

end-of-life care in AL funded by the National Institute on Aging (R01AG047408), we investigate informal care partners' involvement in end-of-life care and identify challenges related to informal caregiving that might contribute to care burden. Grounded theory analysis of ethnographic data and in-depth interviews (average interview length = 97 minutes) with 59 racially and ethnically diverse informal care partners (mean age = 60) shows that informal care partner involvement in end-of-life care varies across participants and over time and is shaped by multiple intersecting social and structural determinants. At individual levels, these include many personal, situational, and relational factors. Personal factors include but are not limited to care partners' own physical and mental health and material resources (e.g., ability to pay for supplementary care). Situational and relational factors include care partners' awareness (or lack thereof) of residents' impending death and the quality of the caregiving relationship. AL and wider community-level factors include understaffing, staff turnover, inadequate hospice support, and lack of access to these services. We find that informal care partners navigate these caregiving challenges through a basic social process we conceptualize as "negotiating risks." Strategies for easing caregiver burden and improving informal care partner and resident quality of life at end of life are implicated.

DEVELOPMENT AND EVALUATION OF THE CARING AHEAD: PREPARING FOR END OF LIFE IN A DEMENTIA QUESTIONNAIRE

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A palliative approach is recommended in long-term care to support persons with dementia and help families prepare for end-of-life. Despite this, 50% of family caregivers of persons with dementia report feeling unprepared for death. A questionnaire is needed to assess caregiver death preparedness as an outcome measure for strategies within palliative care. A mixed methods design with qualitative and quantitative phases was used to develop and evaluate the 'Caring Ahead: Preparing for End-of-Life in Dementia' questionnaire. The questionnaire has 30 items organized into Medical, Relationship/Personal, Spiritual and Practical subscales with a 7-pt Likert response scale. To date, the questionnaire has been tested with 117 participants who are 61 years old on average, female (86%), adult children (77%) caring for a person with dementia in long-term care. The mean item score is 5.61 (SD 0.71). Participants report limitations in preparedness related to: 1) communication with healthcare providers about traditions and preferences for end-of-life care; 2) knowledge of the dying process and; 3) life purpose after death. A test-retest with 32 participants demonstrates a high degree of reliability; Intraclass Correlation Coefficient 0.91 (CI95%: 0.31-0.97). A moderate positive correlation between participant total scores and a single global preparedness item suggests concurrent validity, $r=.66$ (CI95%: 0.51-0.80). These findings will be used to refine the questionnaire and contribute a valuable measurement tool for clinicians, researchers and policy-makers working in palliative care.

LAST PLACE OF CARE AND END-OF-LIFE QUALITY OF LIFE IN THE UNITED STATES: EVIDENCE FROM A NATIONAL REPRESENTATIVE DATA SET

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Background: Quality of life (QoL) during last stage of life has raised expanded interests as an important aspect of person-centered care. Last place of care (LPC), refer to the last place decedents received their formal end-of-life care (EOLC), has been identified as a key indicator of older adults' end-of-life QoL, but the relationship was understudied. This study explores the association between LPC and end-of-life QoL among American older adults. Methods: Data used seven waves of Last Month of Life data with a total sample of 3068 Medicare decedents in NHATS. Outcome is end-of-life QoL assessed by eleven measures on four domains: pain and symptoms management (SP), quality of healthcare encounter (HE), person-centered care (PC), and overall quality of care (QC). LPC was categorized into home, hospital, nursing home, and residential hospice. Multivariate logistic regression analyses were used to examine the relationship with covariates. Results: LPC varied by most demographic characteristics, except immigration status and education. Older adults whose LPC is hospital, compared to those who had home-care, were less likely to have great experiences on HE, PC, and QC. People dying at nursing homes are more likely to receive care meeting their dyspnea and spiritual needs. Residential hospice is negatively related to respected care, clear coordination, and keeping family informed, but are more likely to provide PS and spiritual care. Discussion: Home-based end-of-life care has certain advantages but still has room to improve on SP and religious concerns. Hospitals should keep reforming their service delivery structure to improve patients' QoL.

RATES OF DIAGNOSES INDICATING OPIOID DEPENDENCE AFTER HOSPICE LIVE DISCHARGE: A NATIONAL STUDY

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Opioids are an important tool for managing Medicare Hospice beneficiaries' pain and symptoms. Little is known about the prevalence of opioid dependence among patients discharged alive from hospice. Using 100% Medicare hospice, acute inpatient, and Part B claims from Federal Fiscal Years (FY) 2017-2018, we identified hospice beneficiaries that were discharged alive during FY2017-2018 and associated with diagnosis codes in subsequent health care incidents indicating opioid dependence. We used a crosswalk from the Agency for Healthcare Research and Quality to determine which codes represented opioid dependence. We characterized beneficiaries and their hospice providers using information from the Medicare Enrollment Database and Provider of Services file. There were 468,204 live hospice discharges during FY2017-2018, among which 9,282 (2.0%) were