Sheila Marshall,[5] Janice Keefe,[6] and Carole Estabrooks,[1]
1. University of Alberta, Edmonton, Alberta, Canada, 2. Staff, Edmonton, Alberta, Canada, 3. University of Alberta, Calgary, Alberta, Canada, 4. Centre for Health Evaluation and Outcomes Sciences, Vancouver, British Columbia, Canada, 5. University of British Columbia, Vancouver, British Columbia, Canada, 6. Mount Saint Vincent University, Halifax, Alberta, Canada

The aim of the "Trajectories" project is to compile measures of nursing home (NH) quality to better characterize the final year of life for residents. In the first phase, we worked with various stakeholder groups to identify their priorities to focus the selection of possible outcomes relevant to end-of-life needs. Policy- and decision-makers from 5 Canadian health regions participated in an on-line, modified Delphi process to reach consensus on 3-4 measures of each burdensome symptoms and potentially inappropriate care practices. NH residents and families or care aides participated in an interview process using the Action Project Method. To date, all participants identified pain, mental health care, polypharmacy, and dyspnea as priorities. Policy- and decision-makers additionally identified infections and acute care transfers as priorities, while residents and families additionally identified mobility, cognition, and pressure ulcer care as priorities. There was general consistency across groups in terms of priorities but additional measures seemed to reflect either a system-wide or more personal perspective, depending on the source. Data collection with frontline staff and managers is on-going. Moving forward, we will use this list of prioritized outcomes to quantitatively assess the trajectories of these outcomes and associated factors, and to create a profile that allows for monitoring of end-of-life care in NHs.

QUALITY OF END-OF-LIFE CARE FOR VIETNAM VETERANS: IMPLICATIONS FOR PRACTICE AND POLICY

Joan Carpenter,[1] Dawn Smith,[2] Hilary Griffin,[2] Daniel Kinder,[2] Joshua Thorpe,[2] Mary Ersek,[2] and Ann Kutney-Lee,[2] *1. Department of Veterans Affairs, Berlin, Maryland, United States, 2. Department of Veterans Affairs, Philadelphia, Pennsylvania, United States*

In federal response to the aging population of Vietnam-era Veterans, Congress directed the Department of Veterans Affairs (VA) to create a pilot program to identify and develop best practices for improving hospice care for this population. A first step in VA's response was to identify whether the end-of-life (EOL) care needs and outcomes of Vietnam-era Veterans differed from previous generations. Using medical records and bereaved family surveys, we examined clinical characteristics, healthcare utilization, and EOL quality indicators for Vietnam-era Veterans who died in VA inpatient settings between 2013-17. Contemporaneous comparisons were made with World War II/Korean War-era Veterans. Compared to prior generations, higher percentages of Vietnam-era Veterans had mental health/substance use diagnoses and disability. Similar percentages of family members in both groups reported that overall EOL care was excellent; however, post-traumatic stress disorder management ratings by families of Vietnam-era Veterans were significantly lower. Although current VA EOL practices are largely meeting the needs of Vietnam-era Veterans, greater focus on mental health comorbidity, including post-traumatic stress disorder, Agent Orange-related conditions, and ensuring access to quality EOL care in the community is warranted. Policymakers and healthcare professionals should anticipate more physical and mental health comorbidities among Veterans at EOL as Vietnam-era Veterans continue to age. Findings are being used to inform the development of standardized EOL care protocols and training programs for non-VA healthcare providers that are tailored to the needs of this population.

REVERSALS IN DECISIONS ABOUT LIFE-SUSTAINING TREATMENT AMONG TERMINALLY ILL OLDER KOREAN PATIENTS

suhyun kim,[1] and Jung-Ja Choi,[2] *1. Kyungpook National University, Daegu, Republic of Korea,*
2. Kyungpook national university, Daegu, United States

Purpose: The purpose of this study was to investigate the patterns and factors of reversals in decisions about life –sustaining treatment (LST) among older patients with terminal stage of chronic cardiopulmonary diseases. Methods: In a retrospective correlational descriptive study, data were collected using medical chart review from 124 deceased older patients with terminal stage of cardiopulmonary disease who had made reversals of LST decisions in an academic tertiary hospital in 2015. Multivariate logistic regression analysis was used to identify the factors associated with the reversal to higher intensity of LST treatment. Results: Primary decision makers were offspring (72.6%), spouse (13.7%), acquaintance (8.9%), and patients (4.8%), in order. While 31.5% of the reversed decisions were made toward higher intensity of LST, 21.9% were made toward lower intensity of LST, and 46.6% were made for each treatment without change of overall code status. The use of inotropic was the most frequently reversed LST treatment (47.5%), followed by CPR (30.6%), intubation (27.4%), ventilator therapy (24.2%), and hemodialysis (17.8%). Patients who had lung diseases (vs. heart diseases), were single, divorced or bereaved (vs. married), and had acquaintance as a primary decision maker (vs. patients themselves) were significantly more likely to reverse the LST decisions to higher intensity of LST treatment. Conclusion: This study demonstrate the complex and turmoil situation of the LST decision making process among older patients with terminal stage of cardiopulmonary disease and suggests the importance of support for patients and families in their LST decision making process.

SELF-REPORTED FEARS BY HOSPICE PATIENTS AT THE END OF LIFE

Jeannette Kates, *Thomas Jefferson University, Philadelphia, Pennsylvania, United States*

Fear is a common emotion that involves the intense anticipation of threat to a person. At end of life, this fear is often conceptualized as existential distress, which suggests a connection to spirituality. Processing impending death is essential to end-of-life closure and acceptance. Existing evidence suggests that spirituality is associated with greater coping, better psychosocial well-being, and dignified dying; however, the relationship between fear and spirituality at end of life, as well as the specific fears experienced, are not known. The purpose of this study was to explore the relationship between fear and spirituality in patients upon hospice admission. In