

ORAL ABSTRACT #1 and winner of the top oral presentation

Loop: A community focused, patient-centred, online clinical collaboration system

Communication between individuals, settings and organizations is a central problem in delivering high quality palliative care. In a partnership between the Temmy Latner Centre for Palliative Care at Mount Sinai, UHN's Healthcare Human Factors Team at the Centre for Global e-Health Innovation, Cancer Care Ontario, Hospital for Sick Children, Princess Margaret Cancer Centre and St. Michael's Hospital, we have developed a web-based mobile system for collaborative care in complex patients. Patients and their caregivers are an integral part of the collaborative care. The objective of the tool is to build capacity and enable collaborative care across settings, organizations and the patient's actual team of care. We have used a participatory design method to develop the vision for the tool, a user-centred approach to development, and the Medical Research Council complex intervention framework for evaluation. We are in the beta-testing phase, followed by a pilot randomized controlled trial. The outcomes of interest are continuity of care, patient, caregiver and primary care engagement, and public and private costs of care. The overall impact will be transformative by providing a user-friendly, time saving, team-building and fun tool for enabling collaborative care.

Participants will:

1. Learn an approach to user-driven e-health innovation
2. Learn how to implement a trial of a complex intervention

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ORAL ABSTRACT #2

Substance abuse and dependence; A survey of Canadian Palliative Care Physicians' knowledge, attitudes, and practices

Context: Substance abuse affects 11% of Canadians, and its prevalence is estimated to be as high as 1 in 4 patients receiving palliative care. Patients with substance abuse/dependence (SAD) suffer a higher symptom burden and are referred earlier for palliative care. Very little research exists surrounding palliative care for patients with SAD. Objectives: To determine the training and current knowledge of Canadian palliative care physicians surrounding SAD and to explore their current screening and management practices. Methods: A survey was distributed to all 374 members of the Canadian Society of Palliative Care Physicians. The survey included 35 questions over 6 domains: Previous Training, Current Practice, Knowledge, Attitudes, Role Support and Self-Efficacy. Responses adopted a standard Likert-scale format. Results: The response rate after two mailings was 48.7%. 88.4% reported <5hrs of training on SAD during residency, and 46.4% reported no training during palliative care fellowship. Regarding clinical practice, 46.4% frequently identified patients with SAD yet 81.8% reported they rarely/never conduct urine drug screening. 85.1% were concerned with medication misuse, and 40% did not feel confident in adjusting pain medications and would be hesitant to increase dosages. Furthermore, over half of respondents did not feel they could find someone to help formulate a treatment plan. Half of respondents (50.3%) were satisfied with how they currently manage pain in patients with SAD. Conclusions: SAD is encountered frequently among Canadian Palliative Care physicians yet it is not a focus of training. Further training and access to experts may be needed to assist physicians.

Participants will:

1. Understanding of current clinical practices of Canadian palliative care physicians when managing patients with substance abuse/dependence
2. Highlight areas of practice discrepancy, current state of training, and opportunities for improvements in patient care.

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ORAL ABSTRACT #3

The systematic appraisal of delirium clinical practice guidelines and adaptation for an inpatient palliative care unit.

Although there is a lack of high level evidence for the management of delirium, multiple clinical practice guidelines have been published. In order to better inform the content for a clinical practice guideline being developed on our palliative care unit (PCU), we undertook a formal librarian-assisted systematic literature search for existing delirium guidelines for all clinical settings in multiple electronic databases: Cochrane Library, Medline, Embase, CINAHL, PsycINFO, Scopus and TRIP database. A hand search of Google, Google Scholar, guideline organization databases and websites of national delirium associations was also performed. Using the Appraisal of Guidelines Research and Evaluation (AGREE II) instrument, which focuses on the guideline development process, two independent reviewers (SB, KM) assessed the rigour domain of delirium guidelines published between 2008 and 2013. The quality scores for the rigour domain of evaluated guidelines will be reported. This standardized process ensures that only high-quality guidelines will be used to better inform the adaptation process of guidelines. We are currently creating a recommendations matrix before the subsequent implementation of delirium guidelines on our PCU. The process of the early stages of guideline adaptation, which we will describe in this presentation, will also be applicable in other settings. The next steps in this 'Work in Progress' will be: (1) the full appraisal of the quality of selected guidelines by four independent reviewers using the full AGREE II instrument, (2) drafting a local guideline, and (3) a formal evaluation of the implementation of the final local delirium guideline/algorithm on the unit.

Participants will:

1. Explain the challenges of sourcing delirium clinical practice guidelines (CPGs) and the development of a suitable broad search strategy
2. Describe the process of appraising guidelines using the Appraisal of Guidelines Research and Evaluation (AGREE II) tool and conducting CPG content analysis by creating a recommendations matrix.

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ORAL ABSTRACT #4

The palliative care needs of patients living with life-limiting neurological illness - applications to clinical practice and palliative care education-

Background: Palliative care for patients living with life-limiting neurological illness is an emerging field. Because advances in therapeutics are lengthening survival and increasing the duration of disability in patients with life-limiting neurological illness, it is important to improve the current knowledge and educational resources to enhance end-of-life care for our patients. Informed by a systematic review of the current literature related to the palliative care needs of patients living with life-limiting neurological illness, we conducted a series of expert focus groups to explore these issues in greater depth. Five focus groups with a variety of health care professionals were recorded and transcribed; qualitative thematic analysis is ongoing. The information gathered and synthesized in this project will serve as a needs assessment that will underpin the development of a neurological palliative care curriculum for neurologists, palliative care physicians and allied health care who work with patients living with life-limiting neurological illness. Knowledge and skills: Participants will gain insight into the both the complex palliative care needs of patients living with life-limiting neurological illness and the process of curriculum development. The knowledge gained from this presentation will be applicable to specialist palliative care clinicians and trainees and will be transferable to daily clinical practice.

Participants will:

1. Identify the current best evidence and expert opinion of the palliative care needs of patients living with life-limiting neurological illness.
2. Develop an innovative curriculum for palliative care in neurology.

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ORAL ABSTRACT #5

Managing End of Life Symptom Crises in the Home: An Innovative Partnership between Palliative Care and the Emergency Medical Services in the Calgary Zone of Alberta Health Services

Patients receiving end-of-life care at home may develop critical symptoms that would normally require transport to hospital, or a long wait for prescribed medications to come from a community pharmacy. The "Unexpected Event Protocol" was implemented in May 2012 in Calgary, Alberta to enable Emergency Medical Services (EMS) to provide injectable medications at home until pharmacy medications arrive. Activity: EMS, Palliative Care and specialist pharmacy services collaborated in developing both the protocol and a prospective, observational evaluation tool. Adult Palliative Home Care patients with an unexpected symptom crisis, who wish to remain at home at end-of-life could use this protocol. A registered nurse (RN) would visit home and then talk to the palliative physician on call (PCMD) to decide on whether to activate the protocol. Once activated, EMS were called. With the onsite RN assessment, the PCMD would verbally give orders to the EMS for medication administration. At the same time, prescription orders were sent to the community pharmacist for delivery of injectable medications. A quality audit was undertaken after a year which showed 100% positive clinician satisfaction rating, and 89% of patients avoiding a hospital transfer. Median time from EMS call to medication administration was 26 minutes. Palliative

Home Care patients with an end-of-life symptom crisis received timely access to medications through this novel protocol. The audience will learn details about the process, which is another way that other health systems can use to enable patients to stay home at end of life.

1. Participants will learn about the design of this innovative protocol
2. Participants will learn about the quality audit that was performed afterwards to assess its effectiveness.

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ORAL ABSTRACT #6

Moving on - the next step in developing an International Classification System for Cancer Pain

The Edmonton Classification System for Cancer Pain (ECS-CP) has been extensively validated and consists of five pain features: mechanism of pain, incident pain, psychological distress, addictive behavior and cognitive function. The primary objective of this ongoing validation was to assess the study feasibility and generalizability of the ECS-CP in a diverse sample of palliative care patients, using modified ECS-CP definitions for neuropathic pain and incident pain; and two different outcome measures: stable pain control based on a standardized pre-defined cut point and stable pain control based on a patient-specific personalized pain goal (PPG). We hypothesized patients with less problematic features as classified by the modified variables would require a shorter time to achieve stable pain control and use less complicated analgesic regimens and that patients' PPGs would differ substantially from a pre-defined cut point. 300 advanced cancer patients were recruited from 3 palliative care sites in Edmonton, Canada: Royal Alexandra Hospital (n=100), University of Alberta Hospital (n=100), and Tertiary Palliative Care Unit, Grey Nuns Hospital (n=100). A palliative care specialist completed an ECS-CP for each enrolled patient. Additional information collected included patient demographics; initial pain, anxiety, depression and well-being intensity; performance status; alcohol addiction history; smoking history; initial 24 hour opioid use; use of adjuvant analgesics and other methods of pain control; and the patient's PPG. Preliminary findings and implications for the further refinement of a standardized pain classification system will be presented. Questions of significance and practical application include: - 1. What is stable pain control – can a personalized pain goal help? 2. Can chronic pain and a smoking history contribute to complexity of pain management? 3. Moving on – how do improved definitions impact predictive validity of the ECS-CP? 4. Changes in pain classification during the care trajectory. 5. Interprofessional team use as a measure of complexity of pain management needs.

Participants will:

1. Understand the complexity and clinical importance of classifying cancer pain.
2. Learn how research can help the ongoing innovation and development of an international assessment system for classifying cancer pain.

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POSTER ABSTRACTS

This first abstract by Dr. Watanabe was the winner of the poster competition

What is the most appropriate time frame for assessing symptoms? A validation study of the Edmonton Symptom Assessment System-Revised (ESAS-r) in advanced cancer patients

Aim: The Edmonton Symptom Assessment System (ESAS) is widely used symptom assessment tool developed for advanced cancer patients. The ESAS-r offers advantages over the ESAS by revising problematic items while retaining core elements, including assessing symptoms “now.” Validity evidence is needed to determine an appropriate time frame for assessing symptoms and compare the tool with similar measures. **Purpose:** To gather validity evidence by assessing differences in ESAS-r responses between “now” and “24 hour” assessments, and comparing the ESAS-r with a palliative care-specific quality of life measure (EORTC QLQ-C15-PAL), with symptoms rated “over the past 7 days.” **Methods:** 50 advanced cancer patients receiving palliative care services in a tertiary cancer facility completed ESAS-r Form A (rated “now”), ESAS-r Form B (rated “during the last 24 hours”), and the QLQ-C15-PAL. Correlations were calculated using Spearman's rho (rs). **Results:** In a preliminary analysis of the first 32 patients, Forms A and B were moderately to highly correlated for total symptom distress scores (SDS) (rs=.90) and individual items, ranging from .70 (drowsiness) to .87 (depression). Total SDS for Forms A and B were moderately correlated with total score for the QLQ-C15-PAL (rs=.67 and .65, respectively). **Conclusions:** This is the first study to demonstrate that using a time frame of “now” versus “during the last 24 hours” for the ESAS-r does not substantially influence patients' responses. Also, the ESAS-r appears to be effective for assessing quality of life. The results support the use of the ESAS-r for clinical, research and administrative purposes.

Learners will: 1) Understand the potential influence of time frame of assessment on ESAS-r responses
2) Become aware of the utility of the ESAS-r as a quality of life measure in clinical, research and administrative settings

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Dexmedetomidine compared to midazolam for symptom control in advanced cancer patients: A pilot randomized controlled trial (RCT)

Objective: What is the feasibility of a multi-centre RCT comparing dexmedetomidine with midazolam in enhancing control of pain, dyspnea, nausea and/or delirium in advanced cancer patients? **Design:** A double blind randomized design was planned with patients randomized to receive either dexmedetomidine (treatment group) or midazolam (control group) in a 1:1 group assignment ratio. **Method:** All advanced cancer patients admitted to the Abbotsford Tertiary Palliative Care Unit over one year were screened for eligibility and invited to pre-consent to the pilot RCT if proportional sedation with midazolam would be an acceptable treatment for intractable symptoms. Enrolment would occur at the time intractable symptoms developed. For those who did not have the opportunity to pre-consent, consent was obtained from the patient or substitute decision-maker at the time of developing intractable symptoms. **Results:** Of 258 admitted patients, 83% were screened, 32% eligible and 10% consented. No patients were enrolled in the pilot RCT. Off study, 28 patients received midazolam continuous subcutaneous infusion (CSCI), 2 patients received dexmedetomidine CSCI. **Conclusion:** The pilot RCT concluded that a multicenter RCT comparing dexmedetomidine to

midazolam did not appear to be feasible due to difficulties in enrolment. Using the study protocol, dexmedetomidine CSCI effectively treated intractable pain and delirium in one patient. A case series of patients treated with CSCI dexmedetomidine is planned.

Attendees will understand the challenges of performing a randomized double blind controlled trial in a tertiary palliative care environment. Participants will learn about the ethics and difficulties experienced with pre-consent, third party consent, deferred consent, and in urgent situations, consent obtained by the most responsible physician. Gate keeping will be discussed as a significant barrier to enrollment.

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The risks of debilitating falls (DFs) in Manitoba patients (pts) with cancer

Background: Falls and fall-related injuries are significant pt safety challenges. We sought to identify if cancer pts were at greater risk of DFs. Methods: Using a retrospective population-based study design, we linked the Manitoba Cancer Registry with health care use records from Manitoba, Canada. Our study cohort consists of all adult community-dwelling pts with a first cancer diagnosis between April 1, 2003 and March 31, 2008, matched by age and gender to three cancer-free controls. DFs were defined as falls requiring hospitalization (ICD billing codes) between the time of cancer diagnosis and Dec 31, 2009. Regression models using death as a competing risk were used to compare DFs separately for those <65, 65-79 and 80+. Each model was adjusted for individual year of age, sex, medication use, neighborhood income, previous falls and co-morbidities. Results were expressed using sub-hazard ratios (SHR). Results: 27,164 cancer pts were matched to 83,928 controls; 50% of the overall cohort was female, with a median age of 68 years. DFs occurred in 866 cancer pts (3.2%) vs. 2883 (3.4%) controls. DFs for cancer patients by age groups <65, 65-79, and 80+ were: 151 (1.3%), 349 (3.3%), and 366 (6.9%). Without adjustment, short-term (<1 year) DF risk was greater in cancer versus control pts (Table 1). For all pts except those 80+ this increased risk was explained by study covariates. Adjusted long-term (>1 year) DF rates were statistically lower in cancer pts 65+ years old vs. controls. The SHRs for death in cancer pts compared to controls during <1 and >1 year were: <65, 104.4 and 20.6 (p<.001); 65-79, 41.2 and 7.7 (p<.001); 80+, 26.6 and 3.7 (p<.001). Conclusions: In this population-based study, cancer pts were at increased risk of DFs, compared to matched controls, during the 1st year after diagnosis. The increased risk disappeared after adjusting for confounding factors except in those > 80. After 1 year of follow-up, cancer pts no longer had a higher risk of falls in part due to their higher risk of death.

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Enhancing Communication Amongst Health Care Professionals in End-of-Life Care: An Evaluation of the Correlation between the Palliative Performance Scale (PPS) and the Clinical Frailty Scale (CFS)

The objective of our study was to establish a translation chart between the Palliative Performance Scale (PPS) and the Clinical Frailty Scale (CFS), functional status scores assigned by Palliative Care and Geriatric teams respectively. This conversion chart allows a common language to facilitate communication between palliative care and geriatric teams. Method: PPS and CFS scores were

assigned to patients from two academic health centres; inpatients admitted to a palliative care and chronic care unit, outpatients who attended a geriatric clinic, and new inpatient referrals seen by a palliative care consult team. Each of these patients was assessed with a PPS score, by a palliative care doctor and nurse, and a CFS score, by a geriatric doctor and nurse. Inter-rater reliability within each measure was calculated using Cohen's weighted kappa. Inter-rater reliability between each measure was calculated for every possible combination of PPS and corresponding CFS scores, to determine the combination with maximum agreement. Results: Inter-rater reliability within each measure was very high for both the CFS and PPS, weighted $\kappa = .92$ and $.80$ respectively. The CFS-PPS score matching that achieved the maximum agreement, $\kappa = .71$, was used to create the CFS-PPS conversion chart. Conclusions: The created CFS-PPS conversion chart is a reliable means for translating scores between the CFS and PPS. This tool is useful for geriatric and palliative care health care professionals collaborating in the care of elderly patients suffering from symptoms related to terminal illness and nearing the end of life. - Geriatric health care professionals will gain a useful tool for collaborating with palliative care in the care of elderly patients suffering from symptoms related to terminal illness or nearing the end of life. - Palliative care health care professionals will gain a useful tool for collaborating with geriatrics in the care of elderly patients suffering from symptoms related to terminal illness or nearing the end of life.

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Care and symptom trajectory in advanced non-small cell lung cancer patients

The available literature shows that patients with advanced non-small cell lung carcinoma (NSCLC) have a limited survival since they are diagnosed late in the disease trajectory. They experience high symptom burden which impacts in their daily life functioning, physical and emotionally. Also, some studies revealed that there is a subgroup of patients with advanced NSCLC who consistently report high symptom scores who may require closer monitoring and specialized care. Oncology guidelines include early integration of Palliative Care (PC) in patients with metastatic cancer but they lack of specific criteria for referral to PC. We conducted a prospective study including patients with advanced NSCLC (stage IIIb/IV) from August 2012 to November 2013 who were assessed during their regular followups with their oncologists (every 3-5 weeks). We collected demographics, treatment and symptom burden with the Edmonton Symptom Assessment System (ESAS-r). We included 67 patients with ages between 28-82 years-old (mean 64 ± 10.5 ; 50% males) who had a mean of 5.6 assessments/patient (range 1-18). 23 patients (34.3%) had symptom scores ≥ 7 at some point of their disease trajectory and 13 (19.4%) had repeated high symptom scores for at least 2 followups. There is a significant prevalence of persistent severe symptom scores in patients with advanced lung cancer not referred to PC (19.4%); moderate symptom scores should also be explored. More research is required to develop and validate algorithms identifying appropriate symptom management and referral to Palliative Care.

This presentation will heighten learners' awareness of the significant prevalence of persistent high symptom burden in advanced NSCLC patients, and of the need to develop clear symptom management algorithms and PC referral criteria.

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Therapeutic Touch TM in a Geriatric Palliative Care unit - A Retrospective Review

Introduction: Complementary therapies are increasingly used in palliative care as an adjunct to the standard management of symptoms to achieve an overall well-being for patients with malignant and non-malignant terminal illnesses. A Therapeutic Touch Program was introduced to a geriatric Palliative Care Unit in October 2010. Two volunteer Therapeutic Touch Practitioners offer the therapy to patients who have given verbal consent. Objective: To conduct a retrospective review of Therapeutic Touch services provided to patients in an in-patient geriatric palliative care unit to better understand the impact of the Therapeutic Touch Program on patient care. Methods: A retrospective medical chart review was conducted on both patients who received Therapeutic Touch as well as a random selection of patients who did not receive Therapeutic Touch. Client characteristics and the Therapeutic Touch Practitioners' observations of the patient's response were collected. Descriptive analyses were conducted on all variables. Results: Patients who did not receive Therapeutic Touch tended to have lower admitting Palliative Performance Scale scores, shorter length of stay and were older. Based on the responses provided by patients and observed by Therapeutic Touch practitioner the majority of patients receiving treatment achieved a state of relaxation or sleep. Conclusions: The results of our chart review suggest beneficial effects for significant numbers of participants and deserve a more robust comparison study in future. Recommendations also include revising the program procedures to improve processes and documentation, and ensure all or most patients are offered the therapy.

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Longitudinal body composition changes in patients diagnosed with advanced cancer

Objectives: Patients with advanced cancer commonly experience cachexia: the progressive and irreversible loss of muscle mass with or without fat mass. The present study aims to determine the onset and rate of muscle and fat loss in patients with advanced cancer from the time of diagnosis. Methods: One-hundred and sixty-five patients with a new diagnosis or recurrence of advanced cancer from the McGill University Health Centre and the Jewish General Hospital in Montreal, Quebec were followed longitudinally until death. Patients' routine computed tomography scans were extracted from their clinical records, and muscle and fat cross-sectional areas were analyzed at the third lumbar vertebrae. We used growth curve analysis to determine the patterns of changes in muscle and fat indices [cross-sectional area (cm²) per squared-height (m²)] overtime. Results: At diagnosis (baseline), mean muscle area was 46.98 cm²/m² and mean fat area was 111.93 cm²/m². The patterns of both muscle and fat loss fit linear growth models. Patients lost muscle at a rate (mean \pm SEM) of 0.24 \pm 0.12 cm²/m² per month, and fat at a rate of 2.87 \pm 0.90 cm²/m² per month. These results translate to losing 0.51% of their baseline muscle area and 2.57% of their baseline fat area per month. Conclusions: Our results show that when considering their higher fat area at diagnosis, patients with advanced cancer lose fat approximately five times faster than they lose muscle. This body composition trend has yet to be reported in the literature, and has implications for redefining the cachexia experience of patients with advanced cancer.

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Communication as an Element of Satisfaction on Palliative Care Units

Purpose: To identify elements of quality care and patient satisfaction on a variety of palliative care unit (PCU) inpatient settings, as described by inpatients, family caregivers and healthcare professionals. **Methods:** Qualitative interviews and focus groups were conducted across four Toronto PCUs, with a total of 46 patient/caregiver interviews and 8 staff focus groups. All interviews and focus groups were semi-structured to elicit thoughts about the characteristics of satisfaction with care and quality of care for inpatients and families on a PCU. Data were analyzed using a grounded theory method of analysis with an inductive, constant comparison approach to identify themes, which were coded to saturation. **Results:** Communication was identified as the most prevalent theme, and included five subthemes describing elements of communication that were deemed important by patients, caregivers and staff. These included: 1) developing rapport with patients and caregivers to build trust and kinship; 2) clarifying goals of care to establish realistic expectations; 3) keeping patients and families informed about the patient's illness and decisions about care; 4) listening actively to validate patients' concerns and individual needs; and 5) creating a safe space where conversations about death and dying can occur. **Conclusion:** Communication is a crucial component of PCU quality of care and patient and family satisfaction, as identified by patients, family caregivers and healthcare professionals. Palliative care education should focus on both general communication skills as well as specific communication techniques required when providing end-of-life care.

- 1) Aspects of communication that impact patient satisfaction on a palliative care unit
- 2) The impact this has for palliative care education

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A public health approach to Palliative Care; Understanding and Implementing Health Promoting Palliative Care (HPPC) and Compassionate Communities (CC)

Approaches and Initiatives: Public Health approaches to palliative care have been steadily implemented in many countries and regions around the world over the past 10- years to better meet the needs of an aging population. The Health Promoting Palliative Care (HPPC) approach was defined in Australia, the UK and subsequently many other jurisdictions, based on the philosophy of the World Health Organization's (WHO) Ottawa Charter for Health Promotion. Its view is that healthcare should be participatory and involved the wider community. It aims to provide education, information and policy-making that supports wellbeing and optimal health despite illness and up to the very end of life. As a community partnership approach to care, it involves co-creation by the community members supported by healthcare leadership. Compassionate Communities (CC) is a HPPC model that has been developed on the WHO Healthy Cities model. CC models have been seen as critical to normalizing the experience of our aging citizens and ultimately producing more sustainable care systems. Despite rapid uptake internationally, application and identification/evaluation of HPPC/CC models have been lacking in Canada. In this presentation, participants will learn of the genesis of this

social movement, how to use our own Canadian frameworks and resources to identify Canadian HPPC/CC best practices, and to consider their own facilitation and leadership for HPPC/CC in communities and palliative care programs across Canada.

Participants will:

1. To gain a basic understanding of a Public Health approach to Palliative Care including the Health Promoting Palliative Care (HPPC) paradigm, and the Compassionate Communities (CC) model used to implement HPPC.
2. To understand how to adapt and apply, or make explicit, the public health approach, in ones own, or to ones own organization/community/practice here in Canada.

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Use of Ultrasound for Identification and Guided Treatment of Malignant Effusions in the Home Setting

A large number of palliative patients develop symptomatic effusions near the end of life. Diagnosis of effusions in the home setting is currently limited to physical examination. Patients are often poorly mobile with potentially complicated effusions, and currently have to travel to an outpatient hospital setting for confirmation and imaging-guided drainage. Point of care ultrasound has become the standard for in-hospital bed-side procedures. This technique increases success while decreasing the risk of complications. Ultrasound probes have been developed that connect to computers or tablets using USB cables, thereby facilitating the portability of this modality without a prohibitive cost for equipment. We are developing a project to study the feasibility of home-based ultrasound to assist in the identification and treatment of pleural effusions and ascites, and to lower overall costs for treatment. For suspected pleural effusions, which cannot be drained at home, ruling out other conditions can save a trip for the patient and costs for the health care system. For ascites, identifying a safe paracentesis entry point can save a trip for the patient, costs to the system, and lower the complication rate compared to unguided procedures. This project has the potential to raise the standard of care by improving safety, quality of life, and decreasing health care costs in the homebound palliative population.

Participants will:

1. Appreciate the difficulties homebound palliative patients face in travelling to hospital for malignant effusions.
2. Describe the potential benefits of home-based point of care ultrasound in diagnosing and directing treatment of malignant effusions.

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Palliative care for the patient with end-stage heart failure: develop a collaborative care program

Background: Patients with advanced heart failure represent a population that is significant in number, health system utilization, and symptom burden. In 2000, patients with advanced heart failure accounted for the second highest number of hospital days in Canada. The condition is responsible for a high burden of hospitalization for symptoms that are currently difficult to manage in the ambulatory setting. Objective: To address this patient and system burden we are developing a collaborative model of symptom management and home-based care for patients with advanced heart failure. Once in place, we plan to study the outcomes for patients and their caregivers, including symptom scores, caregiver burden scores, continuity of care and costs. Activity/Methods: In collaboration with cardiology and primary care, our palliative care team is developing a program to facilitate home-based, multidisciplinary care for patients with advanced heart failure. The program is developing education and process tools to advance home-based care of this population. These include a home diuresis protocol with guidelines for oral and intravenous diuretic therapy; an overview of how to assess and manage common symptoms in patients with advanced heart failure and guidelines for rational withdrawal of cardiac medications. Relevance: Home-based care of patients with advanced heart failure that includes optimizing diuresis, can lead to improved symptom management and a decreased number of hospitalizations. In turn, we hope it can reduce both patient and system burden and result in greater health-related quality of life for patients with advanced heart failure.

Participants will:

1. Gain an appreciation of the management of symptoms in advanced heart failure
2. Be introduced to a tool for diuretic use in the home and palliative care unit setting that may contribute to improved pain and symptom management

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Likes, Shares and Tweets: Social Media and Palliative Care- The Edmonton Experience

The Edmonton Zone Palliative Care Program (EZPCP) is a comprehensive, integrated, palliative care service designed to facilitate and support access to high quality, cost effective palliative care services throughout the greater Edmonton area. Components of care include home care support, family physicians, outpatient clinic, inpatient tertiary palliative care unit, four hospices and palliative consultants in the community, at the cancer centre and in multiple acute care hospitals. Palliative care services are provided by physicians, nurses and members of the inter-disciplinary allied health team. A webpage (www.palliative.org) exists to help coordinate and inform patients, families, the general public as well as palliative and non-palliative health care providers about clinical, educational and research activities in the EZPCP. The EZPCP Facebook page (www.facebook.com/EZPCP) was launched in January 2014 to compliment the webpage, add additional features and to engage users of this popular social media platform. Numerous Facebook pages exist for Canadian hospice organizations and palliative care advocacy groups however few if any have been developed to enhance and support a primarily clinical program. This presentation will outline the EZPCP Facebook page's inception, key content features including virtual hospice tour, google enabled maps to hospice, posting guidelines and additional clinical and educational utility. The process of developing a content team and promotions plan will be discussed, as will challenges encountered and future possibilities for the page.

Participants will:

1. Gain a basic understanding of social media platforms with a focus on facebook
2. Understand how social media can be harnessed to enhance the clinical and educational activities of a palliative care program.

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A moving target: episodic communication and inconsistent terminology complicate palliative care conversations on the heart failure (HF) team

Background: Patient-centred palliative care conversations should be informed by experiences and expectations to identify the patient's 'goals of care' so that 'care plans' act in accordance with these goals. However, a preliminary literature search suggests inconsistent use of these two concepts. This presentation examines how the use of these concepts, the patients' experience and the communication practices among team members influence these conversations within the HF team. Methods: This presentation draws on data from a constructivist grounded theory study of HF care team experiences. Individual interviews of 42 patients with NYHA Class III or IV HF and their 106 healthcare team members produced 36 team-sampling units (TSUs) consisting of 3-10 interviews per patient. A constant comparative analysis approach identified recurrent themes. Results: Multiple episodic conversations involving different TSU members who used the concepts of 'goals of care' and 'care plans' interchangeably and unreliably created ambiguity amongst participants. Patients' shifting disease trajectories and evolving goals compounded this ambiguity. Conclusion: Data from TSUs suggest that palliative conversations on the HF team are a moving target, complicated by their episodic nature, their occurrence at various points in the patient's evolving disease trajectory, and their inconsistent use of the concepts of 'goals of care' and 'care plans'. Efforts to address these features could support more meaningful patient-centred outcomes in HF, strengthen team communication and inform educational principles.

Participants will:

1. Identify factors influencing the evolving palliative care conversation on the HF team.
2. Discuss why addressing these factors may improve patient care.

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Patient and Caregiver Satisfaction on Palliative Care Units: A Qualitative Study

Purpose: To identify aspects of quality care and satisfaction with care and to have a better understanding of the components necessary for a measure evaluating quality of care on a variety of palliative care unit (PCU) inpatient settings, as described by inpatients, family-caregivers and

healthcare professionals. Methods: Qualitative interviews and focus groups were conducted across four Toronto PCUs, with a total of 46 patient/caregiver interviews and eight staff focus groups. Interviews and focus groups were semi-structured to elicit comments about satisfaction with care and quality of care for inpatients and families on a PCU. Data were analyzed using a grounded theory method, with an inductive, constant comparison approach to identify themes, and were coded to saturation. Results: Themes identified as important to quality care and patient satisfaction were grouped into seven domains: 1) team approach, whereby an interdisciplinary staff delivers care and interacts effectively; 2) responsiveness, referring to provision of immediate and attentive care; 3) palliative philosophy, prioritizing patients' comfort and dignity; 4) competency, emphasizing specialized palliative care knowledge and staff professionalism; 5) family-centered care, supporting families and allowing family-caregivers to participate in care decisions; 6) efficient and equitable care, ensuring PCU provides adequate resources and access to consistent care; and 7) supportive setting, referring to unit's physical atmosphere and mood. Conclusion: Key elements of quality care and patient satisfaction for PCUs have been identified. Further research will develop and validate a tool to evaluate patient and caregiver satisfaction with care on PCUs.

Participants will:

1. Identify elements of satisfaction with care and quality of care as described by inpatients, their family-caregivers and healthcare professionals on a palliative care unit.
2. Identify components that are necessary for inclusion on a tool measuring patient satisfaction and quality of care on a palliative care inpatient unit

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Interdisciplinary rehabilitation as a new model for delivering palliative care to patients with advanced cancer

It is now well recognized that patients with advanced cancer should receive palliative care (PC) from the time of diagnosis. To realize this objective new models are needed. These models should be based on sound nutritional, psychosocial and physical therapies, which enlist patients and family members as leading team members. We have developed a model of delivering PC in the early phase of the cancer trajectory: an interdisciplinary cancer –nutrition rehabilitation (CNR) program. The goal of the program is to improve symptom control, nutritional status, physical function and quality of life. The program duration is 8-12 weeks and consists of individually tailored interventions designed by a physician, nurse, dietitian, physical therapist, occupational therapist, psychologist and social worker, along with patients and their families. Through the use of our published results, workshop participants will (1) gain a detailed overview of the structure and process of an interdisciplinary CNR program, and (2) be informed of the potential benefits for patients with advanced cancer. Interdisciplinary team member roles, patient assessment methods, program development, and outcome evaluation will be outlined. As this CNR program was successfully implemented in a hospital setting, the speaker will briefly present a new research initiative that aims to establish and evaluate a similar program in a community-based setting. By communicating the value of interdisciplinary rehabilitation for patients with advanced cancer, we intend to promote its integration into centres across Canada, allowing for the provision of true comprehensive cancer care for patients and their families.

Participants will:

1. Gain a detailed overview of the structure and process of a new model of delivering palliative care to patients with advanced cancer: an interdisciplinary cancer nutrition-rehabilitation program
2. Gain an understanding of the potential benefits of interdisciplinary cancer rehabilitation for patients with advanced cancer and their families.

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Addiction in Palliative Care: Stop Diverting the Issues

Drug addiction, particularly to opioids, has escalated in Canada over the past decade to arguable epidemic proportions. Overdose is second only to motor vehicle accidents as a cause of unintentional death. In addition, deaths from endocarditis, and other complications of IV drug use are spiraling. The life expectancy of a person abusing drugs intravenously is less than that of a person with breast or prostate cancer. Patients with drug addictions are often marginalized by society and by the Health Care System. Furthermore, medical myths and practices have contributed to the problem and our accountability is often ignored. In this presentation we will explore drug addiction as a chronic, life limiting illness, which fits the definition of a palliative condition and needs and deserves our attention and advocacy. We will understand the benefits and limitations of current harm reduction strategies and learn appropriate screening, early intervention and counseling techniques which are effective. We will also explore particular challenges when treating patients with concurrent or previous opioid addiction and other palliative conditions such as cancer, including management of complicated pain and the unspeakable issue of diversion.

Participants will:

1. Understand IV drug addiction and why we need to recognize it as a Palliative condition
2. Improve the care and outcomes of people with addiction, with and without other palliative conditions

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The impact of an early palliative care intervention on the quality of death and dying in cancer patients.

Introduction: Early palliative care interventions have been shown to improve the quality of life of patients with advanced cancer. It is unknown whether such early interventions improve the quality of death, however. Objectives: We aimed to evaluate the quality of death and dying experienced by patients with advanced cancer who received early palliative care, as perceived by their informal caregivers. Methods: Caregivers (N=129) were originally recruited as part of a cluster randomized controlled trial of an early palliative care intervention (PC) versus usual care (UC) at the Princess Margaret Cancer Centre, Toronto, between December 2006 and February 2011, and were followed longitudinally until the death of the patient. Caregivers were asked to complete the Quality of Death

and Dying (QODD) questionnaire. Results: There were no differences between PC (N=73) and UC (N=56) participants based on age, gender, relationship to patient, tumour site or time since death. QODD scores were high for both the PC and UC groups, both overall and for the QODD subsets, with no statistically significant differences between the 2 groups. Although the UC group did not receive early PC, the majority received PC at some point during the patients' illness (N=45, 82%). Conclusions: Although early PC involvement improves quality of life among patients with advanced cancer, it does not appear to influence the quality of death and dying. PC involvement at any point during the cancer trajectory appears to be associated with a high quality of death and dying.

Participants will:

1. Learn how to use the QODD questionnaire
2. Discuss how palliative care involvement may influence the quality of death and dying

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Validation of the numerical rating scale versions of ESAS and ESAS-r in an ambulatory palliative care clinic

Background: The ESAS is usually presented as a numerical rating scale (NRS); but has been validated for outpatients with cancer only as a visual analogue scale. We aimed to validate the NRS versions of ESAS and ESAS-r, and to assess patient preference for either version. Methods: Patients with advanced cancer (N=202) attending ambulatory palliative care clinics at the Princess Margaret Cancer Centre, Toronto, completed both the conventional ESAS, with an added time window of "past 24 hours" (ESAS-PM), and the ESAS-r-PM, with a time window of "now" and symptom definitions. Participants completed the Memorial Symptom Assessment Scale (MSAS) and a patient-rated version of the Eastern Cooperative Oncology Group (ECOG) performance status measure. Physicians rated the ECOG independently. At 24 hours, 26 patients completed a test-retest study. Results: ESAS and ESAS-r total distress scores correlated well with total MSAS scores (Spearman's rho: 0.62 and 0.64, respectively). Correlation of individual ESAS symptoms with MSAS symptoms ranged between 0.57-0.8 for ESAS and 0.52-0.73 for ESAS-r. While participants preferred the ESAS-r (42.8% versus 18.6%), the time window of "past 24 hours" (52.8%) was favoured over "now" (21.3%). Shortness of breath and nausea correlated better with the "past 24 hours" time window (0.8 and 0.72 versus 0.74 and 0.64, respectively). The 24-hour test-retest evaluation of the ESAS showed strong correlation (ICC = 0.74). Conclusions: The ESAS and ESAS-r NRS versions are valid and reliable for outpatients with advanced cancer. The 24-hour time window was preferred and may best capture fluctuating symptoms in this population.

1. The benefits of utilizing the ESAS-r over the conventional ESAS in an ambulatory palliative care setting
2. The importance of a defined "time window" within which patients should base their responses when using ESAS/ESAS-r, and how these time windows can influence responses.

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Dexmedetomidine for the treatment of intractable pain and delirium in a tertiary palliative care unit: A case study

Activity: The alpha 2-agonist dexmedetomidine was administered by continuous subcutaneous infusion (CSCI) to a patient with advanced cervical cancer over 21 days to successfully treat intractable neuropathic pelvic pain and delirium. **Innovation:** A new protocol was devised for the delivery of dexmedetomidine by CSCI in the palliative care environment. To guide CSCI drug titration, a new outcome measure was created to assess for satisfactory improvement of intractable symptoms. **Significance:** Not only can treatment with dexmedetomidine effectively relieve intractable symptoms of pain and delirium, but it provides an option of rousable sedation and improved quality of dying for patients who value being able to communicate, maintain a sense of control, and continue relationships with loved ones. Oral intake is possible during treatment with dexmedetomidine. Treatment with dexmedetomidine compared to standard treatment with midazolam is an option for treating intractable symptoms when the prognosis is weeks and not just hours or days.

1. By attending this case study presentation, participants will be provided with a decision framework for managing intractable symptoms based on whether a symptom is truly intractable or just difficult to control, patient prognosis, and patient goals of care.
2. Attendees will learn about the pharmacology, actions, potential indications, and administration of dexmedetomidine in the palliative care environment applicable to tertiary palliative care and hospice settings. A new paradigm of targeted treatment for intractable symptoms will be introduced for discussion.

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An innovative strategy for assessing postgraduate family medicine learners completing a block palliative care rotation

Although competency-based curricula allow for greater emphasis on learner outcomes, concerns have been raised regarding effectively assessing learners. An ideal assessment method is one focused on performance-based outcomes, is both valid and reliable and confirms the attainment of multiple competencies. "Entrustable professional activities" (EPA's) are the units of work in which a clinician routinely engages and in educational terms represent the integration of multiple competencies. This makes the EPA construct particularly promising as an effective method of learner assessment however only recently introduced in to medical education with a small number of reports that directly address EPA's. For the setting of postgraduate family medicine training, palliative care clinical skills have long been considered core elements of comprehensive family medicine however formal palliative care educational experiences have only recently been incorporated as a core component of postgraduate curricula. Palliative care related competencies among family physicians will be of particular importance given the increasing demands on family physicians to effectively care for an aging population with more complex chronic conditions. The aim of this work is to introduce EPA's as an innovative educational strategy and describe the process of identifying the palliative care related EPA's considered most important for comprehensive family physicians. Given palliative medicine teachers may be in the best position to supervise the acquisition of these EPA's a process will be

proposed for determining the feasibility of incorporating EPAs in to a palliative care block rotation for postgraduate family medicine learners.

Participants will:

1. Gain clarity on the EPA construct and appreciate its significance as a method of learner assessment
2. Gain an appreciation of how the EPA construct could apply to a rotation-based postgraduate training program and enable attaining palliative care-related competencies

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Evidence of increasing public participation in advance care planning– Serial Polls of Albertans 2007-2013

Background Advance Care Planning (ACP) encompasses both verbal and written communications expressing preferences for future health and personal care and helps prepare people for health care decision-making in times of medical crisis. Governments and healthcare systems are increasingly promoting ACP as a way to inform medical decision-making but it is not known whether public engagement in ACP activities is changing over time. Methods Raw data from two independently conducted public polls of ACP engagement over a 6 year time period were analyzed to answer (1) Did participation in ACP activities change over time? (2) Did intra-provincial variation in ACP health system policy explain differences in engagement? Results Statistically significant increases were observed between 2007 and 2013 in recognition of the definition of ACP (54.8% to 80.3%, OR 3.37(95% CI 2.68-4.24), discussions about healthcare preferences with family (48.6% to 57%, OR 1.41 (95% CI 1.17-1.69) and with healthcare providers (9.1 to 16.5%, OR 1.98 95%CI (1.51-2.59), written ACP plans (21 to 32.1%, OR 1.77 (95%CI 1.45-2.17) and legal documentation (23.4 to 39.4%, OR 2.13 95%CI (1.75-2.59). These remained significant after adjusting for age, education and self-rated health status. Public participation in ACP could not be explained through intra-provincial variations in ACP policies. Interpretation Despite improvements in ACP engagement over time, the overall frequency of engagement remains low. Examination of factors responsible for the increase may provide insight into areas for future investments. We also discuss potential reasons why health system policy presence alone may not influence public participation.

Participants will:

1. Increased understanding of how public participation in ACP is changing over time
2. Be able to describe potential reasons for these changes

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Optimizing Family Medicine Residents' Palliative Care Rotation: A Mixed Methods Exploration of Residents' Learning Experiences and Future Plans to Engage in Palliative Care

Objective: This presentation is an exploration of family medicine residents' experiences on their palliative care rotation, which consisted of two weeks in hospital and two weeks of home palliative care. The aim is to better understand how their palliative care rotation impacts residents' self-rated competencies and preparedness to engage in palliative care in the future. **Methods:** Qualitative analysis of in-depth semi-structured one-on-one interviews with family medicine residents and quantitative analysis of knowledge, attitudes towards palliative care and self-rated competencies at baseline and mid-rotation. To date, 15 quantitative surveys and nine interviews have been completed and included in this preliminary analysis of data (further data will be included in the analysis on a monthly basis over the next three months.) **Results:** Infrastructural barriers to provide home visits for dying patients caused residents to feel unprepared to engage in palliative care in the future. Residents felt explicit discussion of how a family physician can best overcome these perceived barriers may have improved their preparedness to provide home visits. In contrast, residents acknowledged that they felt more prepared to look after similar patients in their outpatient clinics because of their improved skills in opioid-prescribing and competencies to engage in goals of care discussions. Residents also noticed that their home-based experience provided a unique perspective on the value of maintaining long-term relationships with dying patients and their families. Preliminary quantitative analysis of surveys did not show improvement in knowledge test scores however there were small positive changes in both resident attitudes towards caring for palliative patients and in self-rated competencies. **Conclusion:** The palliative care rotation appears to improve self-rated competencies in palliative care however family medicine residents' experience with specialized palliative care providers may unintentionally reinforce a belief that only these physicians have the infrastructure to provide these services, highlighting a need to create educational experiences that proactively aim to address this misconception.

Participants will:

1. Gain an appreciation for reversible factors that affect family medicine preparedness to engage in home-visits for their dying patients in the future.
2. Gain an appreciation for the palliative care learning outcomes and experiences that were highly value by family medicine residents.

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