# Society of Pain and Palliative Care Pharmacists

# Research Forum 2025

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## Track 1

TR 1.1: Navigating Buprenorphine: Partial Agonist, Full Confusion – How Clinicians Navigate the Gray Areas of Pain Managmeent

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**Background**: Buprenorphine is a unique opioid analgesic with a distinct pharmacokinetic profile that makes it well-suited for managing chronic pain in patients with complex opioid needs. As a partial mu-opioid receptor agonist, it provides effective analgesia while minimizing common opioid-related adverse effects such as respiratory depression. Its high receptor affinity and slow dissociation enhance its safety, particularly in opioid-tolerant individuals. Additionally, buprenorphine is available in multiple formulations, including sublingual, buccal, and transdermal, offering flexibility in dosing and making it a valuable option for long-term pain management in palliative care.

Despite these advantages, buprenorphine remains underutilized in palliative care settings, largely due to variability in clinician familiarity with its pharmacologic properties and optimal dosing strategies. This knowledge gap contributes to inconsistent prescribing practices and potential underuse of buprenorphine for chronic pain management. To address this issue, an educational case-based study was designed to assess healthcare providers' decision-making processes and identify gaps in knowledge regarding buprenorphine use in serious illness.

**Methods**: This study employs an educational case-based design to assess clinical decision-making among pain, palliative care, and hospice clinicians regarding buprenorphine use. Three clinical case scenarios were developed to reflect real-world challenges in prescribing buprenorphine for chronic and serious illness pain management, focusing on initiating buprenorphine in opioid-naïve patients, dosing strategies for opioid-tolerant individuals, and managing complex pain. Each case includes multiple-choice responses designed to highlight common clinical dilemmas and potential decision-making pitfalls. This study was reviewed and approved as exempt research by the University of Maryland Institutional Review Board.

To ensure accuracy and clinical relevance, the cases underwent expert review using a modified Delphi method. A panel of seven pain and palliative care experts, highly experienced in buprenorphine prescribing, reviewed the cases and assessed the correctness of the evidence-based "best" response as well as the rationale for correct and incorrect answer choices. The document was revised until at least 75% agreement was reached among the expert panel.

Participants, including physicians, advanced practice nurses, nurses, pharmacists, and physician assistants, received the finalized case scenarios and independently selected answers based on their clinical decision-making. After completing the cases, participants received a summary comparing their responses to the expert panel consensus and serving as an educational tool to enhance knowledge and prescribing practices.

**Results**: In progress.

**Conclusion/Impact**: In progress

# TR 1.2: Improving the Utilization of Opioid Management Agreements in Supportive Oncology: A Qualitative Improvement Project

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**Background:** State law in Massachusetts requires that a provider enters into a written pain management treatment agreement with the patient when prescribing an extended-release long-acting opioid. This pain management agreement, also known as an opioid management agreement (OMA), must address the benefits and the risk factors, including misuse, of the prescribed substance and be filed in the patient's health record.

To be compliant with the law in Massachusetts, OMA completion rate should be at 100%, however this is not the case at Dana-Farber Cancer Institute (DFCI). Community pharmacies that fill these extended-release long-acting opioids are not responsible for ensuring an OMA is completed, leaving compliance dependent on the individual prescriber and institution.

Since January 2024, the OMA Compliance rate with the DFCI adult palliative care clinic is 61.8%. The palliative care clinic was chosen as the focus for this quality improvement project because of 1) ease of access, 2) high opioid utilization, 3) receptive providers, and 4) already established relationships between study team and providers. This quality improvement project will focus on improving the adult palliative care clinic's OMA compliance at DFCI.

**Methods:** This quality improvement project was conducted at a cancer institute with a 20-person adult palliative care team with the aim of increasing OMA compliance to 85% by April 30, 2025. A team consisting of pharmacists was formed and necessary stakeholders were contacted throughout the process. The project utilized the Plan-Do-Study-Act (PDSA) cycle framework to guide the improvement process.

Baseline data on compliance was collected utilizing a Tableau dashboard. A survey and qualitative interviews were then conducted to identify key factors contributing to noncompliance. Based on these findings, several interventions were implemented, including personalized email reminders to providers, team specific documentation in patient charts, and creating and distributing a weekly leaderboard to rank compliance.

Data was collected continuously throughout the intervention period, and biweekly team meetings were held to assess progress and make necessary adjustments. The primary outcome measure was percentage of OMA compliance; total OMAs completed / total # of long-acting opioids completed. Statistical analysis was conducted utilizing QI Macros. The project adhered to ethical standards, ensuring patient confidentiality, and was approved by the institution's IRB.

**Results:** Primary drivers related to OMA noncompliance were 1) visit time constraints, 2) availability and accessibility of the form, 3) no set way to identify which patients need an OMA, and 4) lack of accountability between providers. Secure email communication, team specific documentation in patient charts, and informing providers of their personal compliance have increased OMA compliance (73.1%, 73.7%, and 77% respectively) within the adult palliative care clinic. Additional interventions and analysis continue to durably improve OMA compliance rate.

**Conclusion:** It is critical to ensure OMA compliance within Dana-Farber Cancer Institute to establish conformity with Massachusetts law. Over the next several months, we plan to continue improving OMA compliance through improving current interventions and initiating new interventions with the Dana-Farber Cancer Institute adult palliative care clinic.

## TR 1.3: Characteristics of Burnout Among Palliative Care Pharmacists

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**Background:** Burnout in healthcare professionals has been linked to decrease quality of patient care and worsened personal wellbeing. McQuade et al. found up to 37% of health-system pharmacists experienced significant burnout driven by high workloads, inadequate staffing, and the emotionally challenging nature of patient care. The COVID-19 pandemic also contributed to palliative care professionals' burnout. This study aimed to examine post-pandemic burnout levels among pain management and palliative care pharmacists. Secondary objectives included comparing results to historical data collected in 2021 during the height of the COVID-19 pandemic and assessing for predictors of burnout and satisfaction with work-life balance.

**Methods:** This prospective cross-sectional study utilized the Maslach Burnout Inventory (MBI) to measure burnout across three dimensions: emotional exhaustion, depersonalization, and personal accomplishment. This study was reviewed and approved as exempt research by the University of Maryland Institutional Review Board in both 2021 and 2024. Participants completed a survey in 2024/2025 distributed via professional association listservs and social media platforms. Participants were included if they identified themselves as pain management, and/or palliative care pharmacists. Baseline demographic data related to job descriptions and work-life stressors was collected, and results were analyzed descriptively. Historical 2021 data, collected using the same methodology, was compared using paired t-tests and regression analyses.

**Results:** In 2021, 43 pharmacists completed the survey, while 41 participated in the re-release in 2024-25, for a total of 84 participants. The overall prevalence of burnout, defined as a high score in at least one subscale of the MBI-HSS, remained stable between 2021 (58.1%) and 2024-25 (56.1%) ($p = 0.9$). Burnout rates did not significantly differ based on gender, practice setting, funding source, work hours, salary, board certification, or state practice laws. However, pharmacists with ≥11 years of experience had significantly higher burnout rates ($p = 0.04$), and those with remote work flexibility had lower burnout (median 20% remote in non-burnout vs. 5% in burnout, $p = 0.03$). Participants represented a variety of practice settings, including academia, acute care hospitals, hospice, long-term care, and outpatient palliative care.

**Conclusion/Impact:** Burnout remains a significant concern among pain and palliative care pharmacists, with overall prevalence remaining stable between 2021 and 2024-25. However, the association between longer practice experience and higher burnout suggests potential cumulative stressors over time. Additionally, limited remote work flexibility was linked to higher burnout, highlighting workplace structure as a modifiable factor. While these findings emphasize the need for targeted interventions to improve career sustainability and work-life balance, limitations include small sample size, self-reported data, and potential confounding factors influencing burnout. Future research should explore qualitative perspectives on burnout contributors and assess intervention effectiveness over time.

# TR 1.4: Evaluation of Low-Dose Naltrexone Use for Chronic Pain Conditions in a Veteran Population

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**Background:** Many Veterans suffer from chronic pain. Current guidelines support utilizing nonpharmacologic and nonopioid options for first-line management. While there are many nonopioid options available, many Veterans have other comorbid conditions that are contraindications or have continued uncontrolled pain with the standard options. The pain clinic at Birmingham VA Health Care System sees many such patients. Low-dose naltrexone, which must be compounded into smaller doses than manufactured, has evidence for treating fibromyalgia and neuropathic pain. Birmingham VA Health Care System has been offering low-dose naltrexone as an additional option since 2022. The goal of this project was to identify if current prescribing practices are appropriate and if it has been beneficial to Veterans.

**Methods:** This project was a retrospective chart review designated by IRB as a quality improvement project. All patients who had an order for low-dose naltrexone from February 3, 2022, until October 24, 2024, were enrolled. Each patient chart was reviewed to identify if an indication of neuropathic pain or fibromyalgia, continued or discontinued therapy, the type of prescriber who initiated the medication, if the patient had been seen by pain clinic, and if a non-formulary request was placed for the medication. Additionally, if reported, any changes in pain scores were assessed. The primary outcomes were to determine if low-dose naltrexone was initiated for an appropriate indication, at an appropriate place in therapy, and ordered by appropriate measures in reference to VA formulary practices. The secondary outcomes were to assess the impact on chronic pain scores and percent of patients who discontinued therapy during the timeframe evaluated. Primary outcomes and the secondary outcome of discontinuation will be reported as a percentage of patients meeting characteristics described above. The secondary outcome of impact on pain scores will be assessed by percentage of patients with a pain reduction of ≥30% from baseline after initiation of low-dose naltrexone.

**Results:** During the designated timeframe, 130 low-dose naltrexone orders were identified corresponding to 85 unique patients. Average age at initiation was 59 (range 32-78), with 60 male and 25 female participants. Patients identified as white (40), black or African American (37), Asian (1), Native Hawaiian or Pacific Islander (1), or unknown (6). All orders had a corresponding nonformulary consult placed and were doses of 4.5 mg daily for a 90 day supply. Ninety-two percent of orders originated from pain clinic providers with the majority coming from pain pharmacist practitioners (72). Other identified prescribers included pain nurse practitioners, pain physicians, primary care providers, rheumatology specialists, and community care providers. Sixty-nine percent of patients ordered low-dose naltrexone have discontinued therapy. Full results are in progress.

**Conclusion/Impact:** Preliminary results suggest no concerns with provider adherence to the local formulary process. Most orders were initiated by pain clinic from pharmacists indicating pharmacists may be the most comfortable prescribing this option at this facility. Data collection is ongoing and expected to conclude in April 2025. Full results will include reasons for discontinuation which is expected to impact future prescribing and local criteria.

# TR 1.5: Improving Skeletal Muscle Relaxant Stewardship

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**Background:** The postoperative use of skeletal muscle relaxants (SMRs) has increased substantially in recent years, primarily as non-opioid co-analgesics in response to the opioid crisis. However, this increase is not supported by strong evidence for SMR use in non-spasm indications, and these medications carry significant risks as central nervous system (CNS) depressants, especially in the postoperative setting where polypharmacy with other CNS depressants is common. The project aim was to reduce inappropriate postoperative SMR prescribing by 30% among targeted surgical services by June 30, 2024, without increasing morphine milliequivalents (MME) prescribed at dismissal.

**Methods:** A retrospective chart review of all inpatient surgeries at Mayo Clinic Rochester from March 1, 2023, to April 30, 2023. Encounters with at least one postoperative SMR order were assessed for prescription rates and refill patterns. Fishbone and SWOT analyses identified systemic factors impacting prescribing at dismissal, with particular focus on electronic health record (EHR) order defaults and reference materials. Interventions included EHR order set updates, Ask Mayo Expert (AME) pathway modifications, and clinician education—particularly among the highest SMR-prescribing service, Neurosurgery. Post-intervention assessment included all surgeries from April 2, 2024, to June 2, 2024. IRB exemption was obtained for this quality improvement project.

**Results:** Pre-intervention, 902 of 3,518 (26%) postoperative patients received SMRs, and 544 (60%) of those were discharged with SMRs, with 22% of prescriptions including a refill. Post-intervention, scheduled SMR orders decreased by 50%, overall SMR administrations decreased by 8%, and 'as needed' SMR administrations decreased by 9%. Outpatient prescribing improved, with a 12% reduction in SMR prescriptions with at least one refill. Importantly, the counterbalance measure was achieved, with no increase in MME prescribed at dismissal.

**Conclusion/Impact:** A multifaceted stewardship approach—including EHR changes, education, and reference updates—reduced inappropriate SMR prescribing in the postoperative setting without increasing opioid use. Early engagement with key prescribers and surgical pharmacists was identified as a lesson learned to enhance sustainability and adoption. Ongoing monitoring has been implemented, with a handoff to clinical staff pharmacists to ensure continued progress and expansion. Future efforts will focus on standardizing postoperative SMR prescribing akin to opioid stewardship.

# TR 1.6: Integration of Palliative Pharmacists to Standard Oncologic Care of Patients with Head and Neck Cancer

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**Background:** In the past decade, the integration of palliative care services into the standard oncologic care of patients with advanced cancer has demonstrated an improvement in patient's perceived quality of life, symptom burden, coping skills, and overall survival rate compared to standard care. Considering the overall decline in practicing physicians, oncologists in the US have limited time to adequately assess symptoms, revisit goals of care, and provide psychosocial support while also managing cancer treatment. By integrating primary palliative care through a pharmacist, increases in quality patient care and patient and oncology provider satisfaction can be achieved.

**Methods:** This study was a prospective, proof of concept study. Two groups of patients diagnosed with several types of head and neck cancer receiving or having completed goal-directed therapy were followed up to 6-months (excluded patients with full palliative care consult). Group one (G1) was followed by a PGY2 palliative care and pain management pharmacy resident and the primary oncology team. Group two (G2) was followed by the primary oncology team. The primary oncology team consisted of a registered nurse, a certified physician assistant, and a medical oncologist. Patient satisfaction was assessed through completion of a pre-/post-service implementation quality of life and symptom management survey, with questions modeled from previously published survey tools. The survey items were measured on a 5-point Likert scale ranging from 1 to 5, with 1 being "not at all" to 5 being "all the time". Provider perceptions were assessed by a survey at the end of the study period. The pharmacy resident tracked recommendations given and implemented (e.g., patient/caregiver counseling, symptom assessments, transitions of care, medication recommendations) during the time spent in clinic, typically about 10 hours, one day per week. A retrospective chart review was completed to determine the number of emergency department (ED) visits in each group over the study period. University of Iowa IRB approved.

**Results:** As of March 24, 2025, ten patients were enrolled in G1 and nine patients in G2. Comparison of pre-implementation patient satisfaction surveys between the two groups were similar. Total average scores (out of possible 45) of symptom assessment for G1 vs G2 was 19.1 vs 19.6, respectively. Symptoms of interest for assessment included pain, shortness of breath, loss of appetite, nausea, weakness, insomnia, constipation, depression, and fatigue. Most common interventions were symptom assessments (46 interviews in 10 clinic days) and counseling on symptom management (17 events in 10 clinic days). G1 had one patient with three separate ED visits for tracheostomy-related hypoxemia, G2 had no ED visits.

**Conclusion/Impact:** On average, the primary oncology team has twenty, 20-minute clinic appointments each day. Based on both groups' pre-implementation patient satisfaction surveys results, the oncology provider in this study dedicated time to thoroughly discuss treatment options and answer patient questions. At times, this led to delays in patients seeing the oncologist. The addition of a palliative care trained pharmacist focused on symptom assessment and management enhanced the oncologist's clinic

efficiency without compromising quality patient care. This also improved communication and transitions to specialty palliative care when needed.

## Track 2

TR 2.1: Urgent Opioid Rotations to Sublingual Buprenorphine/Naloxone (Suboxone) for Pain and Substance Use Disorder Utilizing Buprenorphine Low Dose Initiations: a Case Series

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**BACKGROUND:** Buprenorphine is a semi-synthetic opioid currently approved for acute pain, chronic pain, and opioid use disorder (OUD). If not enough time has lapsed between a patient's last dose of a full mu opioid receptor (MOR) agonist and a large initial dose of sublingual buprenorphine, a high risk for precipitated withdrawal exists, which can be discomforting for a patient and prevent further efforts to transition them to an otherwise safe and effective treatment for opioid dependence and/or chronic pain. However, mounting evidence supports a newer initiation method that does not carry such a risk, known as a buprenorphine low-dose initiation.

**RESULTS:** Here, we outline five successful cases at a local Veterans Affairs Medical Center of such a low dose initiation strategy utilized among patients with chronic pain and/or opioid use disorder who clinically required urgent transitions from their full MOR agonist opioids to sublingual buprenorphine and for whom a standard induction strategy would have been highly challenging and unrealistic. After local institutional review board (IRB) review, it was determined that this project met the definition of a "Case Report" and did not require IRB and research and development committee (R&DC) review. First, a patient with chronic pain admitted for suicidal ideation on fentanyl transdermal patches planning on overdosing on these patches and/or committing suicide by gunshot wound if he were to endure withdrawal as a result of opioid discontinuation. Second, a post-operative patient with opioid use disorder preparing for discharge on high-dose full agonist opioids without a plan for transition to OUD treatment. Third, a patient with active use of illicit oxycodone also on a prescribed intrathecal morphine pump requesting medication treatment for OUD. Fourth, a patient with chronic misuse of prescription oxycodone for chronic pain wishing to transition to a safer alternative prior to a family vacation in one week. And fifth, a patient with chronic pain with a history of opioid dependence on methadone with an opioid treatment program requesting to transition to buprenorphine for pain and OUD and unable to further taper his methadone. Through all five of these cases, buprenorphine low-dose initiation protocols were designed and implemented, and all patients completed such protocols without demonstrating any notable withdrawal symptoms. All five patients were able to make full transitions to sublingual buprenorphine without return to full agonist use.

**CONCLUSION/IMPACT:** In the cases described in this series, we demonstrate the versatility of buprenorphine low dose initiations across a variety of urgent clinical settings with unique baseline opioid regimens. These cases further strengthen the clinical utility of buprenorphine low-dose initiations and continue to reinforce its possible role as a first-line induction strategy for sublingual buprenorphine.

# TR 2.2: Evaluation of the Impact of Oral Ketamine on Opioid Requirements and Pain in Patients with Opioid Use Disorder

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**Background**: Fentanyl contamination in illicit substances continues to complicate pain management and the management of opioid withdrawal in patients with opioid use disorder (OUD). Chronic fentanyl use contributes to dangerously high opioid tolerance and, paradoxically, patients can develop hyperalgesia. Ketamine, an NMDA receptor antagonist, is an analgesic agent that shows promise in pain management in patients with OUD. Ketamine disrupts pain transmission and influences other neurotransmitter systems, contributing to its analgesic, anti-hyperalgesic, and anti-inflammatory effects. Additional research is needed on the use of ketamine for the treatment of pain and withdrawal in patients with OUD. The purpose of this study was to determine whether oral ketamine contributes to a difference in morphine milligram equivalents per day (MMED) in patients with OUD being treated for pain and withdrawal.

**Methods**: This was an IRB approved retrospective, comparative cohort, chart review conducted at two large academic medical centers in Philadelphia between August 1st 2023 to August 1st 2024. There were two cohorts: (1) a control group, defined as patients who were admitted and did not receive oral ketamine and (2) an intervention group, which consisted of patients who were admitted and received oral ketamine. The primary outcome was the change in opioid consumption, as measured by oral MMED within the first five days of admission. The secondary outcomes included analgesic efficacy and safety, hospital length of stay, and patient-directed discharge rates.

**Results**: A total of 100 patients were included, with 50 in each cohort. Baseline characteristics were similar between groups, with the exception of differences in age and historical use. Cohort 2 had an older average age (mean [SD] , 40.2 [6.9]) by 4 years and less historical illicit opioid use. For the primary endpoint, the daily percentage difference in MMED within the first five days of admission between the control and intervention group were 19% (p-value 0.04), -1% (p = 0.49), -30% (p = 0.15), -24% (p = 0.23), and -19% (p = 0.4), respectively. There were no major differences between groups in analgesic efficacy, patient-directed discharge rates, length of stay or safety outcomes.

**Conclusion/Impact**: This study demonstrated that while there was not a statistically significant between group difference in the MMED required during the first five days of admission, oral ketamine may provide an opioid sparing strategy for pain management in patients with OUD. Further large, prospective, comparative studies are needed to substantiate these findings and identify the role of oral ketamine in the management of pain and withdrawal in patients with OUD.

# TR 2.3: Medications for Opioid Use Disorder in Patients Discharging with a Referral to Hospice

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**Background**: With rates of opioid use disorder (OUD) rising, hospice providers are more likely to encounter patients with OUD who require medications for opioid use disorder (mOUD), in addition to their symptom management medications. Yet hospice providers still commonly feel uncomfortable managing mOUD.

The Johns Hopkins Hospital (JHH) Palliative Care and Addiction Medicine services work collaboratively to ensure patients with OUD discharging from the hospital with hospice referrals have adequate plans for managing symptoms and OUD. The purpose of this study is to assess mOUD management in patients with OUD discharging from JHH with a hospice referral.

**Methods**: This quality improvement study is an IRB exempt retrospective chart review in adult inpatients with OUD discharged from JHH with a hospice referral between February 1, 2023 – October 14, 2024, who had methadone or buprenorphine administered during the hospital admission. Patients were excluded if they did not have OUD or were discharged as deceased. Data related to patient demographics, OUD status, and mOUD were collected via electronic health record reports and manual chart review. The objectives of this study were to characterize the population of patients with OUD discharged from JHH with hospice, characterize the patients' plan for mOUD, characterize the symptom burden of patients at discharge, and describe how the mOUD plan changed from hospital discharge to hospice admission. Data analysis was completed using descriptive statistics.

**Results**: A total of 34 patients with 39 hospital encounters were included in the final analysis. The mean age of patients was 56 years (SD 11.31). Overall, 52.9% of patients were female and 58.8% were black. The majority (61.8%) of patients had an oncologic condition listed as their terminal diagnosis. Fifteen patients (44.1%) had active OUD, 15 patients (44.1%) were in remission, and the status of OUD was unknown in 4 patients (11.8%). Of the individuals with active OUD, 10 (66.7%) used nonprescribed opioids daily. Twenty-eight patients (71.8%) were on mOUD prior to hospital admission. During the hospital encounter 7 patients were newly started on mOUD, 3 patients switched from one mOUD agent to another, and 3 patients had their mOUD discontinued. Palliative Care and Addiction Medicine were consulted in a majority of encounters (98.9% and 56.4%, respectively). Upon hospital discharge, most patients had a referral for home hospice (48.7%) or inpatient hospice (38.5%). Further analysis of patients' mOUD plan on hospital discharge, changes to mOUD on hospice admission, and symptoms burden will be provided at the Research Forum.

**Conclusion/Impact**: Individuals with OUD discharging from the hospital with a referral for hospice care are complex and require collaborative management to ensure their symptoms and OUD are adequately managed. It is anticipated that the results of this study will aid in identifying areas of improvement for patients' transitions of care when discharging from the hospital with a referral for hospice. Further results, conclusions, and impacts to practice at JHH will be provided at the Research Forum.

# TR 2.4: Buprenorphine Transdermal Patches and Magnetic Resonance Imaging Safety

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**Background:** Few literature reports on the safety of using transdermal buprenorphine patches for managing moderate to severe pain in patients undergoing magnetic resonance imaging (MRI). Buprenorphine is a common treatment option in pain management for chronic cancer pain, and the transdermal form offers a convenient and effective means of delivery. However, there are limited studies on the safety of transdermal opioid patches during MRI procedures.

**Methods:** We conducted a literature review by searching PubMed using the search terms “buprenorphine”, “transdermal patches”, and “magnetic resonance imaging” during the period of 2008 to 2025. Additionally, we contacted the drug manufacturers of buprenorphine to retrieve more information on post-marketing surveillance reports.

**Results:** Our research resulted in twelve articles. Among those, five are primary literature and seven are review studies, three drug companies were contacted and two representatives provided additional information about post-marketing reports. We found that various manufacturers of buprenorphine recommend against wearing the transdermal patch during an MRI. At the same time, a few indicate no safety concerns, as the buprenorphine transdermal patch contains no metallic components. However, it is advised to follow the recommendation of the physician and adhere to hospital protocols if applicable. At the time of this research, no clinical trials regarding the safety of wearing a buprenorphine transdermal patch during an MRI were found.

**Conclusion/Impact:** This literature search identifies gaps in current safety guidelines for MRI procedures involving patients using opioid transdermal patches. The research concludes by highlighting the need for further studies to establish comprehensive safety protocols that ensure the efficacy of opioid treatment while maintaining MRI safety for all patients.

# TR 2.5: Evaluation of Buprenorphine Buccal Film and Transdermal Patch in the Treatment of Malignant Pain

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**Background**: The management of malignant pain plays a key role in a veteran's cancer treatment. Full mu opioid receptor agonists are traditionally used to treat malignant pain; however, significant opioid related adverse effects can occur. Buprenorphine is potentially a more advantageous choice given it can also provide pain relief, but is thought to have a lower risk of opioid related adverse effects. The primary objective for this quality improvement (QI) project is to evaluate the outcomes and role of buprenorphine buccal film and transdermal patch for malignant pain at the West Palm Beach Veterans Affairs Healthcare System (WPB VAHCS) hematology/oncology center.

**Methods**: This QI project was a retrospective chart review that evaluated the therapeutic outcomes of buprenorphine buccal film and transdermal patch for the treatment of malignant pain. Veterans identified were those initiated on a buprenorphine product for malignant pain from July 1st, 2022, to June 30th, 2024, within a single ambulatory care hematology/oncology center at the WPB VAHCS. Data collected included, patient demographics, malignancy type, mental health/ pain comorbidities, emergency room encounters, documented overdoses or suicide attempts, duration of treatment, reason for discontinuation, baseline and follow-up pain, enjoyment of life and general activity scale (PEG) scores, dose of buprenorphine patch/film at satisfactory analgesia, morphine milligram equivalent daily dose (MEDD) at baseline and follow-up, adverse effects, and use of multimodal analgesia.

**Results**: There are 115 veterans identified who were initiated on a buprenorphine product for malignant pain from July 1st, 2022, to June 30th, 2024. Of those identified, 89.57% (n=103) were initiated on buprenorphine patch and 10.43% (n=12) were initiated on buprenorphine buccal film. Those veterans will be evaluated for inclusion and exclusion criteria to determine if they are eligible for this QI Project. This project was IRB approved and was determined to meet the guidelines for non-research QI project. Results of this project are still pending.

**Conclusion/Impact**: Results of this project are still pending.