

racially and religiously diverse chaplains trained to address diverse patients, including nonreligious patients. The prespecified primary outcome was anxiety (Generalized Anxiety Disorders-7) assessed 6-8 weeks after discharge. Depression (PHQ-9), posttraumatic stress (IES-R), spiritual well-being (FACIT-sp), satisfaction (Patient Satisfaction Instrument—Chaplaincy), and positive religious coping (RCOPE) were secondary outcomes.

Results. We enrolled 192 patient/surrogate dyads, completed follow-up for 128 (66.7%). Patient mean age was 54.8 years (SD 18.2); patients were 45.7% female and 20.7% African American. Surrogates were most commonly the spouse (35.1%). Anxiety was significantly lower in the intervention group at follow-up (GAD-7 intervention group median score of 1 (range 0-5); control 4 (1-9), $p < .0001$), as were depression ($p = 0.0042$) and posttraumatic stress symptoms ($p = 0.0257$). Satisfaction with spiritual care improved ($p = .0005$) but not spiritual well-being ($p = 0.1226$) or positive religious coping ($p = 0.0857$).

Conclusion(s). The study demonstrates the importance of spiritual care in the well-being of ICU surrogates.

Impact. Results can inform palliative care teams about the value of spiritual care for ICU families and serve as evidence for greater inclusion of chaplains in palliative and intensive care.

Improving Continuity for Long-Stay Patients in the Pediatric ICU: A Randomized Controlled Trial (SAPLEN 103)

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Outcomes.

1. Identify the potential impact that attending continuity strategies for long-stay patients may have on patient and family caregiver Outcomes

2. Discern the potential impact of an attending continuity strategy on the clinical team caring for the patient on a week-to-week basis

Importance. The effects of a "primary attending" who follows a patient throughout an admission have not been tested in the chronically critically ill population in the pediatric intensive care unit (PICU).

Objectives. To evaluate PICU patient and family-level outcomes and attending acceptability of a continuity care intensivist (CCI).

Methods. Patient-parent dyads admitted 7 days in PICU were enrolled and randomly assigned to receive usual care (UC) or a CCI. The intervention consisted of volunteer PICU attendings who underwent communication skills training and standardized expectations for weekly parent and team contact. Parents completed surveys at enrollment and after PICU discharge about satisfaction with communication (PFS-ICU), and parental anxiety and depression. CCI and UC attendings were surveyed after the study about acceptability of the intervention. Intention to treat analysis with multivariate linear regression was used for primary length of stay outcome and secondary parent outcomes, controlling for parent age, race, and date of enrollment.

Results. 114 patient-parent dyads (58 CCI, 56 usual care) participated; average child was 5.8 years old, male (57%), White (50%), and with respiratory failure (96%); average parent was 36.7 years old, female (80%), White (59%). CCI intervention had no significant effect on PICU length of stay (average CCI 31.6 vs. UC 35.2; $P = 0.5$). CCI intervention also had no significant effects on assessment of physician communication ($P = 0.55$), satisfaction with decision making ($P = 0.25$), parental anxiety ($P = 0.79$), or depression ($P = 0.68$). 80% CCI providers and 70% other PICU attendings agreed that having a CCI led to more efficient decision making for patients.

Conclusion(s). CCI intervention did not significantly impact PICU length of stay or family outcomes but was perceived by attendings to have been useful to the team.

Impact. Further research should explore whether CCI intervention impacts the team's ability to care for patients.

End-of-Life Experiences Among "Kinless" Older Adults: The Case of Denmark (CO201A)

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Outcomes.

1. Outline risks faced by "kinless" older adults (those who lack a partner or a child) at the end of life

2. Outline the component of a "family-based model of care" and list examples of how this model may exacerbate inequality for women, unpartnered individuals, and the childless

Importance. Cross-nationally, end-of life (EoL) care systems are highly reliant on families to provide and facilitate support. Yet relying on and promoting family-

based care at the EoL ignores the growing global population of individuals without traditional family ties (e.g., unpartnered or childless adults), often referred to as “kinless.” “Kinless” older adults are at risk for higher-intensity EoL experiences (e.g., more visits to hospitals, intensive care units, emergency departments).

Objective(s). We examine the impact of family structure on intensity of EoL experiences in a country context designed to be particularly supportive of older adults without traditional family—Denmark (characterized by high individualism, low fertility, and strong state-based support)—to identify potential lessons for the United States.

Method(s). We analyze civic registry data of 137,599 individuals aged 60+ who died of natural causes (2009-2016) to examine associations between family structure (partnership status, parent status) and likelihood of having intensive EoL experiences (visits to hospitals, ICUs, and EDs in last 30 days of life). We also examine differences by sex, using multivariable logistic regression models adjusting for decedent sociodemographic and clinical characteristics, including cause of death.

Results. Unpartnered childless decedents were the least likely to visit the hospital (OR=0.74, CI=0.70-0.77), ED (OR=0.90, CI=0.86-0.93), and ICU (OR=0.71, CI=0.67-0.75), followed by unpartnered parents. Among the partnered, those with and without children had similarly more intense EoL experiences. There were no major differences by sex.

Conclusion(s). Our results reveal an unexpected pattern at the EoL wherein unpartnered older adults, especially unpartnered childless (“kinless”), experience lower-intensity EoL care. This pattern raises several considerations, including alternative support options for the unpartnered, the role of children in facilitating more intensive care, and potentially different interpretations of high-intensity EoL care outcomes across country contexts.

Impact. These results suggest that family structure impacts EoL experiences in unique ways and call into question the limited lens of family-based care in the context of changing demographics globally.

Examining Racial Differences in Nursing Home Palliative Care Across the United States (CO201B)

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Outcomes.

1. Evaluate the current status of palliative care in nursing homes across the United States by varying

concentrations of Black and Hispanic residents, respectively

2. Interpret areas of palliative care services to increase provision on nursing homes with higher concentrations of Black and Hispanic residents, respectively, with the goal of advancing health equity

Importance. Approximately one-quarter of all deaths in the United States occur in nursing homes (NHs). Disparities in NH end-of-life (EOL) care are pervasive for Black and Hispanic residents. Palliative care (PC) is essential in providing high-quality EOL care, but more information is needed on the provision on NH PC for Black and Hispanic residents.

Objective(s). Our aim is to examine the provision of PC services among NHs with varying concentrations of Black and Hispanic residents (aged 65+), respectively.

Method(s). Cross-sectional analysis of a nationally representative sample of NHs that were surveyed. The survey identified NH PC services (summative score 0 to 100). The survey was linked to Minimum Data Set 3.0 and the Master Beneficiary Summary File (NH resident characteristics) and the Certification and Survey Provider Enhanced Reporting data (NH facility characteristics). Weighted descriptive statistics of PC services and NH facility-level linear multivariate regressions, controlling for percentage Medicaid residents and rurality, were calculated. All models were stratified by census region. NHs were categorized by the concentration of Black and Hispanic residents, respectively (<3, 3-10%, >10%), and all models were stratified by census region.

Results. Our sample included 869 NHs (weighted n = 15,020) nationwide that completed the survey (49% response rate). NHs in the South provided fewer PC services compared to other regions. In adjusted analyses, NHs in the Northeast and West with higher concentrations of Black residents provided significantly fewer PC services. NHs in the West with higher concentrations of Hispanic residents provided significantly fewer PC services.

Conclusion(s). We observed significant NH PC differences with higher concentrations of Black and Hispanic residents, respectively, and by region.

Impact. The first step in advancing health equity is to identify the inequities, and our findings demonstrate that inequities exist in NH PC services.

Unmet Support Service Needs Among Rural Family Caregivers: A Population-Based U.S. Study (CO201C)

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