

has the potential to be a safe, effective means of promoting psycho-social well-being in newly diagnosed patients and may also have positive effects for veteran patients. Further investigation into the use of one to one, peer support for brain tumour patients is an important research priority.

**PS1 – 160**

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**A Telephone Based Cognitive Assessment Tool for Brain Metastases Patients**

*M.N. Tsao<sup>1</sup>, K. Edelstein, L.J. Bernstein, J. Wong, N. Laperriere, J.R. Perry, A. Sahgal, C. Menard, H. Soliman, E. Chow, T. Barnes, C. Danjoux, B.A. Millar, R. Wong, W. Wells, R.S. McIntyre, W. Mason, C. Chung*

<sup>1</sup>University of Toronto, Toronto, ON [may.tsao@summybrook.ca](mailto:may.tsao@summybrook.ca)

Improving neurocognitive outcomes following treatment for brain metastases have become increasingly important. We propose that a brief telephone-based neurocognitive assessment may improve follow-up cognitive assessments in this palliative population. Aim: To prospectively assess the feasibility and reliability of a telephone based brief neurocognitive assessment compared to the same tests delivered face-to-face. Methods: Brain metastases patients to be treated with whole brain radiotherapy (WBRT) were assessed using a brief validated neurocognitive battery at baseline, at 1 month and 3 months following WBRT (in person and over the phone). The primary outcome was feasibility and inter-procedural (in person versus telephone) reliability. The secondary objective was to evaluate the change in neurocognitive function before and after WBRT. Results: Out of 39 patients enrolled, 82% of patients completed the baseline in-person and telephone neurocognitive assessments. However, at 1 month, only 41% of enrolled patients completed the in-person and telephone cognitive assessments and at 3 months, only 10% of patients completed them. Results pertaining to reliability and change in neurocognitive function will be updated. Conclusion: The pre-defined definition of feasibility (at least 80% completion for face to face and telephone neurocognitive assessments) was met at baseline. However, a large proportion of participants did not complete either telephone or in person neurocognitive follow-up at 1 month and at 3 months post-WBRT. Attrition remained a challenge for neurocognitive testing in this population even when a telephone-based brief assessment was used.

**PS1 – 163**

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**Engaging in Difficult Discussions with Neuro-Oncology Patients: A Case Conference Based Quality Improvement Initiative**

*C. Mueller<sup>1</sup>, D.B. Bilodeau, A.C. Chakraborty, J.E. Ellis, L.G. Gibson, E.I. Isenberg-Grzeda, C.M. Moroney, J.M. Myers, A.S. Scalco, A.S. Speke*

<sup>1</sup>Sunnybrook Health Sciences Centre, Toronto, ON [christina.mueller@sunnybrook.ca](mailto:christina.mueller@sunnybrook.ca)

Due to the non-curative nature of high grade brain tumours “difficult discussions” about goals of care, advance care planning, palliative care, and end of life are inherent to the practice of the

neuro-oncology team. Clinician and patient barriers are common and may include anxiety about destroying hope, lack of readiness to discuss end of life topics, difficulty managing emotional responses, and concerns over competency in facilitating difficult discussions. Nonetheless, clinician comfort and skill in facilitating these discussions is critical and can impact patient perception of illness, coping response, and ability to make decisions about care. Methods At our regional cancer centre, a novel quality improvement initiative was designed to bring monthly case presentation of “difficult discussions” into a pre-existing weekly multi-disciplinary case conference (MCC). We will describe the rationale and developmental processes behind this initiative. Roughly 15 neuro-oncology clinicians attended each case conference, with guest attendance from palliative care and psychosocial oncology. Clinician groups represented included physicians (77%), nurses (8%), nurse practitioners (10%), and occupational therapists (5%). Baseline and monthly surveys were administered to determine clinicians’ self-rated practices, skills, and attitudes towards “difficult discussions”. Results Early findings indicate that the initiative has been well-received. Physicians indicated highest levels of agreement with the statement “I feel that having difficult discussions is part of my responsibility”. Non physician groups indicated the greatest agreement that the intervention is beneficial to their practice. Discussion: Our challenges and successes may help guide others to incorporate a similar initiative at disease-site meetings.

**PS1 – 188**

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**Rehabilitation Consultation: An Integrated Model for Addressing Rehabilitation Concerns in the Primary Brain Tumor Population**

*I. Lax<sup>1</sup>, M. Daniels, C. Kanter, W. Mason, K. Edelstein*

<sup>1</sup>University of Toronto, Toronto, ON

[ilyse.lax@uhn.ca](mailto:ilyse.lax@uhn.ca)

Individuals with primary brain tumors experience a range of physical, cognitive and psychosocial sequelae which impact their independence, safety and quality of life. These impairments may be addressed through rehabilitation intervention. Despite acknowledgement that timely rehabilitation services over the course of the disease process is of benefit, few outpatient neuro-oncology treatment teams include a rehabilitation professional. Purpose: The aims are: (1) to describe a rehabilitation consultation model of care integrated into outpatient neuro-oncology treatment for individuals with primary brain tumors; and (2) to describe the characteristics of individuals referred for rehabilitation services. Methods: This retrospective descriptive study examined data from 200 individuals that received rehabilitation consultation from January 2015 to March 2016 at Princess Margaret Hospital, Pencer Brain Tumor Centre. Information on patient demographics, referral characteristics, and number of patient care visits was collected. Descriptive statistics were calculated. Preliminary Results: Of all patients, (n=195), the most common diagnosis is glioblastoma, 39% (n=76), and 50% are 50-69 years of age (M = 55, SD = 15.0). The most common reason for initial referral was decline in physical functioning, strength and balance (41%). In 77% of cases, patients were seen immediately at the time of referral. In total, 540 consultations were completed (face-to-face = 230, telephone = 310) with 2.78 on average (SD = 4.0) per patient. Conclusion: Given the range of symptoms that individuals with primary brain