

the number of contacts impacts inpatient admissions across the SDOH groups.

Methods. Data was gathered and analyzed through a retrospective chart analysis with a sample of 1293 patients who had at least one documented contact with a supportive oncology care team member in FY22. Patients were screened for social risk and categorized into low vs high risk SDOH groups utilizing standardized questions from the National Academy of Medicine across four concrete need domains: financial resource strain, housing instability, food insecurity, and transportation.

Results. The majority of patients (68%) had between one and 12 contacts with supportive oncology care with differences seen in number contacts between the low and high risk SDOH groups. The number of contacts is statistically significant in predicting inpatient admissions. Of the high risk patients, 61% were not admitted to the hospital and had more average contacts ($M = 6.37$) than the low risk patient group ($M = 4.79$).

Conclusion. The tremendous needs of diverse patient populations reinforce the urgency for comprehensive supportive services. Universal screening to systematically identify patients with social risks and connect psychosocial interventions with outcomes may impact acute care utilization and promote the value of these services.

Keywords. Patient Outcomes / Quality Improvement

Survival and Characteristics of Elderly Patients with Cardiac Arrest in the ED: A Single Center Retrospective Study

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Outcomes.

1. Understanding that a return to independent living after cardiac arrest is generally less likely as age increases.

2. Deeper understanding of the prognosis of post-arrest patients is helping in guiding families during goals of care discussions.

Key Message. Goals of care discussions regarding cardiac arrest in the emergency department can be challenging on many levels. Understanding patient prognosis, especially regarding functionality, is crucial when guiding families in these discussions. In our review of a decade's worth of data, only 20% of patients over age 50 survived to discharge and less than 10% were able to return home.

Introduction. In the interest of informing end-of-life care and advance directive discussions with patients

and their families, we investigated the rates of survival to discharge by decade of life for patients 50 and older who either arrived in cardiac arrest, arrived post-ROSC, or arrested during their time in the emergency department (ED).

Methods. We performed a single-center retrospective chart review of 2009-2019 at Maimonides Medical Center, an urban, tertiary care center that serves 120,000 patients annually. Study patients suffered cardiac arrest in the ED or just prior. Charts were reviewed for pre-hospitalization residence, length of hospitalization, survival to discharge, and discharge disposition.

Results. We included 674 patients, whose overall survival to discharge was 20%, with survival to discharge rates of 45% for ages 50-59, 29% for 60-69, 20% for 70-79, 15% for 80-89, 19% for 90-99 and 11% for ≥ 100 . 45% of patients died within the first day of hospitalization. Of all remaining patients who survived past the first day (370/675, 55%), length of stay ranged from 2 to 531 days, with a median of 9 days. Ultimately, only 7% were discharged home and 13% were discharged to care facilities.

Conclusion. Information on patients presenting in cardiac arrest helps inform discussions regarding prognosis and goals of care. Our results showed that rates of survival and discharge to home were low, and both generally decreased with age. We interpreted the low rate of being discharged home to suggest that survivors were unlikely to retain independent functioning, which could be meaningful for those who highly value independent living. While communication and experience are crucial to end-of-life care discussions, we hope that our analysis of a decade's worth of data will aid ED physicians in having more intelligent and informed discussions with patients and families regarding the prognosis of their loved ones.

Keywords. Quality Improvement / Prognostication

The Agitation Catch-22: Misconstruing Common Antipsychotic Side-Effects as Worsening Agitation

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Outcomes.

1. To use a case-based, interactive approach to facilitate recognition of EPS induced by antipsychotics,

distinguish EPS from other common causes of agitation, and recommend management of EPS in the context of hospice and palliative medicine.

2. Discuss a practical intervention that clinicians can readily integrate into their clinical settings to improve antipsychotic prescribing practices to minimize medication-related adverse effects.

Key Message. Common antipsychotic side effects may be misdiagnosed as agitation near the end of life, resulting in a catch-22 of inappropriate antipsychotic dose escalation to treat medication-induced agitation, thus worsening patient discomfort. A practical and brief educational intervention can improve prescriber recognition of antipsychotic side-effects, reducing these medication-related adverse events and improving end-of-life care.

Introduction/Context. Antipsychotics are valuable tools for palliating agitation, a common symptom near the end of life. However, over one-third of individuals treated with antipsychotics experience uncomfortable extrapyramidal side effects (also known as extrapyramidal symptoms or EPS). EPS, a consequence of dopamine blockade, encompasses a spectrum from drug-induced parkinsonism to involuntary movements to akathisia (a subjective sense of restlessness). EPS may be underrecognized in the palliative care setting, leading to a catch-22 of escalating antipsychotic doses for what is actually EPS-induced agitation. This risk is compounded by the advanced age and antipsychotic inexperience of most hospice patients, along with the common use of haloperidol, the antipsychotic with the highest EPS risk.

Methods. In a series of four inpatient hospice cases, EPS secondary to haloperidol were misdiagnosed as worsening agitation, prompting inappropriate dose escalation. To address this issue, high-yield antipsychotic use recommendations were compiled and disseminated to eight inpatient hospice providers. Subsequently, all providers completed a survey evaluating the impact of the recommendations on clinical practice and patient symptoms.

Results. In each patient case, discontinuation of haloperidol resolved agitation, supporting EPS as the underlying etiology. As a result of the prescribing recommendations, the inpatient hospice admission orders were modified to reduce the dose and frequency of PRN haloperidol for agitation. Survey *Results:* overwhelmingly indicated that the intervention influenced antipsychotic prescribing practices and increased clinician confidence in EPS assessment. All prescribers expressed a strong desire for additional training on this subject for themselves and bedside nurses.

Conclusion. EPS are common and underrecognized antipsychotic side effects that can precipitate inappropriate dose escalation and worsen discomfort near the end of life. Brief educational interventions can prime

clinicians to consider EPS on the differential diagnosis of agitation refractory to antipsychotics and provide knowledge to treat these symptoms effectively.

Keywords. Pharmacotherapeutics / Pharmacopalliation / Managing Suffering and Distress

The Future of State Workforce Policy in Palliative Care

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Outcomes.

1. Participants will be able to describe the importance of state-level policies in growing the palliative care workforce.

2. Participants will be able to analyze different types of state-level health care workforce-related policies and determine which may be feasible for replication in their own states.

Key Message. There is an urgent need to bolster the palliative care workforce. After surveying over a decade of state-level initiatives in and beyond palliative care, we identify potentially impactful policies for future workforce development. These include loan forgiveness and facilitating workers practicing at the top of their licenses.

Introduction/Context. While state policymakers are increasingly interested in palliative care, there has been limited exploration of state-level strategies to address clinician shortages. As states expand palliative care payment, they must also ensure that there are sufficient specialists and clinicians trained in core palliative care principles and practices to deliver this care.

Objectives. We sought to identify state policies that can grow the palliative care workforce by (1) surveying over a decade of existing state legislation using an innovative database (the Palliative Care Law and Policy GPS, "GPS") and (2) reviewing state-level workforce policies in related fields.

Methods. The GPS is an online public-facing, searchable database of palliative care policies grouped into topic categories. Using this, we reviewed palliative care policies from 2010 - 2022, categorizing them into two groups: building the palliative care workforce and clinical skill-building. Following this, we conducted a literature review using PubMed and Health Affairs to identify policy exemplars that addressed workforce concerns in primary care, oral health, and behavioral health and developed a system to categorize the policies by type.

Results. GPS review yielded 15 bills in 8 states directed towards building the specialty palliative care