for medical treatment and end-of-life care, and durable powers of attorney (DPOA) allow them to identify an individual to make medical decisions on their behalf in the event they are no longer able. These laws vary greatly across time, place, and in their complexity. We estimated fixed effects model, which controls for time-invariant and state-specific factors affecting end-of-life care. Our primary outcome variable is the number of inpatient hospital days during the last six months of life, sourced from the Dartmouth Atlas Project. Our explanatory variables are hand-collected state-level legal statutes including whether the state (a) has default surrogate laws, (b) recognizes the ability to create a DPOA and/or AD, (c) permits oral directives, (d) authorizes a combined AD/DPOA, and (e) provides an official registry for ADs. Preliminary findings show recognizing DPOA and AD are negatively correlated with our outcome variable (-2.6 days; Std err 0.272) as are having default surrogate laws (-0.36 days; std err 0.157). However, allowing oral directives had an opposite effect (-4.46 days; std err 0.157). Neither authorized combined AD/DPOAs nor AD registries resulted with significant correlations. These findings indicate that the existence of a basic framework such as default surrogate laws and a law governing ADs are key policy features correlated with reduced intensity in end-of-life care.

EXPERIENCES OF LGBT PATIENTS AND FAMILIES WITH HOSPICE AND PALLIATIVE CARE: PERSPECTIVES OF THE PALLIATIVE CARE TEAM

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The lesbian, gay, bisexual, and transgender (LGBT) community experiences discrimination and stigma in accessing health care and social services – including palliative, hospice, and long-term care. Healthcare providers not recognize or address disparities in care. Providers and institutions may be uncomfortable with sexual orientation and gender identity and expression issues, and often don’t inquire about these. LGBT patients fear being open about their identities, not receiving equal or safe treatment, and having their family of choice and designated surrogates disrespected or ignored by healthcare staff. This study examines the degree to which hospice and palliative care providers report inadequate, disrespectful, or abusive care to LGBT patients and family members. A cross-sectional study using an online survey was completed by 865 providers, including social workers, physicians, nurses, and chaplains. Among respondents, 55% reported that LGB patients were more likely than non-LGB patients to experience discrimination at their institution; 24% observed discriminatory care; 65% reported that transgender patients were more likely than non-transgender patients to experience discrimination; 20% observed discrimination to transgender patients; 14% observed the spouse/partner of LGBT patients having their treatment decisions disregarded or minimized; and 13% observed the spouse/partner being treated disrespectfully. Qualitative data are presented to illustrate discomfort with LGBT patients and spouses/partners, disrespectful care, gossip and ridicule, inadequate care, and denial of care. Implications and suggestions for implementing non-discriminatory and respectful institutional and public policy, and for staff education and training to provide competent and respectful care to this population are presented.

FAMILY CAREGIVERS’ DECISION-SUPPORT NEEDS BEYOND THE DECISION AID

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Of the estimated 16 million U.S. family members currently providing essential yet unpaid caregiving for persons with dementia (PWD), many will also make end-of-life (EOL) care decisions as surrogates, a process that can be fraught with uncertainty. Even with dementia death rates rising, many families delay advanced care planning (ACP) discussions, and surrogate decision makers often lack crucial information and support, implicating the need to further study this topic in aging. While decision aids (DA) serve as a support tool for caregivers, they can be less effective when failing to address unresolved decisional needs. Utilizing the Ottawa Decision Support Framework (ODSF), which asserts caregiver decision needs affect decision quality, this study sought to identify surrogate decision-support needs extending beyond general ACP. This mixed study used cognitive interviews and focus groups with family caregivers (N=13) and healthcare professionals (n=14) to assess their knowledge and understanding of hospice and artificial hydration and nutrition. Data were audio-recorded, transcribed verbatim, and analyzed with thematic content analysis. Three main themes were identified: DAs alone aren’t enough to foster quality decision making for surrogates; individualized communication is necessary to clarify PWD and caregiver value priorities and disease trajectories; and clarification of the impact of care choices within situational contexts is quintessential. Further development is needed to create a practice protocol from these themes to inform professionals assisting surrogates in ACP at EOL. Practical implications from this study include highlighting the importance of individualized communication between PWD, providers, and caregivers in addressing EOL care decisional needs.

IDENTIFYING GAPS IN KNOWLEDGE AND BARRIERS TO UTILIZATION OF HOSPICE AND END-OF-LIFE CARE SERVICES

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Hospice and end-of-life (HEOL) services have traditionally been underutilized, especially in rural areas. A community assessment, performed in eastern Maine, sheds light on the extent to which public and health care professional attitudes and knowledge explain HEOL service access and utilization levels. Structured surveys were distributed in the fall of 2019 targeting community residents (18 years and older) and hospice/health care professionals. Residents (n=213) displayed significant levels of ignorance concerning the purpose and availability of HEOL services. Although a range of HEOL services were rated as highly important, residents were unable to confirm their actual availability. Overall, one in every two residents did not know if particular HEOL services existed locally (ranging from a low of 27% that were unsure whether grief support services were available to 67% unaware of the presence of a community hospice house). Hospice/health professionals (n=22) were aligned in their belief that the public did not have a clear understanding of the intent of HEOL services. Interestingly, community residents lacked equivalent measures
of confidence in the HEOL knowledge levels of health care professionals. Significant barriers to the timely utilization of HEOL services included: stigma/fear, lack of education as to the purpose of these services, financial barriers to access, and scarcity of selected HEOL services. For both respondent groups, the top ranking suggestions for increasing HEOL services utilization were earlier discussions between providers and patients concerning the need for such services and increased public and professional education around death and dying.

**IT'S LIKE WE SPEAK A DIFFERENT LANGUAGE: SUPPORT NEEDS AND PREFERENCES OF OLDER LGB WOMEN WHO HAVE LOST A SPOUSE OR PARTNER**

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Needs during and following end-of-life (EOL) experiences are distinctive for sexual and gender minority (SGM) people and, in particular, older lesbian, gay, and bisexual women (LGB) women; however, access to supportive services is limited. This poster presents findings from a qualitative study of older (60+) LGB women who have lost a spouse or partner. This work draws on queer gerontological theory, addressing issues of individual agency, systemic silence, and marginalization by invisibility of older SGM women in order to illuminate specific areas in which policy may be changed and improved. The study analyzed participants’ (n = 16) reflections on their experiences of losing a loved one, including how they sought out and received essential grief support and the type of support they would have preferred and from whom, particularly immediately following their spouse or partner’s death. Thematic analysis revealed three main findings: 1) having a women-identifying support presence at the time of death for both themselves and their spouse or partner; 2) needing LGB women (or women allies) during EOL for support; and 3) preferring grief groups comprised of other LGB women (or women allies) based on their feelings of difference from gay men and heterosexual/non-SGM women and men. Findings reveal the need for a better understanding among healthcare and social work support professionals regarding LGB women’s grief needs and preferences; grief options (e.g. lesbian and nonmonosexual (bi+) grief groups); and how to implement policy changes reflecting these needs and preferences.

**MEASUREMENT OF INEQUALITY AND COMPRESSION OF MORTALITY IN INDIA FOR 4 DECADES: 1970–2015**

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The studies relating to measurement of compression of Mortality in India is scarce. Most of the studies relating to mortality in India are focused on either life expectancy, or adult, and child mortality. We have used methods suggested by Kannisto (2000) and Canudos (2008) to measure the compression of mortality phenomenon for India for four decades viz. 1970-2015. Dispersion measures like simple mean, median, modal age at death; and some complicated measures like life disparity, standard deviation above mode, standard deviation in highest quartile, Interquartile range, Gini coefficient, AID and C-family were calculated for India from 1970-2015. We used the age specific death rates from abridged Life tables given by Sample Registration System published by Govt. of India. Our results show that inequality in mortality is decreasing in general but the gap between male and female is increasing. There was an average of three years difference in mean and modal age at death between male females in 2011-15. Overall, mean, median and modal age at death has increased in four decades but other inequality measures like Gini coefficient, AID, Standard deviation (SD) and coefficient of variation has decreased in four decades in India. C50 indicator, which indicates that 50 percent of deaths are happening in that age interval, declined from 26 years to 20 years for males and 27 years to 17 years for females, thus indicating the rate of compression of mortality is higher for females than males in India during 1970-75 till 2011-15.

**OLDER ADULTS’ PERSISTING BELIEFS ABOUT THE DEATH PANEL MYTH AND ADVANCE DIRECTIVES**

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The political debate preceding passage of the Affordable Care Act included controversy over a bill that some claimed would establish a “death panel” to judge if older adults were worthy of receiving medical care. This claim was false, as the bill would instead incentivize physicians to inform Medicare patients about advanced directives: legal documentation of one’s end-of-life preferences. However, the death panel myth led to the removal of this bill from the Affordable Care Act, and a poll five years later found 41% of Americans still believed in the death panel myth. We investigated the effects believing in this myth had on older adults, hypothesizing that those who believed in the myth would have lower advance directive completion rates and more negative attitudes towards advanced directives. Community-dwelling older adults aged 65 to 102 years (N = 182) in a large city in the southern United States completed an interview survey. No relationship was found between belief in the death panel myth and advanced directive completion; however, older adults who believed in the myth had lower perceived need for advanced directives than those who did not. Surprisingly, 47.1% of older adults who believed in the myth also supported incentivizing doctors to inform patients about advanced directives, suggesting that many older adults who believe in the myth do not know that the controversial bill was about advanced directives. Results suggest that the death panel myth may have long-lasting effects, specifically persistent distrust about policies promoting advance directives.

**REFRAMING THE END STAGE OF RENAL DISEASE: HOW AGE MATTERS**

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End Stage Renal Disease (ESRD) conveys high symptom burden, multimorbidity and the greater likelihood of hospital death than other serious illnesses. Increases in people with ESRD occurred most sharply among adults age 75+. Despite high mortality risk, few with ESRD consider end-of-life preferences or discuss with a physician. The purpose of this study