

**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 other 12%. 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.