

AWARENESS OF HOSPICE CARE AMONG RURAL RESIDENTS: FINDINGS FROM SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

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Although the demand for hospice care increases as our society ages, the awareness of hospice care among adults in the southern rural region of the US has not been documented. This study aims to assess the rate of hospice care awareness among rural residents living in the Black Belt Region and examine social determinants of health (SDH) associated with the awareness. A cross-sectional survey was conducted among a convenient sample living in rural Alabama (N=182, age=18-91). Participants' awareness of hospice care, demographic characteristics (i.e., age, gender), and SDH (i.e., financial resources strain, food insecurity, education and health literacy, social isolation, and interpersonal safety) were assessed. Lastly, a binary logistic regression was used to examine the association between SDH and awareness of hospice care among participants while controlling for demographic characteristics. The majority of participants had heard of hospice care (82.4%), and older participants (over 50 years old) were more likely to report having heard of hospice care (OR=7.35, $p<0.05$). Participants reporting worries about stable housing (OR=0.05, $p<0.05$) and higher social isolation were less likely to have heard of hospice care (OR=0.53, $p<0.05$), while participants with higher health literacy had a higher likelihood to have heard of it (OR=2.60, $p<0.01$). Our study is the first study assessing the status of hospice care awareness among residents living in the Black Belt Region. This study highlighted that factors including age and certain SDH (i.e., housing status, health literacy, and social isolation) might be considered in the intervention to improve hospice care awareness.

CAREGIVER TASK DIFFICULTIES AT THE END OF LIFE: A LATENT CLUSTER ANALYSIS

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Caregivers engage in myriad tasks from household help to complex medical care. However, little information is available on how caregivers experience individual tasks – particularly key end-of-life tasks such as managing breathing problems or patients' sadness and anxiety. The purpose of this study was therefore to assess task difficulty. Using data from the National Health and Aging Trends Survey and the National Survey on Caregivers (2015-2017), we assessed eleven caregiving tasks in 241 primary caregivers of care recipients in their last month of life. A latent cluster analysis revealed three key clusters: 1) pervasive difficulties, in which caregivers reported difficulty across most or all of the tasks; 2) minimal difficulties; and 3) emotional management difficulties, in which caregivers reported difficulty with managing sadness and anxiety and lower levels of difficulty on the other tasks. Weighted frequency analyses revealed that caregivers

in the pervasive difficulties cluster were most likely to be filial caregivers (85% versus 63% of the full sample, $p<0.05$) or co-residing with the care recipient (49% versus 37% of the full sample, $p<0.05$). Caregivers identified as having pervasive difficulties were also more likely to report providing intensive care, more than 100 hours per week (54% versus 36% of the full sample, $p<0.05$). Care recipient condition was not associated with cluster membership. The findings highlight the need to consider caregiver coping at the task-level and have implications for understanding unmet needs. Future research will assess predictors of cluster membership and how task difficulties are associated with symptoms and well-being outcomes.

CHANGE IN MEDICAL AND HEALTH CARE DECISION-MAKING PATTERNS AT THE END-OF-LIFE: A COHORT OF THE VERY OLD PEOPLE

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How does medical and healthcare decision-making among the very old people change in their last year before death? We explored patterns of decision-making in the Health ABC cohort study in 2011-14 (years 15-17), which involved 12 waves of quarterly phone interviews. When the participant was unable to do the interview, a proxy completed it instead. We identified a sample of 291 decedents (aged 90.0 ± 2.9 at death, 35.7% Black, 52.6% female) with at least 1-year follow-up before death. Percentages of decedents who have made medical or healthcare decisions in the last four quarters before death were 32.0%, 31.2%, 32.6%, 41.9%, respectively. Decedents made more healthcare decisions in the last quarter before death ($P<0.01$), compared to the baseline. Across all quarters, decision-making is most in need for medications (17.6%), hospital admission (13.2%), and ER/urgent care visit (13.2%). We matched a 1:1 sample of survivors at the time of death by race, sex, and age (within ± 3 years). In random effects models with multiple imputations of missing data, we found that decedents were more likely to make healthcare decisions than survivors across all four quarters before death or censor (Odds ratio=1.99, 95%CI: 1.49-2.65, $P<0.01$). The significance still held after adjusting for age, female, race, education, and interview methods. Overall, compared to matched survivors, the frequency of making medical and healthcare decisions among the very old decedents has already been high in the last year before death. This frequency rose sharply in the last quarter before death.

DEATH AND DYING: BOUNDARIES AND ROLES OF FAMILIES AND HEALTHCARE WORKERS DURING PATIENT END OF LIFE

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While death and dying often occur within or adjacent to the healthcare setting, grief & support of patients at end-of-life (EOL) remain largely within the realm of the family. Given this division of roles, healthcare workers intentionally set professional boundaries that balance their need to be empathetic and compassionate for patient and their families during EOL, while also maintaining a sense of objectivity and detachment which allows them to cope with patient loss and