Results. 221/353 members from 20 Latin American Countries participated, Response rate 63%. Median age 47(SD+/-12), 75% were women. 40% were Catholic. 58% were physicians, 19% nurses, 12% psychology, and other12%. The median time of working in PC was 9 years (+/-7). LAPC considered themselves spiritual (median: 8/10, range 0-10) and religious (5, 0-10). LAPC considered S/R very important in their lives (9/10, 0-10 and 6/10, 0-10), respectively. LAPC reported that S/R was a source of strength and comfort (9/10, SD+/-2), helped them to cope with their problems (8/10, SD+/-3), and helped them to keep their quality of life in a stressful work environment (8/10, SD+/-4), significant in those belonging to a church community (p=0.000), time working in PC (p=0.01), age (p=0.03). 190/221(86%) reported strongly/somewhat agreed with the statement: "I feel called to take care of patients who are dying". 31/221(14%) reported being Burned out. No significant difference among gender, profession, age, years in profession or in PC, or importance of spirituality and religion.

Conclusion. Most of LAPC considered themselves spiritual and religious. Low percentage of LAPC reported presence of burnout. The "call" and feeling energized caring patients dying are associated with less burnout. More research is needed.

Implications for Research, Policy, or Practice. Spirituality and Religiosity helping to decrease burnout in Latin American PC.

Validation of the Palliative Performance Scale (PPS) to Predict Survival of Older Adults Admitted to the Hospital from the Emergency Department (S819)

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Objectives

1. Identify those patients admitted from the emergency department who have a high 6 month mortality rate and could benefit from early Palliative intervention.
2. Recognize that patients who have low baseline functional status will have a lower 6 month survival when admitted to the hospital from the emergency department.

Original Research Background. Emergency clinicians have a role in early prognostication. Babcock et al. (2016) validated the PPS among adult patients admitted to the hospital through the ED. They demonstrated the content validity that PPS of 0-30 and 40-60 predict 6 month survival of 14% and 48%, respectively. However, their study was limited by a modest sample size at a single hospital of a predominantly white affluent patient population. We hypothesize that decreasing baseline PPS score will correlate with decreasing survival and that PPS will be a predictor of mortality. If the PPS can discern those at high risk of death it may provide a method to identify those patients who might benefit from a goals-of-care conversation prior to hospital admission.

Research Objectives. To evaluate the construct validity of the Palliative Performance Scale (PPS) as a measure that can stratify the 6 month survival of older adults admitted to an urban university hospital from the emergency department.

Methods. Adults >55 years admitted from the ED were interviewed by investigators on day of admission. Baseline PPS assessed and on admission and followed up at 6 months.

Results. One hundred and forty five participants were enrolled, 129 participants accounted for and 16 were lost at the end of 6 month follow-up. Survival at 6 months as follows: 86% survival of those with initial PPS of 70-100 (13/95 died), 58% survival of those with initial PPS of 40-60 (18/43 died), and 28% survival of those with initial enrollment PPS of 10-30 (5/7 died) (Chi-squared statistic = 21.15, p=.000026).

Conclusion. Palliative performance scale is validated tool for predicting mortality at 6 months and can be used to screen patients admitted from the ED who could benefit from Palliative care consult.

Implications for Research, Policy, or Practice. P-CaRES tool in combination with PPS could help define this population further and additional studies may be of benefit.

How Do Internal Medicine Residents Perceive Direct Observation for Education in Goals-of-Care Communication? (S820)

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Objectives

1. Describe resident perceptions of direct observation of goals-of-care communication.
2. Describe barriers to direct observation of goals-of-care communication.

Original Research Background. Effective communication with patients and families is a core competency of residency education. While internal medicine residents frequently hold goals-of-care discussions with patients and families, they report inadequate training in goals-of-care communication (GOCC). Direct observation presents opportunities for formative feedback and competency-based assessment of resident GOCC. However, resident perceptions of direct observation as a teaching modality for enhancing goals-of-care communication have not been described.

Research Objectives. To describe resident perspectives on use of direct observation as a method for improving GOCC among residents.

Methods. Fifteen semi-structured interviews were conducted and recorded. Recordings were transcribed, deidentified, and thematically analyzed in grounded theory framework using NVivo 11. A codebook representing salient themes was created. Two reviewers established strong post-inter-rater reliability, $\kappa = .98$ with 3 (20%) of the interviews.

Results. Residents broadly shared negative attitudes towards direct observation as a learning tool, such as feeling uncomfortable or anxious or that the experience was artificial (53%). However, they reported a willingness to be observed, noting that the observation exercise is valuable in their development of GOCC skills (53%). The majority of residents described GOCC as "higher stakes" than other patient-provider communication (60%). Careful preparation and structuring of the direct observation encounter helped mitigate resident unease about direct observation of GOCC. Residents expressed preference for direct observation by faculty with expertise in GOCC (53%). The primary barrier to direct observation of GOCC was time conflicts (60%).

Conclusion. Residents described the experience of direct observation for GOCC as an uncomfortable, yet useful exercise due to the higher stakes nature of these discussions. The challenges to conducting direct observations did not stem from resident unwillingness, but rather logistics.

Implications for Research, Policy, or Practice. Direct observation of GOCC should be encouraged, and procedures should be put in place to set expectations and allow for time for observation and feedback surrounding resident GOCC.

How Family Caregivers Assist with Upstream Healthcare Decision-Making by Community-Dwelling Persons with Advanced Cancer: A Qualitative Study (S821)

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Objectives

1. Describe the roles of family caregivers in patients' healthcare decision-making in the context of advanced cancer.
2. Describe two implications for outpatient and community-based early oncology palliative care concerning enhancing decision support for family caregivers.

Original Research Background. In the palliative care context, the family caregiver role in patients' healthcare decision-making has focused on being a surrogate decision-maker at end-of-life. Less is known about family caregiver's role in supporting upstream patient decision-making in advanced cancer.

Research Objectives. Describe how family members assist community-dwelling relatives with advanced cancer with current and prospective healthcare decisions.

Methods. Qualitative descriptive study consisting of one-on-one, semi-structured interviews with persons with metastatic cancer and their family caregivers. We elicited family members' perspectives on how they assist their relatives with any current and prospective healthcare decisions. Transcribed interviews were analyzed using a thematic analysis approach. Co-investigators reviewed and refined themes.

Results. Caregivers (n=20) averaged 56 years of age and were mostly female (95%), White (85%), and the patient's partner/spouse (70%). Patients (n=18) averaged 58 years of age and were mostly male (67%) in "fair" or "poor" health (50%) with genitourinary (33%), lung (17%), and hematologic (17%) cancers. Themes describing family member roles in supporting patients' decision-making were: 1) seeking information about the cancer, its trajectory, and different treatments options; 2) identifying treatment and disease decision points, including decisions about