

were seen in patients with age ≤ 75 ($p=0.27$), cervical cancer ($p=0.11$), non-recurrent disease ($p=0.69$) and a non-infectious admission indication ($p=0.49$).

Conclusion. In this cohort of non-surgical patients with advanced gynecologic malignancy discharged to SRC, only 20% received additional chemotherapy, and the median survival was 58 days.

Implications for Research, Policy, or Practice. This may be an appropriate population to target for advanced care planning prior to discharge.

Why Do Some Patients Regret Their Decision to Initiate Dialysis? (S865)



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Objectives

1. Discuss the importance of patient autonomy in dialysis decision-making.
2. Discuss the impact of a physician's paternalistic style of decision making on patients' inner peace with the decision.

Original Research Background. Nearly 25% of patients receiving maintenance dialysis withdraw from dialysis each year. Many patients regret their decision to start dialysis.

Research Objectives. To identify factors associated with dialysis regret.

Methods. A forty-one item questionnaire was administered to adult patients receiving maintenance dialysis in seven dialysis units located in Cleveland, Ohio and its suburbs. Of the 450 patients who were asked to participate in the study, 423 agreed. The questionnaire items assessed patients' knowledge of their kidney disease, attitudes toward chronic kidney disease (CKD) treatment, and preference for end-of-life (EoL) care. A single question was used to assess dialysis regret, "Do you regret your decision to start dialysis?" We used logistic regression to identify predictors of decisional regret. Candidate predictors were patient demographics, attitudes toward CKD treatment, beliefs about the dialysis decision-making process, and EoL care preferences.

Results. Eighty of 395 respondents (20.2%) reported dialysis regret. Three variables were associated with dialysis regret: (1) patients chose dialysis over conservative management to please doctors or family members (adjusted odds ratio (AOR) 3.33, confidence interval 1.73, 6.37), $p < 0.0001$; (2) patients thought it was important for their families to be actively involved in dialysis decision-making (AOR 1.97, CI 1.73, 6.37), $p = 0.0001$; (3) patients reported not

having prognostic discussions with the kidney doctors (AOR 2.60, CI 5.85, 1.15, CI), $p = 0.0414$.

Conclusion. Dialysis regret was not uncommon in this sample. Regret is associated with beliefs about the dialysis decision-making process. There was no evidence of demographic (age, gender, race, income) differences in regret.

Implications for research. Future research involving multiple stakeholders (e.g., patients, caregivers, physicians) is warranted to identify modifiable risk factors for dialysis regret and to improve dialysis decision-making.

Trends in Hospital-Based Specialty Palliative Care: Insights from a National Palliative Care Quality Improvement Collaborative (S866)



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Objectives

1. Describe at least two trends in processes of care provided by inpatient palliative care (PC) teams over time.
2. Describe one major change in a clinical outcome achieved by inpatient PC teams over time.
3. Discuss how these trends relate to evolving expectations of and norms within the field.

Background. The field of palliative care (PC) is growing and evolving rapidly in response to increased demand and recognition of its benefits.

Objectives. Describe how processes of care and outcomes achieved by inpatient PC teams have changed over time.

Methods. Data for this study were extracted from the Palliative Care Quality Network database on 03/06/2018 and pertain to 135,197 patients referred to 88 inpatient PC consult teams between 01/01/2013 and 12/31/2017.

Results. The most common diagnoses leading to inpatient PC consult were cancer (32.0%, range between teams: 11.3%–93.9%), cardiovascular disease (13.2%, 0%–29.0%), and pulmonary disease (11.3%, 0%–26.0%). The percentage of referred patients with cancer decreased between 2013 and 2017 (39.0% to 30.0%, $p < 0.0001$), while there was an increase in the percentage of patients with cardiovascular disease (12.0% to 14.0%, $p < 0.0001$) and pulmonary disease (10.0% to 12.0%, $p < 0.0001$).