

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)

Leah Estrada, MA BSN RN, Columbia University School of Nursing. Jordan Harrison, PhD, RAND Corporation. Andrew Dick, PhD, RAND. Patricia Stone, PhD, Columbia University.

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)

Erin Kent, PhD, University of North Carolina at Chapel Hill. Majja Reblin, PhD, University of Vermont. Yiqing Qian, MPH, University of North Carolina at Chapel

Hill Gillings School of Global Public Health. Erin Dobbins, MA, University of North Carolina at Chapel Hill Gillings School of Global Public Health. Eliza Park, MD MS, University of North Carolina.

Outcomes.

1. Describe the prevalence of unmet support service needs for rural caregivers in the U.S. and the distribution of specific unmet service need types

2. Explain the sociodemographic and caregiving-related variables associated with unmet support service needs among rural caregivers

Importance. Rural communities in the U.S. demonstrate growing racial and economic disparities and increasing barriers to healthcare access. Within this shifting landscape, understanding rural caregivers' unmet support service needs can help identify the most pressing gaps in supportive care.

Objective(s). We examined factors related to unmet support service needs among rural caregivers in a large, population-based study.

Method(s). We used data from the Behavioral Risk Factor Surveillance System for the 28 U.S. states (including DC and Puerto Rico) participating in the caregiving module across years 2015-2020. We identified rural caregivers by using metropolitan statistical area (rural) and the item, "During the past 30 days, did you provide regular care or assistance to a friend or family member who has a health problem or disability?" Logistic regression models incorporating sampling weights provided adjusted odds ratios (aORs) of factors associated with unmet support service needs (classes about giving care, help with service access, support groups, individual counseling, respite). Factors included sociodemographic (gender, race, age, education, income, employment status, marital status) and caregiving-related (intensity [± 20 hours/week and ± 2 -year duration], caregiver-care recipient relationship and main care recipient health condition) variables.

Results. Of the 5,934 rural caregivers included, representing 1.7 million individuals, 17% endorsed unmet needs. Help accessing services was most frequently endorsed (47%), followed by support groups (17%) and respite care (16%). Factors associated with higher odds of any unmet need included Black vs. White race (aOR: 1.7; 95% CI: 1.1-2.5), college vs. high school graduate (aOR: 1.8; 95% CI: 1.3-2.5), and higher- vs. lower-intensity caregiving (aOR: 2.1; 95% CI: 1.4-3.1).

Conclusion(s). Many U.S. rural caregivers report unmet support service needs, particularly Black caregivers, those with higher educational attainment, and those with higher caregiving intensity.

Impact. Future interventions to benefit rural caregivers may benefit from focusing on the individuals with the highest unmet needs.

How Does Hospital Culture Influence the Intensity of End-of-Life Care? (CO201D)

Elizabeth Dzeng, MD PhD MPH, University of California San Francisco. Jason Batten, MD MA, Stanford University. Daniel Dohan, PhD, University of California San Francisco. J Randall Curtis, MD MPH, University of Washington.

Outcomes.

1. Identify how hospital cultures influence intensity of end-of-life care

2. Propose hospital policies, practices, and resources that foster hospital cultures that mitigate burdensome end-of-life care

Importance. There is significant institutional variability in the intensity of end-of-life (EOL) care that is unexplained by patient preferences. Hospital culture and individual practice variations may contribute to burdensome or unwanted life-sustaining treatments near the EOL.

Objective. To understand how hospital cultures influence the intensity of EOL care.

Methods. A comparative ethnographic study was conducted at four academic hospitals in California and Washington. Hospitals were selected for differences in intensity of EOL care (e.g., high, medium, and low) based on the Dartmouth Atlas. Semistructured, in-depth interviews were conducted with 112 clinicians, hospital staff, and administrators between December 2018 and December 2020. Data were deductively and inductively analyzed using thematic analysis through a team-based, iterative coding process.

Results. There was a universal default of high-intensity care at all four sites; respondents recognized this as the norm in American healthcare. This default required respondents to use active and concerted efforts to de-escalate high-intensity EOL care, even when treatments were not consistent with patients' goals. Respondents at high-intensity hospitals described attempts to de-escalate high-intensity, goal-discordant care that were thwarted at multiple points during a patient's care trajectory. Conversely, hospital-specific resources, policies, and practices at hospitals whose culture favored low-intensity EOL care facilitated de-escalation. The aggregate tendency of a hospital's environment to either favor or thwart clinician attempts to de-escalate high-intensity EOL care is a foundational feature of different cultures of intensities of care.

Conclusion. Hospital cultures influence the intensity of EOL care through policies, practices, and resources that either facilitate or discourage resistance to a prevailing culture of high-intensity care in American medicine.

Impact. Interventions that target individual behaviors or interactions are insufficient to mitigate burdensome EOL care because extant hospital cultures will