Is Socioeconomic Status a Fundamental Cause of Racial Differences in End-of-Life Care Use? (TH321D)

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Objectives

- Articulate how social theories can help our understanding of inequities in EOLC use.
- Describe social characteristics associated with hospice use, life support use, and hospital death.

Original Research Background. Racial differences in end-of-life care (EOLC) are well documented. De-medicalized care is now the innovation at EOL. Sociological theories suggests those with more education should be the first to use palliative care/less aggressive care and this will lead to inequities in EOLC.

Research Objectives. To determine whether socioeconomic status (SES), as measured by level of education, mediates the relationship between race and three commonly accepted indicators of quality EOLC: hospice use, life support use, and place of death.

Methods. I used modified poisson regression to analyze Health and Retirement Study 2014 Core and Exit Interviews data. The HRS is a longitudinal study surveying a representative sample of Americans age 50 and older. The Exit Interview collects data for respondents who have died during the study. Separate analyses were run for each outcome (hospice use n=1,193; life support use n=893; place of death n=1,198).

Results. In unadjusted models, Blacks were less likely to use hospice (unadjusted risk ratio [RR] =.813; 95% CI=.679-.974; P=0.023), more likely to use life support use (unadjusted RR=1.48; 95% CI=1.18-1.86; P=0.001), and more likely to have a hospital death (uRR=1.29; 95% CI=1.06-1.57; P=0.013) than Whites. After adjusting for education and patient characteristics, Black race was no longer a significant predictor of hospice use (aRR=.993; 95% CI=.826-1.19; P=0.940) or hospital death (aRR=1.17; 95% CI=.942-1.46; P=0.151). Blacks were still significantly more likely to use life support (aRR=1.41; 95% CI=1.09-1.82; P=0.008) than Whites.

Conclusion. Race is significantly associated with indicators of poor quality EOLC. Higher levels of education are significantly associated with a greater risk of hospice use and a lesser likelihood of life support use and hospital death. SES appears to be a fundamental cause of racial inequities in hospice use, but not in life support use or hospital death.

Implications for Research, Policy, or Practice. EOLC quality indicators may ignore cultural heterogeneity of patient preferences. Efforts should be made to better educate persons of lower SES groups about hospice.

Association of Timing and Type of Advance Care Planning Documentation on End-Of-Life Care for Patients with Serious Illness (TH322A)

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Objectives

- Describe the association between earlier advance care planning documentation and intensity of care at the end of life.
- Describe the association between late advance care planning documentation and intensity of care at the end of life.

Original Research Background. It is unclear how the timing of advance care planning (ACP) documentation and type of documentation influence the intensity of end-of-life care for patients with chronic illness.

Research Objectives. To examine associations between timing and type of ACP documentation with intensity of end-of-life care for patients with chronic illness receiving care in one healthcare system.

Methods. We developed a retrospective cohort using Washington State death certificates and electronic health records (EHR) to identify patients with chronic illnesses who died between 2010 and 2015. Association between timing and type of ACP documentation and end-of-life care were examined with multivariate probit regression analysis, adjusted for patient characteristics.

Results. Of 22,100 eligible decedents, 6,660 (30%) had an ACP document in the EHR and most (69%) were completed before the last six months of life, with 11% completed in the last 30 days of life. POLST forms (13%) were the least common ACP document, with increasingly higher documentation of health care directives (14%) and DPOA (20%). Earlier completion of ACP specifying treatment limitations were associated with reduced intensity of end-of-life care, whereas completion in the last 30 days of life was associated with increased intensity. Treatment-limiting POLST before the last 180 days had the strongest influence on end-of-life care, followed by treatment-limiting POLST between the last 30-180 days of life and healthcare directives before the last 180 days of life.

Conclusion. Treatment-limiting ACP documentation was associated with reduced intensity of care when completed more than 180 days prior to death.

However, treatment-limiting ACP documentation in the last 30 days of life was associated with higher intensity care, suggesting an inverse causal relationship that many of these documents are completed during hospitalization and that higher intensity care is leading to increased ACP documentation.