will discuss supporting patients and caregivers experiencing significant existential and spiritual distress who may be suicidal or angry at God. Participants can thus enrich and synthesize their emotional and spiritual support skills for caregivers of patients with devastating neurodegenerative diseases.

They Graduated Early!! When Graduation Is a Bad Thing. Current Approaches to Hospice Revocation (FR266)

Martina Meier, MD HMD, Providence TrinityCare Hospice. Rebecca Yamarik, MD MPH HMDC FAAHPM, Veterans Affairs. Eric Prommer, MD HMDC FAAHPM, Greater Los Angeles Healthcare System. Kathryn McRae, LCSW, Providence TrinityCare.

Outcomes
1. Know three main reasons for live hospice discharges
2. Gain familiarity with 3 common adverse patient outcomes associated with live discharges
3. Develop communication strategies that can support patients and families who are considering hospice revocation

Hospice encompasses palliative and supportive services targeting people with an estimated life expectancy of less than 6 months. Although hospice use is increasing, a concerning statistic is that nearly one of every 5 patients is discharged before death (the “live discharge”). Data suggest that this population of patients tends not to re-enroll in hospice, with more than a third dying within 6 months. Live discharges create burdensome transitions and predict aggressive end-of-life care. Common reasons for live discharge include revocation for acute hospitalization and revocation to resume disease-directed treatments with the goal of life prolongation. Other causes include disqualification due to loss of eligibility, transferring to another hospice, moving out of the hospice provider’s service area, and specific conceptions and attitudes about hospice. More recent research suggests that socioeconomic concerns can lead to hospice revocation. Whatever the cause, the live discharge patient and family lose critical supports for emotional and symptom control.

Interdisciplinary teams themselves can experience moral injury during the revocation process, with team members experiencing distress and often questioning their own clinical and communication skills. How can we prevent these unfavorable transitions or mitigate their effects? How do we communicate effectively with patients and their environment so as to avoid gaps in care? This session explores by way of case presentation, didactics, and interdisciplinary team experience common scenarios of hospice revocation. The presenters will share the leading causes of hospice revocation and describe the gaps in understanding and communication that can lead to the decision to revoke hospice, with a special focus on socioeconomic concerns that predispose to revocation. The common complications resulting from transitioning from hospice to more aggressive medical care will be discussed. Communication strategies to support patients and families considering revoking hospice and ways to continue supporting patients after live discharge will be reviewed.

Seeding a Revolution Post-COVID: Equipping Staff in Long-Term Care to Integrate Palliative Care (FR267)

Allison Silvers, MBA, Center to Advance Palliative Care. Brenda Matti-Orozco, MD FACP, Morristown Medical Center.

Outcomes
1. Recognize opportunities in existing long-term care workflows to assess for palliative care or hospice needs and trigger palliative care consultation
2. Describe four key palliative care services that long-term care professionals can be taught and incorporate into their own practice, including timely referral to palliative care or hospice
3. Devise strategies to improve collaborations with long-term care providers in their own communities

It is estimated that the majority of people receiving long-term care services have unmet palliative care needs, and for those near the end of life, hospice care remains underused. These disparities were highlighted during the COVID-19 pandemic, and now many long-term care programs and facilities are eager to address the palliative care needs of their patients or residents and avoid unnecessary hospital transfers, but they need to understand this in a way that aligns with their own priorities and operations.

Two recent initiatives have provided education, resources, and peer learning to groups of long-term care providers, to expedite the integration of palliative care in long-term care settings. One learning collaborative was led by a local health system aiming to improve
Off the Beaten Path: Caring for People Engaging in Potentially Unsafe Low-Evidence Therapies (FR268)

Adam Marks, MD MPH FAAHPM, University of Michigan. John Hammond, BA, University of Michigan. Jill Schneiderhan, MD, University of Michigan.

Outcomes
1. Define potentially unsafe low-evidence therapies (PULETs) and differentiate them from evidence-informed complementary and alternative therapies
2. Review the ethical and legal issues that may potentially arise in the care of patients who pursue PULETs
3. Discuss a stepwise approach to empathetic communication with patients who pursue PULETs, with an emphasis on humble inquiry and nonabandonment

Palliative care providers regularly care for patients with a serious illness, many of whom are engaging in the use of complementary and alternative medicine (CAM) either alone or along with traditional medical therapies. A subset of these patients may be engaging in therapies that not only have little or no evidence for efficacy but also carry significant potential risks to their health and well-being. However, these therapies may carry a great deal of significance for the patient and family for whom conventional medicine has failed or is otherwise deemed untenable. Thus, dismissing such therapies as “quackery” risks alienating patients and damaging or even severing a therapeutic relationship. When faced with patients who are engaging in potentially unsafe low-evidence therapies (PULETs), providers themselves may experience a great deal of moral distress when deciding how to balance supporting the hope PULETs may represent with the principles of nonmaleficence and autonomy.

In this case-based concurrent session, palliative care and CAM providers will review the definition of PULETs and distinguish them from the majority of CAM therapies. Drawing upon existing writings in the CAM literature, participants will then review a framework to evaluate the relative risk/benefit ratio of such therapies. A review of the ethical and legal aspects of care will then take place, including reporting mechanisms when frank fraud or abuse is suspected. Finally, using existing principles and tools in emotion-based communication, participants will engage in an interactive exercise to apply these tools in a stepwise fashion to foster continued collaboration and care for patients who engage in PULETs. Of note, these small group activities can be adapted for either the in-person or virtual environment.

Advancing Interprofessional Hospice and Palliative Care Teamwork with Entrustable Professional Activities (SA300)

Kashelle Lockman, PharmD MA, University of Iowa College of Pharmacy. Lindy Landzaat, DO FAAHPM, University of Kansas. Laura Morrison, MD FAAHPM, Yale New Haven Hospital. Barbara Jones, PhD MSW, University of Texas at Austin. Rabia Atayee, PharmD, University of California, San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences.

Outcomes
1. Contrast entrustable professional activities (EPAs) and competencies
2. Compare EPAs for hospice and palliative medicine physicians and hospice and palliative care (HAPC) pharmacists
3. Discuss benefits and challenges of integrating EPAs as a framework in HAPC training programs

Effective interprofessional teamwork is a core component of providing quality palliative care, but team dynamics and effectiveness can be compromised when roles and responsibilities are ambiguous or misunderstood by team members from different professions. Entrustable professional activities (EPAs) establish a consensus of essential roles and responsibilities that clinicians can be entrusted to perform without supervision, after achieving and integrating multiple competencies in a profession or specialty. EPAs in hospice and palliative care have been developed for physicians and pharmacists; hospice and palliative care (HAPC) EPAs are yet to be developed for other professions on HAPC interprofessional teams, including chaplaincy,