

Most patients were discharged from the hospital alive (78.7%, range between teams: 44.7%–99.4%), and the percentage of patients discharged alive increased over time (75.0% to 80.0%, $p < 0.0001$). Between 2013 and 2017, there was a substantial decrease in hospice referrals (46.0% to 31.0%, $p < 0.0001$) and an increase in referrals to clinic-based (2.0% to 4.0%, $p < 0.0001$) and home-based PC services (2.0% to 4.0%, $p < 0.0001$).

Conclusions. There is wide variation in practice across inpatient PC teams. Overall, teams are seeing more patients with diagnoses other than cancer and are doing so earlier in the course of illness, which may account for lower rates of hospice referral. Teams are connecting slightly more patients with outpatient PC services at the time of hospital discharge.

Implications. Changes in the practice of PC over time are consistent with guidelines calling for PC for all patients with serious illness earlier in the course of illness. Variations in practice between teams establish benchmarks and reveal opportunities for improvement.

Finding the Path: Incorporating Patient Preferences into an Interactive Clinical Pathway Platform (S867)



Dena Schulman-Green, PhD, Yale University School of Nursing, West Haven, CT. Emily Cherlin, PhD MSW, Yale School of Public Health, New Haven, CT. Renee Capasso, BS, Yale University, New Haven, CT. Sarah Mougalian, MD, Yale Cancer Center, New Haven, CT. Shi-Yi Wang, MD, PhD, Yale School of Public Health, New Haven, CT. Cary Gross, MD, Yale School of Medicine, New Haven, CT. Preeti Bajaj, PhD, Genentech, Inc., South San Francisco, CA. Katherine Eakle, PharmD, University of California, San Francisco, San Francisco, CA. Kerin Adelson, MD, Yale Cancer Center, New Haven, CT. Sharmi Patel, PharmD, Genentech, San Francisco, CA.

Objectives

1. Identify preferences that affect treatment decision-making among women with Stage I-III breast cancer.
2. Describe a new clinical pathway model that will incorporate women's preferences for individualized assessments of prognosis and treatment benefits and challenges, and that will facilitate shared-decision making and use of palliative care services.

Original Research Background. Clinical pathway tools offer physicians a selection of cost-effective, evidence-based treatment options to discuss with patients. Although shared decision-making is essential to patient-centered care, clinical pathway tools have

not integrated patient preferences around treatment burden and outcomes.

Research Objectives. We sought to identify patient preferences for incorporation into MyPATHway, a patient-centered, interactive clinical pathway platform for patients with breast cancer.

Methods. Using interpretive description as an approach, we conducted individual qualitative interviews with women aged 18+ treated for Stage I-III breast cancer at Smilow Cancer Hospital in New Haven, CT. We asked participants if there was additional information they would have liked prior to treatment decision-making, their preferences for and factors affecting decision-making, and their attitude towards an electronic platform, including preferences for learning about and weighing treatment burdens and outcomes. We coded transcribed interviews and analyzed them for themes.

Results. The sample's ($n=21$) mean age was 56.4 (range 29-74). Breakdown of cancer stage was I (33.3%), II (42.9%), and III (23.8%). Participants reported receiving adequate information prior to treatment decision-making, although some wanted more regarding what to expect during and after treatment. Several factors affected treatment decision-making, including physical (e.g., symptom burden), lifestyle (e.g., ability to function in normal roles), provider (e.g., provider opinion), and health care system (e.g., consistency of care) factors. Participants strongly felt they had "final say" in treatment decision-making while preferring involvement of providers and family caregivers. Most were open to using an electronic platform at home or in clinic, but to augment versus to replace face time with providers.

Conclusion. Participants identified preferences regarding content and format that build on currently available clinical pathway tools.

Implications for Research, Policy, or Practice. We will utilize data to design and test MyPATHway so that it facilitates shared decision-making and, potentially, use of palliative care services to better set and meet patient expectations.

Are Pediatric Patients Just Short Adults? Most Commonly Prescribed Drugs for Pediatric Hospice Patients (S868)



Leah Sera, PharmD MA BCPS, University of Maryland School of Pharmacy, Baltimore, MD. Jill Morgan, PharmD, University of Maryland School of Pharmacy, Baltimore, MD. Mary Lynn McPherson, PharmD MA MDE BCPS, University of Maryland School of Pharmacy, Baltimore, MD.

Objectives

1. Describe prescribing practices for pediatric patients receiving hospice care.

2. Compare and contrast prescribing practices for patients with different admitting diagnoses.

Original Research Background. Palliative care for children focuses on holistic care, including the alleviation of physical, psychosocial, and spiritual suffering. Medications are used in hospice patients to palliate physical symptoms of terminal illness, including pain, dyspnea, nausea, and fatigue.

Research Objectives. The purpose of this study was to characterize the most commonly prescribed medications and medication classes in a population of pediatric hospice patients.

Methods. We conducted a retrospective review of a patient information database compiled by a national hospice organization. The database contained demographic information, as well as information on drug name, dosage, formulation, and strength. We compared proportions of the most commonly prescribed pharmacological classes among the three most common admitting diagnoses: cancer, central nervous system disorders, and genetic disorders.

Results. A total of 3,017 medication orders were evaluated. Six of the 10 most commonly prescribed drugs (morphine, lorazepam, acetaminophen, hydroxyzine, prochlorperazine, and haloperidol) were included in symptom management medication kits provided to most patients at admission. Other drugs prescribed for over 20% of patients included metoprolol, diphenhydramine, albuterol, alprazolam, ondansetron, diazepam, polyethylene glycol, and levetiracetam. Opioid analgesics, anxiolytics, anticholinergics, and antiemetics were prescribed to over 50% of patients at some point during admission. Other frequently prescribed medication classes included non-opioid analgesics, anticonvulsants, anti-infectives, laxatives, corticosteroids, acid reducers, antipsychotics, and vitamins/supplements. Of the 20 most commonly prescribed drug classes, patients with cancer were significantly more likely than those with CNS disorders or genetic disorders to be prescribed anticholinergics ($p=0.03$), antiemetics ($p<0.0001$), non-opioid analgesics ($p=0.003$), laxatives ($p=0.003$), corticosteroids ($p=0.0004$), antihistamines ($p=0.01$), acid reducers ($p=0.03$), and antipsychotics ($p<0.0001$).

Conclusion. Medications commonly prescribed for children receiving hospice care include those intended to treat symptoms including pain, dyspnea, nausea, seizures, and constipation.

Implications for Research, Policy, or Practice. A general understanding of medications used in hospice care may be helpful in the development of educational materials, medications guidelines and protocols, and questions for future research.

The Comparison of State POLST Forms: Scope of Life-Sustaining Treatment (S869)



Hannah Spero, BA BSN AGPCNP Program, Emory University, Atlanta, GA. Hyejin Kim, PhD, Emory University School of Nursing, Atlanta, GA. Mi-Kyung Song, PhD RN FAAN, Emory University, Atlanta, GA.

Objectives

1. Analyze the structure and categories included in state POLST form to compare to a form in a neighboring state, and be able to state two similarities and two differences between forms.
2. Explain the potential implications of excluding a "Goals of Care" section from POLST forms, both from the perspective of the provider and the patient.

Original Research Background. Physician Orders for Life-Sustaining Treatment (POLST) is a portable medical order that delineates patients' and/or surrogates' care preferences. Currently, all states have POLST programs, either endorsed or in development. However, we do not know how consistent the treatments in POLST forms are across the states.

Research Objectives.

1. Identify the variations in life-sustaining treatments offered in state POLST forms.
2. Discuss the potential implications of variability in state POLST forms.

Methods. State POLST forms were retrieved in May 2018 from official websites or email correspondence with state program coordinators. Data on the presence of Goals of Care, Cardiopulmonary Resuscitation (CPR), Medical Interventions, Artificial Nutrition, Antibiotics, and other treatment categories were extracted and analyzed using descriptive statistics.

Results. Of the 45 state POLST forms reviewed, only six included a goals-of-care section. POLST forms included two to eight treatment categories: one with two categories (CPR and medical interventions), 17 with three categories (CPR, medical interventions, and artificial nutrition), 11 with four categories (CPR, medical interventions, artificial nutrition, and antibiotics), and 16 with four or more categories of other treatments. The CPR category had CPR and do-not-resuscitate choices in all forms. In 41 forms, the Medical Interventions category had choices of Comfort Measures Only, Limited Interventions, and Full Treatment. Forty-four forms had the Artificial Nutrition category with three choices (None, Defined Period, and Long-Term) with or without additional choices (e.g., hydration, parenteral nutrition). Seventeen forms included the Antibiotics category with two to four choices. Other treatment categories included dialysis, transfer to hospital, and blood transfusion.