

billable (e.g. care coordination) minutes were recorded. Descriptive statistics were conducted. The overall ratio of NB:B minutes and ratios by diagnosis type and vital status were calculated. One-way ANOVA and chi-square tests were used to assess differences in the NB:B ratios.

Results. Out of 98 patients, PPO had billable visits on 54 (55%) and assisted without billing in the care of 44 (45%). Twenty-four (25%) patients are deceased; vital status did not differ by diagnosis type ($p=0.29$). Patients had solid tumors (ST; 42, 43%), brain tumors (BT; 33, 34%), leukemia/lymphoma (L/L; 21, 21%), and other diagnoses (2, 2%). Overall NB:B ratio was 1.03. NB:B ratios differed among diagnoses ($p<0.0001$), with L/L the highest at 2.5 compared to ST (0.9), BT (0.8) and other (0.5). Deceased patients had a higher ratio of NB:B minutes than alive patients ($p<0.0001$; 1.9 vs 0.8).

Conclusion. Care coordination in PPO clinic is time-intensive and grows with clinic volume. For patients with L/L and those who were deceased, non-billable minutes outpaced billable clinical minutes.

Implications for Research, Policy, or Practice. When devising a PPO outpatient program, this NB:B ratio should be accounted for in physician time, and personnel devoted to patient and family assistance.

The Gang's All Here: All-Inclusive Interprofessional Education in a Palliative and Hospice Center (S809)



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Objectives

1. Describe the interprofessional education process that included non-clinical staff.
2. Discuss tools utilized to measure readiness for interprofessional learning, team collaboration, burnout and knowledge.
3. Describe outcomes of the interprofessional educational intervention.

Original Research Background. Nursing assistants (NAs), housekeepers, dietary staff, volunteer coordinators, and clerical staff are integral team members

in inpatient palliative and hospice settings, but may not be included in interprofessional education.

Research Objectives. The primary aim of this study was to evaluate the impact of interprofessional education on collaborative work practices. Secondary aims included: knowledge changes, job burnout, and retention.

Methods. Staff in a new palliative and hospice care center participated in a 12-session interprofessional education program. Participants' preparation included discipline specific reading materials. Session format focused on group exercises to maximize interaction among disciplines. All participants were evaluated pre/post education and at 3-month follow-up using the following tools: Readiness for Interprofessional Learning Survey (RIPLS), Assessment of Interprofessional Team Collaboration Survey (AITCS), and Maslach Burnout Inventory (MBI). Registered nurses (RNs) and NAs also completed knowledge surveys. RNs also completed the End of Life Professional Caregivers Survey (EPCS).

Results. RNs ($n = 15$), NAs ($n = 4$), housekeepers ($n = 2$), cooks ($n = 3$), a volunteer coordinator ($n = 1$), and clerical staff ($n = 3$) participated in the education. A significant increase in participant AITCS and EPCS scores was observed post education and sustained through 3-month follow-up (AITCS 16.4 percent increase at 3-month, $p<0.0001$; EPCS 17.7 percent increase at 3-month, $p<0.0001$). RNs (15.7 total point increase 95% CI (6.3, 25.1)) and NAs (4.3 total point increase 95%CI(0.3, 8.2)) both demonstrated significantly improved scores on knowledge surveys and, and after 3 months, reported significantly reduced emotional exhaustion (20.0, 95%CI (14.9, 25.2)) and depersonalization (6.0, 95%CI (3.2, 8.9)).

Conclusion. Our interprofessional education intervention has improved overall team function, which may ultimately affect patient outcomes and experience with care.

Implications for Research, Policy, or Practice. The education's sustained impact will be evaluated at 6 months follow-up. Interprofessional education will be studied among diverse groups within the broader medical center and region.

General Practitioners' Barriers and Facilitators to Opioid Prescription in Medellin, Colombia (S810)



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Objectives

1. Identify the attitudes and specific practices of general practitioners regarding opioid prescription.
2. Recognize general practitioners' perceived barriers and facilitators of opioid prescription.
3. Describe how general practitioners' knowledge of opioids influence opioid prescription.

Original Research Background. Understanding key attitudes, barriers and facilitators of opioid prescription can help overcome the current undertreatment of pain in Low and Middle-Income Countries (LMICs).

Research Objectives. Identify barriers and facilitators for opioid prescription by GPs in Medellin, Colombia.

Methods. Descriptive-quantitative, cross-sectional study. A 53-item questionnaire was designed to assess: 1) attitudes (concerns and confidence when prescribing opioids), 2) practices related to opioid prescription, 3) perceived barriers and facilitators of opioid prescription; and 4) knowledge of opioids. We surveyed GPs who graduated from medical schools in Medellin, and GPs currently practicing in ten institutions in Medellin, Colombia. 179 participants completed the questionnaire. Descriptive and correlational analyses were conducted.

Results. The mean age was 33.3 years old (SD 10.43), 53.3% were female, 47.8% had been practicing for over 5 years, 51.66% did not receive training in pain management during medical school and only 2.8% received training after medical school. Regarding knowledge, 49.5% responded accurately. Common concerns were managing adverse effects and potential opioid abuse. Participants felt less confident to prescribe opioids to pediatric, pregnant patients, and those with history of substance abuse. Common barriers to opioid prescription were restriction to access, high costs, and insufficient training. Adequate opioid prescription practices were significantly and positively correlated with confidence when prescribing opioids (0.466; $p < 0.01$), knowledge of opioids (0.422; $p < 0.01$), age (0.233; $p < 0.01$), and training in pain management (0.308; $p < 0.01$); and significantly and negatively correlated with perceived barriers (-0.332; $p < 0.01$).

Conclusion. Adequate practices regarding opioid use are related to training, knowledge and confidence when prescribing opioids. However, GPs in our context have insufficient knowledge about pain control and opioid use.

Implications for Research, Policy, or Practice. These results indicate the urgent need to increase pain management training for current and future GPs.

Efficacy Variables in Cancer Versus Noncancer Patients Treated with Methylnaltrexone or Placebo: An Analysis of 2 Placebo-Controlled Studies (S811)



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Objectives

1. Describe that methylnaltrexone is effective in treating opioid-induced constipation in patients with advanced illness with and without active cancer regardless of baseline opioid requirements.
2. Articulate that treatment with methylnaltrexone improves laxation response, has a fast onset of laxation in patients with or without cancer, and reduces the need for rescue laxatives versus placebo.
3. Describe that methylnaltrexone taken every other day or as needed is effective in patients with advanced illness.

Original Research Background. Methylnaltrexone (MNTX) inhibits opioid peripheral adverse effects.

Research Objectives. Post-hoc analysis of pooled data from randomized, double-blind studies and open-label extensions of adults with advanced illness and opioid-induced constipation.

Methods. Patients received SC MNTX 0.15 mg/kg or placebo (study 302) and SC MNTX 8 mg (38–<62 kg), 12 mg (≥ 62 kg), or placebo (study 4000) every other day for 2 weeks and MNTX (same doses as needed) during the first 2 weeks of open-label extensions. Double-blind populations were stratified by those with/without cancer. Endpoints included rescue-free bowel movements (RFBM) within 4 hours after each dose for ≥ 2 of the first 4 doses; time to rescue-free laxation; rescue laxatives use; and ≥ 3 RFBMs/week with ≥ 1 RFBM/week increase in ≥ 3 of 4 weeks.

Results. Median baseline opioid use (mg/day) was greater in cancer (187.9 placebo [n=114]; 180.0 MNTX [n=116]) versus non-cancer patients (80.0 placebo [n=71]; 120.0 MNTX [n=62]). MNTX significantly ($P < 0.0001$) improved the proportion of cancer (56.9%) and non-cancer (58.1%) patients