2003-2017, the rate of CVD deaths occurring at home increased from 21.3% to 30.9%, and rate of hospice facility deaths increased from practically none to 6.0%. Over the same period, the rate of hospital deaths decreased from 36.5% to 27.3%, and nursing facility deaths decreased from 25.1% to 20.6%. With the exception of conduction disorders, temporal trends in place of death were consistent across CVD diagnosis subgroups: ischemic heart disease, hypertensive heart disease, heart failure/cardiomyopathy, cerebrovascular disease, aortic stenosis, and all other CVDs. Differences between demographic groups persisted over the study period, with reduced odds of home death among Hispanic versus non-Hispanic (OR=.942; 95% CI .929-.955) decedents, Black versus White (OR=.837; CI .809-.866) decedents and greater odds of home death among decedents with some college education or more (OR=1.08; CI 1.06-1.09) versus decedents with a high-school education or less. In 2014, home surpassed hospital as the most common place of death for CVD patients. CVD patients often have acute and intense needs at the end of life that are challenging to manage in the home and the quality of care these patients receive should be further investigated.

ETHNIC AND DEMOGRAPHIC DIFFERENCES IN THE UTILIZATION OF ANCILLARY HOSPICE SERVICES

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Background: Research shows that ethnic differences exist in hospice service election, with fewer African American patients enrolling in hospice and having lower satisfaction with care compared to Non-Hispanic Whites. Hospice is interdisciplinary, with nursing care and "ancillary" services (social work, chaplain, nurses' aide, volunteer). Little research exists about whether disparities exist in ancillary service election, and if patient demographics correlate with service utilization. We examined if ethnic or demographic differences exist among hospice beneficiaries in utilization of hospice services. Methods: Mixed-methods data collection took place from two community hospices. The quantitative arm involved retrospective chart review on new admissions from 2012 to 2016: acceptance of ancillary services and demographic data were collected as well as code status and outcome of hospice admission. The qualitative arm collected interview data from hospice personnel about thoughts on hospice care, which patients they think might decline ancillary services, and why. Results: Chart review was completed on 491 patient charts: interviews of hospice staff are ongoing. Sample was 55% female, 77% white, average age 77.8 years. Initial analysis on demographic data did not show statistical significance in utilization. Declination was lowest for social work (3.4% declined) and highest for hospice volunteer (88.9% declined). Initial interview themes involved need for patient education and role of health literacy. Discussion: Initial research does not show statistical ethnic or demographic differences in ancillary service utilization. However, broad utilization differences exist between services. Data can identify areas where hospices can improve care accessibility through patient education and personalization of services.

ALIVIADO DEMENTIA CARE-HOSPICE EDITION: FEASIBILITY AND ACCEPTABILITY RESULTS OF A TWO-PHASED PILOT STUDY

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Limited work has been performed in helping hospice agencies to care for persons with dementia (PWD) and their caregivers in an evidence-based manner despite the increasing number of PWD cared for in this setting. To change the culture of care for PWD and their caregivers receiving hospice, we adapted Aliviado Dementia Care, an evidenced-based interdisciplinary quality improvement program, for use in hospice. The purpose of this pilot study is to examine feasibility and applicability of implementing the Aliviado Dementia Care-Hospice Edition sequentially in 2 hospice agencies in preparation for a nation-wide pragmatic trial. In the first pilot, concluded in March 2019, seven hospice interdisciplinary clinicians were trained as program champions and completed a two-day in-person intensive training on dementia symptom assessment and management, and quality improvement processes. Additionally, 47 interdisciplinary team (IDT) members were provided training via a 5-hour, online program covering dementia symptom assessment and management. All champions trained (100%) reported being satisfied/very satisfied with the program and agreed that the training is applicable to hospice practices. All IDT members who completed the online training (100%) reported being satisfied/very satisfied with the program quality, or agreed/strongly agreed that the content was relevant. The high rates of satisfaction and applicability, reported by the hospice champions and IDT members, provided preliminary evidence supporting the feasibility and applicability of the Aliviado Dementia Care-Hospice Edition.

CHRONIC DISEASE AND TERMINAL DECLINE IN VERY OLD MEN: THE MANITOBA FOLLOW-UP STUDY

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The Manitoba Follow-up Study is in its 71st year of continuous operation. Since 1948, 3,983 aircrew recruits to the Royal Canadian Air Force during the Second World War have submitted routine medical examinations and completed questionnaires. On May 1, 2006, 1001 of these men (25%) were alive mean age of 86 years. The effects of 7 chronic diseases (CDs) diagnosed before 2006 were modeled with multinomial logistic regression to predict the pattern of decline of living and dying through an 11 year window to 2017. By 2017, 11% were still alive, 10% died very early in the window, 44% experienced a slow decline of a least three years to death, 17% experienced a step decline to death, and 18% experienced a terminal drop, death within six months of decline in functioning. Only 30% were free of CD in 2006; 36% had 1 CD, and 34% had more than 1 CD. As the number of CDs increased, the probability of remaining alive by 2017 decreased: 18% alive if no CD, 10% if 1 CD, 8% if 2 CDs, and 3% of >2 CDs. The chance of death with a terminal drop decreased: 22% if no CD, 20% if 1 CD, 14% if 2 CD, 11% if >2 CD. Conversely, the