Research Objectives. To determine the location of death and acute care utilization by people with SCD at end-of-life.

Methods. The study utilized the California Sickle Cell Data Collection Program database, which combines data from administrative sources, vital records, and Medicaid claims. We examined people with SCD who died between 2006 and 2015 (cases) and examined their utilization of the hospital, emergency department (ED), and intensive care unit in their last year of life compared to living controls with SCD matched 1:1 based on age, year, insurance, and income.

Results. The 485 cases with SCD died at a mean age of 44y (SD: 16y). Most people with SCD died in the hospital (63%) after short admissions (mean 3.4d) and the ED (15%). In the last year of life, people with SCD were admitted for an average of 42d (SD: 49d) over 5 inpatient admissions. Utilization patterns were stable throughout the year and comparable for cases and controls until the month before death when the cases had a sharp increase in utilization with the exception of 1) a slow increase in the length of hospital admissions for cases (2.6 days 12 months before death to 5.7 days the month before death) and 2) more ED visits for young adult (22-39y) cases compared with children and older adult SCD cases or young adult SCD controls.

Conclusion. People with SCD are dying acutely and at a young age – with most dying in the hospital (after short visits) and in the ED.

Implications for Research, Policy, or Practice. In SCD, a palliative approach to care should be extended beyond managing chronic pain and psychosocial challenges to include advanced directives and living wills at a young age.

Periprocedural Code Status Discussions for Inpatients Undergoing Percutaneous Gastrostomy Tube Placement (S836)

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Objectives

1. Describe recommendations for "Do-Not-Resuscitate" orders in the periprocedural period.
2. Discuss current low rate of documented periprocedural code status conversations for patients undergoing inpatient G-tube placement.

Original Research Background. Gastrostomy tube (G-tube) placement is a common procedure performed for patients with life-limiting diseases. Patients may present for G-tube with a "Do-Not-Resuscitate" (DNR) order. Despite multiple national societies recommending periprocedural conversations for patients with a DNR status, it is not clear how often these conversations occur.

Research Objectives. We sought to evaluate the frequency of documented code status conversations for inpatients who are DNR at the time of G-tube placement at an academic medical center. We also explored factors associated with the presence of a documented conversation.

Methods. We performed a retrospective chart review for adult in patients undergoing G-tube placement between May 2016 and May 2017. We abstracted demographic information, type of G-tube inserted, code status, indication for G-tube and mortality data. For patients with a code status other than "Full" at time of G-tube, notes five days pre- and post-procedure were reviewed for documentation of a code status discussion.

Results. We identified 254 adult inpatients who underwent G-tube placement during the one-year study period. 101/254 patients (44%) were 66 or older, 62% were male and more than half had the highest severity of illness. The most common indication for G-tube was dysphagia/aspiration (23% of patients). Thirty-three (13%) had code status other than "Full" at the time of procedure. Of those, 9 (27%) had documented code status discussion. Patients for whom anesthesia was involved were significantly more likely to have a documented code status discussion (89% of patients with an anesthesia consult vs. 33% of patients without; p=.0057).

Conclusion. The majority of patients with code status other than "Full" at the time of procedure did not have documented discussions in the chart despite clear recommendations from major medical societies.

Implications for Research, Policy, or Practice. Future work should include investigation into interventions to improve the rate of code status conversations as well as ensuring these are appropriately documented.

A Pilot Study of Hospice Admission Predictors of Hyperactive Terminal Delirium (S837)

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Objectives

1. Identify types of terminal delirium and its relevance to hospice patient care.
2. Describe the relationships between hospice admission data and hyperactive terminal delirium.
3. Recognize opportunities for future research about terminal delirium.

Original Research Background. Terminal delirium is a common occurrence at the end of life. It is a

poor prognostic indicator that is distressing to patients, caregivers, and providers. The pathogenesis of terminal delirium is not well understood.

Research Objectives. The purpose of this study was to explore the relationships between hospice admission data and the incidence of hyperactive terminal delirium. Specifically, the study explored whether physical, psychosocial, and/or spiritual data collected at hospice admission was associated with terminal delirium.

Methods. This was a retrospective cohort study design utilizing chart review. Admission data were collected from the Hospice Item Set (shortness of breath, pain, scheduled and PRN opioids, bowel regimen); psychosocial assessment (psychiatric diagnosis, significant fears); and spiritual assessment (active spirituality). Chi-squared test of independence, Fisher's exact test, and ANOVA tested for relationships between independent variables and the dependent variable of hyperactive terminal delirium.

Results. A sample size of 148 deceased hospice patients was included in this study. The independent variables of psychiatric diagnosis, significant fears, active spirituality, shortness of breath, pain, and scheduled opioid were not found to have significant relationships with hyperactive terminal delirium ($p > .05$). The relationship between PRN opioid and terminal delirium was found to be significant [$\chi 2$ (1, $N = 148$) = 4.587, $p < .05$]. Risk ratios indicated that the risk of terminal delirium, within the category of PRN opioid prescription, increased by 58.5% relative to the group of non-PRN opioid prescription. Logistic regression analysis indicated that while PRN opioid prescription ($B = .806$, $p = .034$) is a significant predictor variable, although when combined with the equation constant, it did not provide a worthwhile predictive model (Nagelkerke R-Square = .041).

Conclusion. There were no clear relationships between physical, psychosocial, and spiritual admission data and hyperactive terminal delirium.

Implications for research. This study provides preliminary data needed to inform future research about terminal delirium predictors.

Impact of Race and Ethnicity on End-of-Life Experiences for Children with Cancer (S838)

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Objectives

1. Recognize data regarding racial and ethnic disparities in the provision of end-of-life (EOL) care within the adult oncology literature, and how these data contrast with the limited literature on EOL disparities in the context of pediatric oncology.
2. Examine the impact of race and ethnicity on EOL variables for pediatric palliative oncology patients in this study.
3. Discuss potential hypotheses to explain why the impact of race/ethnicity on EOL variables may differ between the medical and pediatric oncology literature.

Original Research Background. Racial and ethnic disparities in the provision of end-of-life (EOL) care are well described in the medical oncology literature. However, the impact of racial and ethnic disparities at EOL in the context of pediatric oncology remains poorly understood.

Research Objectives. To investigate associations between race/ethnicity and EOL experiences for children with cancer.

Methods. A retrospective cohort study was conducted on 321 children with cancer enrolled on a palliative care service who died between 2011 and 2015 using a comprehensive standardized data extraction tool comprising a broad spectrum of EOL metrics.

Results. Black patients were more likely to receive cardiopulmonary resuscitation as compared to White patients (correlation coefficient=1.413, confidence interval=0.359−2.467, p=0.009); however, the remainder of variables related to treatment and EOL care did not correlate significantly with race. Hispanic patients were less likely to receive cancer-directed therapy within 28 days prior to death (correlation coefficient =-0.708, confidence interval = -1.398−0.018, p=0.044) as compared to White patients, yet they were more likely to report a goal of cure over comfort as compared to Non-Hispanic patients (correlation coefficient =1.129, confidence interval=0.042−2.216, p=0.042). The remainder of EOL variables were not found to be significantly correlated with ethnicity.

Conclusion. In contrast with data from the medical oncology literature, neither race nor ethnicity correlated with most EOL variables for pediatric palliative oncology patients treated at a large urban pediatric cancer center. Multicenter investigation is needed to ascertain the impact of racial/ethnic disparities on EOL experiences of children with cancer.

Implications for Research, Policy, or Practice. These data suggest that race and ethnicity