

Denver. Regina Fink, PhD AOCN CHPN FAAN, University of Colorado Anschutz Medical Campus.

**Outcomes.**

1. Identify reasons for increased burden in Hispanic caregivers and patients with AD/RD

2. Understand the elements of lay navigator intervention to improve Hispanic caregiver and patient with AD/RD outcomes

**Importance.** Hispanic caregivers to persons with AD/RD experience higher levels of burden due to low rates accessing outside formal services and longer time caregiving for patients with increased impairment compared to non-Hispanic Whites.

**Objective(s).** To determine feasibility and acceptability of an established lay navigator palliative care intervention adapted for Hispanic caregivers of persons with AD/RD.

**Method(s).** A randomized controlled trial compared the navigator-led intervention to enhanced usual care. Enrolled dyads were Hispanic caregivers of persons with advanced AD/RD. Intervention caregivers received approximately 5 home visits focused on exploring goals and values in preparation for future healthcare decisions and caregiver support. All groups received culturally tailored educational materials. Primary outcomes were intervention feasibility and acceptability. Caregiver-reported measures included Caregiver Reaction Assessment (CRA) and Family Decision-Making Self Efficacy Scale (FDM). Qualitative interviews (n = 10) explored acceptability and intervention satisfaction.

**Results.** We identified 54 potentially eligible patients with 7 ineligible, 2 deceased, and 8 unable to contact. Of 37 dyads contacted, 24 enrolled (64%). Mean patient age was  $80.4 \pm 7.9$  and caregivers  $51.2 \pm 12.1$  years. Most patients (58.3%) and caregivers (91.7%) were female. Fewer caregivers (20.8%) had less than a high school education compared to patients (62.5%). Baseline CRA burden was moderate,  $2.7 \pm 0.1$  (1 least, 5 most) with the disrupted schedule demonstrating the highest burden ( $1.5 \pm 0.6$ ). FDM self-efficacy was high at baseline ( $61.3 \pm 7.1$  [scale range 5-65]). Most caregivers found the intervention very helpful, specifically identifying resources, education, and answers to questions as key participation benefits.

**Conclusion(s).** While this pilot demonstrated feasibility (enrollment rate >50%, 100% follow-up), high acceptability, and moderate baseline caregiver burden, caregivers felt prepared for future healthcare decisions at baseline, suggesting that this aspect of the intervention may be less helpful.

**Impact.** This study supports further investigation to improve caregiver outcomes for those caring for Hispanic persons with AD/RD.

***Long-Term Opioid Therapy and Overdose in Patients With and Without Cancer (CO203A)***

Jessica Merlin, MD PhD, University of Pittsburgh. Anne Black, PhD, Yale School of Medicine. Lara Troszak, MA, VA Palo Alto Health Care System. Karleen Giannitrapani, PhD, VA's Health Services Research and Development Service and Stanford University. Karl Lorenz, MD MSHS, VA Palo Alto.

**Outcomes.**

1. Describe opioid trajectories in patients with and without cancer and their implications

2. Explain findings related to overdose risk and cancer status

**Importance.** Pain is experienced by most patients with cancer, and opioids are a cornerstone of cancer pain management. Prominent guidelines reflect the prevalent belief that benefits of palliating pain in cancer with opioids nearly always outweigh potential harms, including opioid overdose, despite limited evidence.

**Objective(s).** Among patients with and without cancer: identify patterns of long-term opioid therapy (LTOT) and their correlates and assess the association between prescribing patterns and risk for opioid overdose, considering the potential moderating role of cancer.

**Method(s).** A 2010-2017 retrospective cohort study using latent growth mixture modeling and Cox proportional hazards modeling. Setting included the Veterans Health Administration electronic health record database. Participants included patients with incident LTOT with and without cancer (N = 44,351; N = 285,772, respectively). Veterans in the cohort were  $\geq 18$  years of age at the time of incident LTOT; engaged in VHA care, defined as  $\geq 2$  outpatient visits or  $\geq 1$  inpatient admissions within the year prior to cohort entry; and received LTOT, defined as receipt of 90 consecutive days' opioid prescription. Exposure included the pattern of opioid prescription received. Main outcomes included all accidental and intentional opioid-related overdose events.

**Results.** Patterns of opioid receipt observed in patients without cancer and replicated in patients with cancer were low-dose, low-dose/de-escalating trend, moderate-dose, moderate-dose/escalating trend, and high-dose/escalating trend. Controlling for covariates, time to first overdose was significantly predicted by higher-dose and escalating trajectories; the two low-dose patterns conferred similar, lower risk. Effects of trajectories on time to overdose did not differ by cancer group status.

**Conclusion(s).** Patients with cancer face opioid overdose risks like those of patients without cancer.

**Impact.** Clinicians and researchers should consider these findings when counseling patients and

developing inclusion criteria for LTOT studies. Future studies should seek to expand knowledge about opioid risk in patients with cancer.

### ***Hospice Improves Last Month of Life Care Outcomes for Older Adults with Dementia (CO203B)***

Krista Harrison, PhD, University of California, San Francisco. Irena Censer, PhD, University of California, San Francisco. Claire Ankuda, MD MPH, Icahn School of Medicine at Mount Sinai. Lauren Hunt, PhD RN FNP-BC, University of California, San Francisco. Melissa Aldridge, PhD MBA, Icahn School of Medicine at Mount Sinai.

#### **Outcomes.**

1. Compare impact of hospice versus nonhospice on the last-month-of-life care quality for people with dementia (PWDs)

2. Compare impact of hospice on the last-month-of-life care quality comparing PWDs vs those with no dementia

**Importance.** The Medicare Hospice Benefit was originally designed around a cancer disease paradigm but increasingly serves people with dementia (PWDs). There is ongoing debate about whether the benefit structure of hospice is suited for PWDs.

**Objective(s).** We sought to evaluate the impact of hospice on perceived quality of end-of-life care for PWDs and whether the impact of hospice differed between PWDs and those without dementia.

**Method(s).** Retrospective study of 2,059 decedents age 70+ using data from the National Health Aging and Trends Study linked to Medicare claims (2011-2017). Last-month-of-life care quality was assessed by a proxy in a post-death survey and included overall ratings of care, management of pain, dyspnea, sadness or anxiety, personal needs, and spiritual support; provision of goal-consistent, respectful, family-involved, coordinated care; and late transitions in the last 3 days of life. Analyses included multivariable logistic regressions, covariate balancing propensity score methodology, and post-estimation commands for adjusted predicted probabilities.

**Results.** Among 2,059 decedents, participants had a mean age at death of 84.6 years (SD 7.1); 46% (n=951) were PWDs. A higher proportion of PWDs used hospice (59% vs 43%,  $p < 0.001$ ). In adjusted analyses, hospice-enrolled PWDs were more likely to rate last-month-of-life care as excellent compared with PWDs who did not use hospice (52.0%, CI 47.7, 56.2 vs 41.4%, CI 34.9, 47.9). Hospice recipients had a higher predicted probability (66.9%, CI 58.9, 75.0) of managed sadness or anxiety compared to PWDs without hospice (45.7%, CI 35.1, 56.2). Hospice recipients had

fewer late transitions: 9.8% (CI 6.6, 13.0) compared to 24.6% (CI 17.9, 31.2) of PWDs without hospice. Interaction terms revealed no differences in the impact of hospice on PWDs versus those without dementia.

**Conclusion(s).** Hospice improves outcomes for PWDs enrolled in hospice, and care ratings are similar for PWDs and those without dementia receiving hospice care.

**Impact.** Given the benefits of hospice to PWDs, policies to facilitate hospice enrollment and prevent live discharge for PWDs seeking hospice care are warranted.

### ***Pathways of Care Prior to Hospice Enrollment: Have We Moved the Needle? (CO203C)***

Claire Ankuda, MD MPH, Icahn School of Medicine at Mount Sinai. Joan Teno, MD MS, Oregon Health & Science University. Amal Trivedi, MD MPH, Brown University. Laura Keohane, PhD, Vanderbilt University School of Medicine. Christopher Santostefano, BSN RN, Brown University School of Public Health. David Meyers, PhD MPH, Brown University School of Public Health. Jennifer Bunker, MPH, Oregon Health & Science University.

#### **Outcomes.**

1. Analyze the most common pathways of care before hospice and describe how they vary by illness, region, and Medicare Advantage (MA) enrollment

2. Appraise potential hypotheses for how MA is shaping hospice pathways and implications of this information for patient and family outcomes

**Importance.** From 2010 to 2019, hospice use increased from 43.8% to 51.6% of Medicare decedents. However, it is unclear whether the location of care preceding hospice enrollment has changed over time or what factors impact pathways to hospice. This is important given concerns that hospice is often used only after hospitalizations and multiple care transitions.

**Objective(s).** We assessed 2011-2018 trends in the pathway to hospice among Medicare decedents and examined differences by hospice diagnosis, region, and Medicare Advantage (MA) enrollment.

**Method(s).** We used Medicare claims to identify 15,203,083 decedents and characterized their location of care over the 30 days before hospice enrollment (hospital, nursing home, home with home health, home without home health). We examined changes in the pre-hospice location of care over time. We then examined trajectories of location of care over the 30 days before hospice enrollment, comparing these trajectories by hospice diagnosis (cancer, dementia, chronic obstructive pulmonary disease, congestive heart failure, stroke), state, and MA enrollment. We