

large qualitative research is possible and holds promise as an effective method to illuminate complex processes influencing end-of-life care for NH residents with advanced dementia.

EVALUATION OF ONLINE PALLIATIVE CARE TRAINING FOR CERTIFIED NURSING ASSISTANTS

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Palliative care for older adults is increasingly needed due to a burgeoning older adult population. Certified nursing assistants (CNAs) in skilled nursing facilities (SNFs) provide assistance with activities of daily living and comfort care. There, however, is a significant gap in evaluated palliative care trainings for CNAs. We used a waitlisted control group design to evaluate the effectiveness of an 8-module online palliative care training. CNAs (n=102) from 6 SNFs were randomly assigned to an experimental (n=51) and a control group (n=51) and completed a baseline evaluation. The experimental group took a posttest about palliative care knowledge upon training completion and a 1-month follow-up assessment about palliative care self-efficacy. The control group completed the assessments at the same time as the experimental group prior to receiving the training. The majority of the participants were female (92%). On average, participants were 31 years old, with 6.5 years tenure in the field. The retention rate was 90% at the posttest (n=92) and 82% at the 1-month follow-up (n=84). Palliative care knowledge (scored 0–100) significantly increased in the experimental group (mean 4.1, $p < .05$), with no significant change in the control group. Palliative care self-efficacy (scored 20–100) significantly improved from the baseline to follow-up in both groups (mean 4.3 and 5.8 respectively, $p < .05$) with no significant difference between study groups. The results indicate the effectiveness of an online palliative care training to improve CNA knowledge. Improvement in palliative care self-efficacy regardless of training participation warrants further exploration.

GOALS-OF-CARE CONSULT AND FUTURE COSTS, ACUTE CARE AND HOSPICE USE IN MATCHED COHORTS OF AFRICAN AMERICANS AND WHITES

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African Americans receive less hospice care and more aggressive end-of-life care than Whites. Little is known about how palliative care consultation to discuss goals-of-care (“PCC”) is associated with future acute care utilization and costs, or hospice use, by race. To compare future acute care costs and utilization and discharge to hospice between propensity-matched cohorts of African Americans with and without PCC, and Whites with and without PCC, we conducted a secondary analysis of 35,154 seriously-ill African American and White adults who had PCC at a high-acuity hospital and were discharged 2014–2016. We found no significant difference between African Americans with or without PCC in mean future acute care costs (\$11,651 vs. \$15,050, $P=0.09$), 30-day readmissions ($P=0.58$), future hospital days ($P=0.34$), future ICU admission ($P=0.25$), or

future ICU days ($P=0.30$), but found greater discharge to hospice among African Americans with PCC (36.5% vs. 2.4%, $P<0.0001$). We found significant differences between Whites with PCC vs. without PCC in mean future acute care costs (\$8,095 vs. \$16,799, $P<0.001$), 30-day readmissions (10.2% vs. 16.7%, $P<0.0001$), future days hospitalized (3.7 vs. 6.3 days, $P<0.0001$), and discharge to hospice (42.7% vs. 3.0%, $P<0.0001$). Results suggest PCC decreases future acute care costs and utilization in Whites and, directionally but not significantly, in African Americans; and increases discharge to hospice in both races (15-fold in African Americans, 14-fold in Whites). Research is needed to understand how PCC supports end-of-life decision-making and hospice use across races and how systems and policies can enable effective goals-of-care consultations across settings.

RECOGNIZING DECLINE AND SUPPORTING CARE TRANSITIONS IN OLDER ADULTS: HOMECARE NURSE PERSPECTIVES

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Older adults with serious illness residing in the community are at risk for decline and death. Homecare Registered Nurses (RNs) are in an ideal position to recognize serious illness and engage older adults and their caregivers in discussions about goals for care, while guiding transitions to supportive care services such as palliative or hospice care. However, little is known about this process, or how homecare RNs act upon this information. Using a grounded theory approach, data were collected through focus group interviews with 35 RNs working in homecare. A social process rooted in relationship-based care over time was identified using the constant comparative method. RNs recognize serious illness and support care transitions by identifying changes in illness trajectories and assessing the impact of such changes on quality-of-life, adapting and accommodating care to support older adults in the home for as long as possible, communicating with the care team, engaging stakeholders, and maneuvering through complex systems of care; ultimately relinquishing care to other providers and settings. Our findings also reveal that RNs feel inadequately prepared and frustrated with a fragmented healthcare system and lack of collaboration among the team in supporting the best care transition for older adults and their caregivers. Our findings reinforce the importance of promoting care continuity in homecare settings whenever possible, suggesting a critical need to develop training and team processes that support and empower RNs, so that they may lead care transitions as changing needs emerge during serious illness management of older adults.

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ASSESSMENT (PAPER)

BALANCE AND REACTIVE STEPS IN OLDER ADULTS WITH AND WITHOUT SELF-REPORTED MUSCULOSKELETAL CONDITIONS

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