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 leading to increased monitoring. Although many guidelines exclude treatment of palliative patients, it remains important to evaluate all patients receiving opioids for substance misuse to ensure safety.

Research Objectives. The primary objective was to determine if current opioid prescribing regulations are perceived by adult cancer patients as a barrier to adequate pain management.

Methods. Following a review of the literature and discussion with palliative experts, we identified potential concerns for patients with prescribing guidelines and developed a 21-item survey. We used a convenience sample of patients receiving opioids in the University of Virginia Palliative Care clinic during the period from February to April 2018. We used chi-square and t-tests to evaluate the correlation between patient perceptions that regulations made pain management difficult and demographic variables, pain and physical function scores, and the opioid risk tool (ORT).

Results. Ninety patients completed the survey. The majority (88.9%) were aware of opioid prescribing laws and 83.2% agreed that opioid abuse is a problem. One-third reported increased regulations made it difficult to manage pain (37.1%) or that insurance issues were a barrier to getting pain medications (32.6%). 38.9% of patients reported their doctor is less likely to prescribe strong pain medications due to the opioid crisis and 24% stated family or friends have told them not to take opiates. In univariate analyses, patients with higher ORT scores ($p=0.025$) and those with higher pain scores ($p=0.0058$) were more likely to report difficulty obtaining pain medications due to prescribing regulations.

Conclusion. This initial survey suggests many palliative care patients feel the increase in opioid prescribing regulations is a barrier to adequate pain management.

Implications for Research, Policy, or Practice. Further research is needed to explore the impact of the current opioid crisis and prescribing regulations on patients receiving adequate pain management.

What's the Risk? Naloxone Co-Prescribing in an Outpatient Palliative Care Clinic (FR440C)

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Objectives

- List the three most prevalent risk factors for opioid-induced respiratory depression in patients receiving palliative care.
- Discuss the potential benefits and burdens of naloxone co-prescribing in palliative care.

Original Research Background. Centers for Disease Control and Prevention (CDC) guidelines on opioid prescribing for chronic pain recommend co-prescribing naloxone for patients with risk factors for Overdose or Serious Opioid-induced Respiratory Depression (OSORD). While palliative care is excluded from this guideline overall, many patients receiving palliative care need chronic opioid therapy; prevalence of OSORD risk factors in this population is unexplored.

Research Objectives. This study aims to 1) describe prevalence and patterns of risk factors for OSORD among ambulatory palliative care patients at an academic medical center and 2) identify frequency of naloxone co-prescribing in a pilot initiative using an integrative risk tool, the Risk Index for OSORD (RIOSORD).

Methods. Patients taking opioids and followed in outpatient palliative care in March–June 2017 were included in this retrospective chart review. Demographics, published risk factors for OSORD, RIOSORD score, and naloxone prescription were extracted. RIOSORD score ≥ 18 was designated as indication for naloxone co-prescription. Descriptive statistics were used to evaluate data.

Results. Risk factors of note among 91 included patients were prescription of ER/LA opioid formulation(s) (54.9%), benzodiazepine(s) (29.7%), MEDD > 100 mg (49.5%), and MEDD > 50 mg (74.7%). Sixty-one patients (67.0%) had an indication for naloxone, and 28 of these patients (45.9%) were co-prescribed naloxone. Naloxone may have been appropriate for an additional 18 patients if single AMA or CDC recommendations were applied. Twenty-one patients had RIOSORD scores in the highest risk class. Sixty-seven percent of patients had active cancer; 14% were in survivorship.

Conclusion. Patients receiving palliative care have similar risk factors for OSORD versus patients without serious illness and may benefit from naloxone co-prescription, when consistent with their goals of care.

Implications for Research, Policy, or Practice. An integrative risk tool may be useful to stratify patients for naloxone co-prescribing. Future studies should determine the most predictive risk factors of OSORD and the impact of naloxone co-prescribing on quality of life in this population.

Impact of Parenteral Opioid Shortage on Opioid Prescriptions Among Patients Seen by the Palliative Care Team of a Comprehensive Cancer Center (FR440D)

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