adults have 3 or more chronic illnesses. Chronic illnesses require significant self-management or management by nursing staff. This paper highlights the use of a change model to assist in sustaining nursing interventions in assisted living environments. We utilized embedded sensors measuring heart rate, respiratory rate, time in bed, restlessness in bed, and gait parameters to manage chronic illness. The embedded sensors use an algorithm to signify when a measure has changed for a resident, based on the past 2 weeks of data. Early health messages are emailed or texted to nursing staff. Nursing staff can use these messages as tools to further assess the resident's condition. It was important to revisit the education, hold the staff accountable, phone in suggestions/reinforcement of what the alerts meant, and provide positive messages. This interdisciplinary study has been deployed in 6 assisted living settings (n=386) (facility-wide) in the midwest. We used a wait-list control group (n=482) of facilities awaiting sensor installation. Outcome variables included length of stay, hospitalizations, falls, and medication changes. Results included a decrease in all outcome variables length of stay 1.98 years longer (F=3.67; p=0.003); hospitalizations (F=2.15; p=0.048); falls (F=1.899; p=0.012); and medication changes (F=3.9; p=0.0008) when compared to the control group. We feel these results may benefit other clinicians in the future when implementing new protocols and practices.

USING CHRONIC DISEASE SELF-MANAGEMENT TO ENHANCE PATIENT-PROVIDER PARTNERSHIPS

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The Partners in Aging Strategies and Training (PAST) project employed a bilateral approach to educate both healthcare professionals and consumers. Our theory is that improved health outcomes are attained by teaching healthcare providers and consumers how to engage better with each other, especially when consumers use the skills learned in community-based programs, such as self-management and healthy lifestyle choices. PAST activities provided an integrated educational program for healthcare providers and older adult patients, their families and caregivers to learn skills that enhance their ability to form productive patient-provider partnerships. We used three types of training: 1) multi-disciplinary health professions and primary care provider continuing-education face-to-face workshops and webinars; 2) older adult patient and caregiver workshops, resource materials; and 3) reverse marketing comprised of sending information to physicians whose patients attended a workshop that included the topics covered in the workshops and the patients' three- to six-month action goals. We found that physicians who attended the grand rounds presentations were very receptive to the 'nuts and bolts' approach to things like doing a quick mobility assessment, effectively communicating with patients, health literacy, and referring patients to community-based non-medical services and supports. We conducted seven types of evidence-based workshops. Over 90% of participants gave permission to send a letter to their physician to tell them they attended the workshop. We used pre-post confidence scales based on each workshop's learning objectives to measure changes in workshop participants' self-management confidence. There was positive change in confidence for all seven workshops.

SESSION 4010 (SYMPOSIUM)

DIVERSITY IN HOSPICE AND END-OF-LIFE EXPERIENCES: THE INFLUENCE OF CHRONIC DISEASE AND SOCIOCULTURAL FACTORS

Chair: David Russell, *Visiting Nurse Service of New York, New York, New York, United States*
Co-Chair: Elizabeth A. Luth, *Weill Cornell Medicine, New York, New York, United States*
Discussant: Ruth Masterson Creber, *Weill Cornell Medical College, New York, New York, United States*

Hospice provides supportive and palliative services to persons nearing the end-of-life. Use of the Medicare hospice benefit has grown to cover nearly half of all Medicare decedents. Even more notably, hospice agencies now serve patients with a diverse range of terminal conditions, including those not traditionally served by hospices, such as dementia and heart failure. In addition to expanded use of hospice care by patients with multiple types of chronic disease, demographic transitions in the United States over the last several decades have also led to increased use of hospice services among patients with diverse socio-cultural and linguistic backgrounds. Limited research has identified the unique experiences of patients enrolled in hospice who have diagnoses of dementia and heart failure, or explored how socio-cultural factors act to influence the course and outcomes of hospice care. This symposium features interdisciplinary collaborations between academic researchers and clinical practitioners at a large non-profit hospice agency in a multicultural urban environment. These collaborations, which draw on multiple theoretical perspectives and research methodologies, shed new light on patient experiences in hospice and identify opportunities for improving care and comfort at end-of-life. Presentations will include an exploration of the unique symptoms and experiences of hospice patients with heart failure, an evaluation of a clinical program for heart failure hospice patients, an exploration of collaborative goal setting between patients-providers, and an examination of cultural health capital as it relates to race/ethnic and socioeconomic disparities in hospitalization among hospice patients, and factors for disenrollment among hospice patients with dementia.

SOCIAL AND CULTURAL FACTORS FOR HOSPICE CARE OUTCOMES: PERSPECTIVES OF PATIENTS, CAREGIVERS, AND PROVIDERS

David Russell,[1] Dawon Baik,[2] Lizeyka Jordan,[1] Frances Dooley,[1] and Ruth M. Masterson Creber[3], *1. Visiting Nurse Service of New York, New York, New York, United States, 2. Columbia University, New York, New York, United States, 3. Weill cornell Medical College, New York, New York, United States*

Use of hospice services in the U.S. has grown to cover an expanding number of patients with varying conditions and demographic characteristics. Notably, hospice agencies increasingly serve patients with diverse socio-cultural and linguistic backgrounds. Limited research has explored

how these factors act to influence the course and outcomes of hospice care, or their role in shaping race/ethnic and socioeconomic disparities in burdensome outcomes like acute hospitalization. This presentation uses the theoretical lens of Cultural Health Capital to explore how socio-cultural factors affect patient-provider interactions within the home hospice setting. Qualitative interviews were conducted with both providers (N=32) and patients/caregivers (N=7) at a large not-for-profit hospice agency in New York City. Themes identified from these interviews included prior knowledge and familiarity with hospice, family dynamics and social support, and linguistic and cultural barriers to care. Findings indicate the need for greater attention to socio-cultural influences on interactional dynamics within home hospice.

RISK FACTORS FOR DISENROLLMENT AMONG HOME HOSPICE PATIENTS WITH DEMENTIA

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Hospice delivers care to a substantial and growing number of individuals with primary and comorbid dementia diagnoses. Dementia diagnosis and racial/ethnic minority status are risk factors for hospice disenrollment. However, little research examines racial/ethnic disparities and other risk factors for hospice disenrollment among hospice patients with dementia. This paper uses multinomial logistic regression to explore sociodemographic and functional status risk factors for hospice disenrollment among 3,949 home hospice recipients with primary or comorbid dementia. Results indicate that patients with a primary dementia diagnosis, racial/ethnic minority groups, and those higher functional status have elevated risk of disenrollment due to hospitalization, disqualification, and electively leaving hospice care. Additional research is needed to understand why primary dementia diagnosis and underrepresented racial/ethnic status are associated with multiple kinds of hospice disenrollment so that hospice practice can be tailored to respond to the needs of these individuals.

CARE MANAGEMENT CHALLENGES AND PROGNOSTIC TOOLS FOR HEART FAILURE PATIENTS IN HOSPICE

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Heart failure (HF) patients enroll in hospice at lower rates despite their worse prognosis. This multi-method study explores the characteristics and challenges associated with caring for HF patients. Data from qualitative interviews with hospice providers (n=32) and quantitative records (N=1,114) were used to identify care management issues and prognostic tools. Hospice providers described HF patients unique and often unpredictable symptomatology, their limited understanding and discordant hospice expectations, and difficulties managing symptoms at home. Providers also highlighted HF

patients use of assistive medical devices and complex medication regimens. Palliative Performance Scale (PPSv2) scores at hospice enrollment were found to be strongly associated with hospice survival (AUC: 7 days=0.80; 14 days=0.77) and live discharge risk (PPSv2 50-70% AOR=5.68 [CI=3.66-8.79]). Findings underscore the need for specially-tailored trainings and protocols for providers to prevent unplanned discharges and support HF patients at end-of-life.

THE DEVELOPMENT AND IMPLEMENTATION OF A CARDIAC HOME HOSPICE PROGRAM FOR ADVANCED STAGE HEART FAILURE PATIENTS

Lizeyka Jordan,[1] Ruth Masterson Creber,[2] David Russell,[3] and Dawon Baik[4], *1. Visiting Nurse Service of New York, New York, New York, United States, 2. Weill Cornell Medicine, New York, New York, United States, 3. Appalachian State University, Boone, North Carolina, United States, 4. Columbia University, New York, New York, United States*

Heart failure (HF) patients encounter distressing symptoms at the end-of-life including dyspnea, edema, and fatigue. Left untreated, these symptoms increase risk for hospice disenrollment. This presentation used the RE-AIM framework to examine a cardiac home hospice program for HF patients. Qualitative interviews with hospice providers (N=32) and quantitative medical record data were used to examine the program. Reach—1,183 HF participants were served between 2013-2016. Effectiveness—Enrollment of HF patients in the hospice program increased from 7.9% to 9.5% after the cardiac protocol was implemented. Adoption—implementation was spearheaded by a clinical champion aware of the challenges of HF symptom management. Implementation— additional support services (i.e., paramedicine, infusion services, cardiac comfort medication kits) were incorporated in the cardiac protocol to better manage complex clinical cases in the home. Maintenance— Reinforcing factors include ongoing training for nursing staff and a 3.5-hour introduction module providing information about HF case management and symptoms/treatments.

PERSPECTIVES ON SETTING GOALS OF CARE AMONG HOSPICE PATIENTS WITH HEART FAILURE, THEIR FAMILIES, AND HEALTHCARE TEAM

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Older adults with heart failure (HF) face many end-of-life care issues. Shared decision making (SDM) in hospice is an important process that allows HF patients and their family caregivers to discuss their preferences on goals of care (GOC) with their healthcare team. Yet, little research has explored how the values and preferences of HF patients and their family are integrated into their care plans through SDM process. This presentation examines facilitators and barriers to setting GOC among hospice HF patients. Qualitative interviews were conducted with HF patients/family caregivers