the goal of preventing serious health problems associated with loneliness and social isolation, allowing residents to age in place.

EXAMINING THE IMPACT OF INDIVIDUAL AND SHARED BIOLOGICAL RISKS ON HEALTH AMONG OLDER MARRIED COUPLES

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Relationship research has suggested that health among spouses is interdependent and should be considered jointly. Using data from the 2008/2010 and 2016/2018 waves of the Health and Retirement Study (3858 qualified couples; age=67.0±9.6), we investigated the joint influence of married partners' individual and shared cumulative biological risk on future health outcomes. Two risk indicators were constructed to indicate biological health in different domains. Individual grip strength, walk speed, lung function, and cystatin-C were biomarkers selected to construct frailty risk whereas blood pressure, pulse, waist circumference, C-reactive protein, glycohemoglobin, high-density lipoprotein cholesterol, and total cholesterol were biomarkers used to construct cardiometabolic risk. Shared risk was calculated as the number of risks the partners shared. We employed multilevel Poisson regression models to nest partners within couples and examine the effects of individual and shared cumulative risks on future functional limitations. Heckman correction was performed to correct potential selection bias. Our unadjusted models showed individual (frailty: b=0.22, p<.001; cardiometabolic: b=0.10, p<.001) and shared (frailty: b=0.17, p<.001; cardiometabolic: b=0.08, p<.01) risks are associated with greater future functional limitations. Further, shared cardiometabolic risk moderated the effect of individual risk (b=-0.01, p<.05). In the adjusted models, the direct associations between shared risks and future functional limitations were explained by indicators of partner selection and shared experiences. In the fully adjusted model, the cross-level interaction for frailty risk became statistically significant. The unique set of dynamics shown in our study offered new insights into understanding how couples influence one another in the context of multisystem biological health.

EXAMINING THE RELATIONSHIP BETWEEN HOSPICE AGENCY CHARACTERISTICS AND COMPLAINT DEFICIENCIES

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The U.S. hospice industry has expanded over the last decade. Similar to nursing homes, research guided by the Donabedian framework has documented quality differences in hospice based on agency characteristics, including profit status and rural status. Yet, compared to nursing homes, quality oversight and transparency in hospice remain limited. When families report substandard care, a complaint survey is launched to investigate allegations. Using publicly available regulatory oversight data (e.g., CMS QCOR, Medicare PACPUF, CAHPS HIS, Hospice Compare), and guided by the Donabedian framework, this study describes hospice agency structure and process characteristics associated with care complaint deficiencies (outcome). Of the 4,415 hospice facilities examined, 453 (or 10.3%) have had complaint survey deficiency citations between January 2018 and December 2020. Chi-square and ANOVA tests were conducted to compare facility characteristics (e.g., ownership status, percentage of Medicare beneficiaries in rural zips), nursing and social work involvement, and CAHPS scores between hospices with and without complaint survey deficiencies. Results indicated that the average proportion of beneficiaries with a rural zip for Medicare correspondence was significantly lower in hospices with deficiencies (p<.001). Finding also suggested that weekly total nursing and social work minutes were significantly higher in hospices with deficiencies. Additionally, family ratings of hospice team communication, symptom management, and overall satisfaction were higher in facilities without complaint survey deficiencies. Future research and practice implications will be discussed.

EXPERIENCES OF RURAL AND URBAN ASSISTED LIVING COMMUNITIES IN OREGON DURING COVID-19 PANDEMIC

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This study presents findings on the impact of the COVID-19 pandemic as reported by a representative sample of Oregon assisted living communities (AL) between December 2020 and March 2021. Of the 559 AL eligible to participate, 346 completed eleven questions related to their experiences since March 2020. These questions covered topics such as access to personal protective equipment (PPE) and accurate information, communication with and support from government agencies, ability to find staff and new residents, ability to address pandemic-related concerns of residents' families and staff, use of virtual visits and telehealth for residents, and visitor restrictions. Response categories ranged from 0 (strongly disagree) to 4 (strongly agree) and we coded "agree" and "strongly agree" responses as having experienced that issue. Among responding AL, 42% were located in rural or frontier areas. We present three findings. First, most AL experienced adverse impact due to COVID-19, especially regarding issues likely to be outside of their control compared to those within their control. Second, while almost all urban-based AL reported that their residents used virtual communication technologies and tools for telemedicine/telehealth (96%) or virtual social visits (96%), rural AL were less likely to report so (90% and 92%, respectively). Finally, rural AL experienced significantly greater staffing difficulties (75%) compared to their urban counterparts (82%). In sum, while all AL would benefit from better regulatory guidance on policies and access to PPE, rural AL might especially benefit from additional, context-specific resources.

FACTORS ASSOCIATED WITH ATTACHMENT AND CARE DECISIONS

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