

multidisciplinary assessments, team huddles and care recommendations. Underlying implementation is an organizational change process. Study aim was to evaluate the implementation and outcomes of SAFE Care™ in three additional hospitals. Two units from each hospital were randomized to SAFE Care™ or usual care. Process evaluation employed semi-structured interviews. Inpatients were aged 65+ years with positive frailty risks (N = 1,151). Outcomes evaluated ICU admission, length of stay (LOS), and discharge destination. All outcome analyses were conducted with intention to treat models. Patients were on average 80 years old, 54% female, 58% Caucasian, 83% English speaking, with 3.4 positive frailty risks. Median LOS was 4.2 days, 6.5% ICU admissions, 32% discharge institutional care. Hospitals differed in patient demographics and outcomes. While no differences between treatment groups in patient demographics, intervention patients had more frailty risks and longer expected LOS. 62% of intervention unit patients received intervention. There were no univariate treatment effects on outcomes. In multivariate analysis, intervention unit patients had shorter LOS. While hospitals reported different experiences, all reported challenges in preparing the electronic health record to support SAFE Care™. Staff reported increased interprofessional team communications. Differences among the hospitals in patients and organizational attributes argue strongly that implementation should be tailored to meet varying institutional needs while common measures and processes underlying implementation should be followed closely.

#### WHOLE-PERSON, WHOLE-TEAM APPROACH TO QUALITY IMPROVEMENT: WHY PERSON-CENTERED CARE MATTERS

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The Department of Veterans Affairs (VA) began its culture transformation journey in 2006, supporting its nursing homes in providing high-quality, person-centered care in person-centered environments. We implemented a quality improvement intervention to support frontline staff from low-performing VA nursing homes in providing high-quality care using a whole-person, whole-team approach. The intervention consisted of a bundle with four components: 1) specialized frontline staff huddles that encouraged high-quality frontline staff communication and collaboration, 2) micro-root cause analyses and targeted interventions to promote resident sleep and reduce resident falls through individualized care, 3) in-depth frontline conversations regarding residents' distress behaviors and mobility, and 4) targeted, team-based, person-centered performance improvement projects. The intervention was implemented at 8 low-performing VA nursing homes (August 2018 - April 2019) via in-person and virtual sessions and facilitated through CLC-based champions and intervention team-based coaches. We monitored the intervention's impact using

pre-post Centers for Medicare and Medicaid Services quality star ratings. We also conducted 17 post-intervention interviews with key informants at 7 participating nursing homes and conducted a content analysis of the data. Pre intervention, all 8 nursing homes had a history of being 1 or 2 stars in overall quality. Post intervention, 3 homes increased 1 star; 1 home increased 2 stars; 2 homes increased 3 stars; 2 homes increased 4 stars. Post intervention, participants perceived improved delivery of person-centered care (e.g., providing individualized sleep hygiene, de-implementing alarms). Our findings suggest a whole-person, whole-team intervention can effectively and efficiently improve both person-centered care and care quality.

#### SESSION 2924 (PAPER)

##### FALL PREVENTION II

#### BIDIRECTIONAL LONGITUDINAL RELATIONSHIPS BETWEEN HOMEBOUND STATUS AND FALLS AMONG OLDER ADULTS

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Research has shown an association between homebound status and falls among older adults. However, this association was primarily drawn from cross-sectional studies. Using the National Health and Aging Trends Study, we examined 1) whether prior-wave falls predicted homebound status in a later wave in 2,916 non-homebound participants in Wave 1 and 2) whether prior-wave homebound status predicted falls in 2,512 participants with no falls in Wave 1. Homebound status (non-homebound and homebound) was determined by the frequency, difficulty, and needing help of outdoor mobility. Falls were ascertained by asking participants whether they had a fall in the last year. Generalized estimation equation models were used to examine their bidirectional association, adjusting for demographics, health-related, and behavioral factors. Participants who had fallen in later waves were more likely to be older non-Hispanic black, comorbid, and have more pain, depression, disabilities, worse health status vision impairment, and low physical activities. Participants who were homebound in later waves tended to older, female, non-Hispanic black, less-educated, living alone or with others only, comorbid, obese, and have more pain, depression, disabilities, worse health status, more hospitalizations, vision and hearing problems, and low physical activities. Previous falls significantly predicted later homebound status (adjusted odds ratio [OR]: 1.28, 95% CI: 1.09-1.50). Prior wave homebound status also significantly contributed to falls in the next year (adjusted OR: 1.28, 95% CI: 1.12-1.46). The bidirectional longitudinal association between homebound status and falls suggests a vicious circle between them. Fall prevention programs should particularly target homebound older adults for falls reduction.