in the setting of a potentially life-limiting illness. Therefore, a dichotomy exists between this setting of growth and ongoing concerns for loss of self and control. It is important to gain the trust of the AYA patient through the use of appropriate language, encouraging the patient to maintain some control, while offering the AYA time to address “the tough stuff.”

This population creates unique challenges for palliative care providers. As the field of palliative care is rapidly growing, many providers are early in their careers and potentially closer to similar developmental stages as these patients, at times making care emotionally taxing for the provider.

This presentation will define the AYA population and outline both unique palliative care considerations and proposed care models for this patient population utilizing exemplary real-life cases. Distinctive provider challenges relating to care for this patient population will also be discussed.

Where Do We Draw the Line? Navigating Personal and Professional Boundary Challenges in Palliative Care (FR438)

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Objectives

- Define the concept of boundaries in the realm of the clinical encounter and describe its importance to medical practice.
- Explain how maintenance of healthy boundaries may be uniquely challenging in palliative care, particularly for those early in their career.
- Identify specific strategies that palliative care professionals can use to maintain healthy boundaries in their work.

Boundaries in clinical medicine are the limitations we place around the emotional and physical relationships between patients and providers and between medical colleagues. Healthy boundaries are critical in fostering a trusting provider-patient relationship, ensuring dignity and equity in care, and maintaining appropriate roles among members of the care team. Despite the importance of this topic, within medical training there has historically been inadequate attention given to boundary setting and maintenance. Palliative care providers are commonly faced with emotionally charged situations while working in a team-based system where appropriate boundaries between the patient and provider or between members of the care team can easily be compromised. Am I spending the appropriate amount of time with this patient? What’s the right balance between emotional availability and professional distance? Does the work I’m doing fall within my role on the team? Boundaries may also become blurred as the provider strives to preserve personal time and relationships in the context of demanding professional work. Palliative care clinicians, especially those early in their practice, may be uniquely vulnerable to such boundary challenges. Not maintaining healthy boundaries may lead to a lack of sustainability and ultimately to burnout. In this session, a panel of early career palliative care professionals and a palliative care psychologist will use case examples to explore the boundary challenges that arise in our field, explain their importance to patient care and provider well-being, and identify specific strategies to address and prevent them. This session seeks to empower attendees with tools for maintaining healthy boundaries with their patients, their colleagues as well as among the various roles the provider plays in their professional and personal life so as to promote greater resilience and sustainability in our work.

Inviting Ourselves to the Party: Cystic Fibrosis as a Model for Implementing Palliative Care Practice, Research, and Policy in "New Diseases” (FR439)

Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Laura Moreines, RN NP CRNP, Yale, New Haven, CT. Elaine Chen, MD, Rush University Medical Center, Chicago, IL. Elisabeth Potts Dellon, MD, UNC School of Medicine, Chapel Hill, NC.

Objectives

- Describe the opportunities and challenges involved in developing an outpatient palliative care clinic for patients with cystic fibrosis.
- Describe a patient-centered model for developing a palliative care intervention in a disease population without much palliative care evidence, as well as the challenges in conducting clinical research in CF palliative care.

Cystic fibrosis is a chronic, progressive, and fatal disease. Individuals living with CF suffer from myriad physical and psychosocial burdens that dramatically degrade patient and caregiver quality of life.

Although the evidence base for palliative care in CF is scant, patients living with CF and their caregivers undoubtedly possess palliative needs. Yet, no established model of PC exists for this population of high-need patients. Distinctive characteristics of CF, such as its lifelong nature, unpredictable trajectory, advancing therapies that may alter the course of illness dramatically for some, and the complexities of lung transplantation merit evaluation of how PC should be designed for CF. CF is one of many underrepresented disease populations with palliative needs, yet without as strong an evidence base or clinical presence as other classic palliative care populations (e.g., oncology).

This multidisciplinary, multi-institutional panel of clinicians and researchers in palliative care, pulmonology, and nursing will highlight opportunities and challenges of "breaking into" new disease populations, using CF as an exemplar. First, we will present a multi-pronged approach of identifying palliative needs in CF using qualitative methods and a nationwide survey, to aid in building support for and developing clinical programs. Second, we will describe the process and lessons learned during the development and conduct of the first clinical trial of palliative care in CF. Third, we will share insights on developing an outpatient CF palliative care clinic. Lastly, we will discuss our experiences with developing practice guidelines for palliative care in populations where need and enthusiasm exist, despite little evidence.

Lessons learned in this session will be applicable to other fledgling populations with less established research and clinical presence from palliative care. Through shared learning, this forum will nurture future work to level the playing field so that all patients with life-limiting illness benefit from palliative care, regardless of disease.

Examining Relationship Between Post-Traumatic Stress Disorder (PTSD) and Inpatient End-of-Life Care in Veterans Affairs (VA) (FR440A)

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Objectives

- Describe potential differences between patients with and without PTSD at the end of life.
- Consider how these findings may relate to caring for patients with PTSD at end of life.

Original Research Background. The effects of PTSD on the end of life are not well studied. PTSD is a symptomatic illness, affecting pain sensation, anxiety, and sleep. High symptom burden, reliance on avoidant coping strategies, and high comorbid substance use in PTSD, all suggest that these patients may have a more complicated end-of-life trajectory.

Research Objectives. To conduct an exploratory descriptive analysis of end-of-life care for veterans with and without PTSD dying in VA hospitals.

Methods. This was a secondary analysis of a multiple-baseline, stepped-wedge design implementation trial to improve end-of-life care processes for VA inpatients. Variables were collected via direct chart review, using a chart abstraction form. Inter-rater reliability was good to excellent. Analysis included descriptive statistics and chi-square analyses with Bonferroni correction.

Results. PTSD was present in 8.76% of the sample (468/5341). The PTSD population was 98.7% male and 36.5% Black (171/468), with a younger mean age at death than those without PTSD (PTSD 65.4, no PTSD 70.5, $p<0.0001$). Patients with PTSD had higher mean VA hospital admissions and emergency room (ER) visits in the last 12 months of life (admissions: PTSD 2.8, No PTSD 2.4, $p<0.0001$; ER visits: 3.2, 2.5, $p<0.0001$). During the final hospitalization, patients with PTSD had higher rates of intensive care unit (ICU) use (49.6%, 42.7%, $p=0.0041$) and higher rates of advanced directives (48.1%, 37.9%, $p<0.0001$), trending toward lower rates of do-not-resuscitate status (66.5%, 71.0%, $p=0.037$). In the last 7 days of life, patients with PTSD had higher rates of receiving benzodiazepines (47.4%, 39.7%, $p=0.0012$) and antipsychotics (26.3%, 15.7%, $p<0.001$), trending toward higher receipt of opiates (73.3%, 68.3%, $p=0.026$).

Conclusion. Veterans with PTSD dying in VA hospitals appear to experience differences in end-of-life care, compared to those without PTSD.

Implications for Research, Policy, or Practice. Further analysis is needed to confirm this finding, to evaluate contributing factors, and to determine applicability outside of the VA population.

The Opioid Epidemic and Opioid Prescribing Regulations: A Survey Exploring Potential Barriers to Adequate Pain Management in Adults with Cancer (FR440B)

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Objectives

- Identify current opioid prescribing regulations and describe their perceived impact on adult cancer patients in an outpatient palliative care clinic.
- Identify factors that impact adult cancer patients' experience of pain and pain management in the current climate of the "opioid crisis."
- Identify future areas of needed research to lessen the adverse impact of the "opioid crisis" and prescribing regulations on palliative care patients.

Original Research Background. In the United States, there has been an increase in opioid misuse