

University of Manitoba, Winnipeg, Canada. Lynda Balneaves, PhD, University of Manitoba, Winnipeg, Canada. Andree Neron Montreal, Canada. Erin Prosk, MSC, Santé Cannabis, Montreal, Canada.

Objectives

- Describe current and future examples of research on medical cannabis for palliation in advanced cancer patients.
- Understand the various challenges to providing access and monitoring to medical cannabis in community-based, tertiary care and long-term care residences.
- Review key practical recommendations on the integration of cannabinoids for symptom management in palliative care patients.

Integration of cannabinoids into palliative care has been delayed by many obstacles, such as paucity of clinical research data, poor clinical knowledge on how to initiate and monitor cannabinoid treatments and conflicting or unsupportive regulatory frameworks. Cancer patients, on the other hand, are known to have high rates of cannabis use and desire but are not receiving information about cannabis from oncology providers. This session proposes to illustrate the different clinical settings where the use of the traditional plant botanical cannabis and its derivatives could be considered, as well as provide an overview regarding their appropriate use from an integrative medicine perspective –cannabinoid integrative medicine. The discussion will primarily be focused on the palliative care needs of patients with advanced cancer. The group of authors include both US and Canadian-based clinician-scientist/scholars who have developed a practical approach for the integration of cannabis into oncologic palliative care, including guidance on choice of chemovars (strains), titration and monitoring as well as development of clinical pearls based on their clinical experience and the published literature. Areas covered include symptom management, palliation of existential distress, and experimental use of cannabinoids in disease modification.

Shared Decision Making for Long-Term Opioid Therapy for Cancer Pain (SA528A)



Karleen Giannitrapani, PhD, VA Health Services Research and Development Service/Stanford, Palo Alto, CA. Azin Azarfar, MD, University of Central Florida, Orlando, FL. Maria Silveira, MA MD MPH FAAHPM, University of Michigan, Ann Arbor, MI. Amanda Midboe, PhD, Veterans Affairs, Palo Alto, CA. Peter Glassman, MBBS, VA Greater Los Angeles Healthcare System, Los Angeles, CA. William Becker, MD, VA Connecticut Healthcare System, West Haven,

CT. Karl Lorenz, MD MS MSHS, Stanford–VA Palo Alto Health Care System, Palo Alto, CA.

Objectives

- Describe provider and patients' process of weighing the risks and benefits of chronic opioid therapy for patients with cancer and pain.
- Identify strategies that support shared decision making between providers and patients about the appropriate use of opioids for goal concordant pain care.

Original Research Background. Simultaneously, opioids pose potential risks and many patients with cancer pain are appropriately managed on long-term opioid therapy (LTOT).

Research Objectives. To compare patient and provider perspectives on weighing the risks and benefits of LTOT and strategies to support shared decision making for cancer pain.

Methods. Semi-structured interviews with 20 patients and 20 providers (Palliative care, oncology, and primary care based advanced practice nurses (APRNs) and physicians) from 2 VA medical centers. Transcripts were analyzed with constant comparison.

Results. *Provider Results* providers use stage, state, prognosis (“given the amount of time a person with terminal cancer is going to live, the risk is relatively small compared to the benefit”), mental health concerns, and history of substance use disorders to continuously weigh the appropriateness of LTOT for cancer pain. Given the dynamic nature of weighing the above, they also highlight the need for frequent touch points with patients and increasing provider time burden associated with prescribing opioids. *Patient Results:* patients report that current cancer prognosis/symptoms/related fears (“There are side effects [e.g. chemotherapy] that scare me a lot more than the opioids’ side effects”), personal experiences with substances (opioids, cannabis, previous addictions) witnessing opioid use and addiction experiences of family and close friends, and not being able to “afford being functionally impaired” by pain impact perceptions of the risks and benefits of opioids for their circumstance. Patients prefer to focus oncology visits on discussing cancer treatment rather than opioids. In lieu of using physician visit time, patients feel able to navigate dosing and tapering decisions with palliative care advanced practice nurses (APRNs) and clinical pharmacists.

Conclusion. Providers and patients have diverse and sometimes competing priorities when weighing LTOT risks; frequent patient-provider communication is necessary for dynamic shared decision making.

Implications for Research, Policy, or Practice. Further developing opioid prescribing roles

of palliative care-trained APRNs and clinical pharmacists represents an opportunity.

Palliative Care Physician Comfort (and Discomfort) with Discussing Prognosis in Hematologic Diseases: Results of a Nationwide Survey (SA528B)



Wil Santivasi, MD, Mayo Clinic, Rochester, MN. Kelly Wu, MD, Mayo Clinic, Phoenix, AZ. Mark Litzow, MD, Mayo Clinic, Rochester, MN. Thomas LeBlanc, MD MA MHS FAAHPM, Duke University School of Medicine, Durham, NC. Jacob Strand, MD FACP FAAHPM, Mayo Clinic, Rochester, MN.

Objectives

- Recognize wide variability in palliative care physicians' comfort in discussing prognosis of patients with hematologic diseases.
- Identify common reasons why palliative care physicians feel comfortable or uncomfortable discussing prognosis in these diseases.
- Discuss opportunities to improve palliative care physicians' comfort in discussing prognosis with hematology patients.

Original Research Background. Palliative care specialists provide supportive care for patients with hematologic diseases. Prior investigations have surveyed hematologists to characterize barriers to delivery of palliative care to these patients, but palliative care physicians' perspectives remain unclear.

Research Objectives. This research is part of a larger study aimed to examine the beliefs, comfort levels, and attitudes of palliative care physicians toward their interactions with the field of hematology.

Methods. A survey was mailed to a random sample of the AAHPM physician contact list in 2017. Results were anonymized. Participants were asked about their comfort in discussing prognosis regarding hematologic malignancies. Written responses were analyzed, themes were identified, and individual topics within responses were coded in a binary fashion (ie, conveying comfort or discomfort).

Results. Four-hundred fifty-nine of 1,000 surveys included a written response. Fifty-point-eight percent of respondents were male. Community (34.9%), academic (38.5%), and hospice (26.7%) physicians were represented. In discussing prognosis of hematologic malignancies, 41.1% of responses contained only topics expressing comfort, 40.5% contained only topics expressing discomfort, 16.6% responses were mixed, and 2% were not applicable. Commonly cited explanations for comfort were training and clinical experience (47.9%), strong relationships with hematologists (37%), and clear trajectory given likely imminent death (12.8%). Nine-point-eight percent reported fellowship training in or practicing

hematology as a reason for comfort. Commonly cited reasons for discomfort were lack of clinical exposure (51.9%), uncertainty of disease trajectories (22.9%), poor relationships with hematologists (17.2%), limited knowledge of hematologic diseases (13.7%), and rapidly-changing treatments (9.2%).

Conclusion. Palliative care physicians report varying comfort in discussing prognosis in hematologic diseases. This may be a function of clinical exposure to these diseases in practice and training, as well as strong relationships with hematologists.

Implications for Research, Policy, or Practice. These findings will help identify opportunities to improve palliative care physicians' comfort in discussing prognosis with hematology patients, leading to better provision of supportive care.

Natural Language Processing to Assess End-of-Life Quality Indicators in Breast Cancer Patients with Leptomeningeal Disease (SA528C)



Kate Brizzi, MD, Massachusetts General Hospital, Boston, MA. Charlotta Lindvall, MD PhD, Dana-Farber Cancer Institute, Boston, MA. Sophia Zupanc Dana-Farber Cancer Institute, Boston, MA.

Objectives

- Describe that leptomeningeal carcinomatosis is a marker of serious illness in patients with breast cancer.
- Recognize the relationship between palliative care involvement and serious illness conversations in patients with leptomeningeal disease.

Background. Leptomeningeal carcinomatosis is a sign of poor prognosis in patients with metastatic breast cancer, and serious illness conversations have been recommended for patients with this diagnosis.

Objectives. Natural language processing (NLP) was used to (1) identify a population of breast cancer patients with leptomeningeal disease and (2) assess documentation of end-of-life process measures in the electronic health record.

Methods. Retrospective cohort analysis of patients with breast cancer and leptomeningeal disease based on administrative billing coding followed at 2 tertiary hospitals in Boston between 2010 and 2016. NLP was used to confirm leptomeningeal disease in magnetic resonance imaging reports. Subsequently, NLP was used to assess specialist palliative care involvement and three serious illness process measures: goals of care discussions, code status limitations, and hospice assessment. Regression analysis was performed to assess the impact of palliative care involvement on subsequent documentation of each process measure.

Results. NLP-assisted MRI review yielded 183 patients with leptomeningeal disease. The mean age was