type, and evolution of CBO engagement with health care providers. In addition, longitudinal analysis (n=374) shows movement at the organization level: 33% of organizations who did not have a contract at T1 but were pursuing one had achieved a contract by T2. This presentation will: describe details of the services delivered, contracting arrangements, and populations served under CBO/health care contracts, as well as challenges experienced by CBOs; examine differences by state and organizational structure; and discuss the implications of state policy on integrated care and contracting.

HOSPICE SERVICES IN THE HOME SETTING AND CHARACTERISTICS OF MEDICARE DECEDENTS

Pauline Karikari-Martin,[1] Lirong Zhao,[2] and Lynn Miescier[2], *1. U.S. Public Health Service Commissioned Corps, Rockville, Maryland, United States, 2. Centers for Medicare & Medicaid Services, Baltimore, Maryland, United States*

There is little empirical work documenting the characteristics of Medicare beneficiaries receiving hospice services in the home setting using the Medicare place of service codes. The objective of this study is to examine differences in Medicare decedents who received hospice services in traditional and non-traditional homes (assisted living, and nursing home settings) defined by these codes. We conducted a secondary analysis of 675,782 Medicare decedents who received hospice services in 2015. Chi-squared and ANOVA tests were used to describe the socio-demographics, health conditions, utilization, and hospice payments of the decedents. Most of the decedents received hospice care in a traditional home (64.9%), but beneficiaries, aged 85 years and over, received hospice services in assisted living (72.1%) or nursing homes (59.8%). Overall, decedents who received Medicare hospice benefits in assisted living had the highest number of hospice days (mean=149.7 lifetime days; median = 30; standard deviation (S.D.) =245), and decedents in traditional homes had the fewest number of hospice days (mean=86.7 lifetime days; median = 24; S.D. =179). Among Medicare–Medicaid (duals) decedents who used hospice care, 49% received hospice care in nursing homes, and infrequently, 7% at assisted living. Medicare hospice payments were highest ($20,439 per beneficiary) for decedents in assisted living, but least for those in traditional homes ($11,830). Hospice services offered to Medicare beneficiaries who are 85 years and older, duals, or have a diagnosis of dementia may require more oversight and coordination of resources to ensure that they receive appropriate hospice services in non-traditional homes.

PHYSICAL ACTIVITY PREFERENCES OF OLDER ADULT MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER CLIENTS

Victoria S. Davila,[1] Lauren Pietzak,[1] Danielle Rossi,[1] Karen Phipps,[1] and Margaret Danilovich[1], *1. Northwestern University, Chicago, Illinois, United States*

Despite the known effectiveness, physical activity (PA) is not currently offered to older adult clients receiving Medicaid Home and Community Based Services (HCBS). To optimize PA implementation within Medicaid HCBS, understanding client preferences for PA programming is needed. Thus, the objective of this exploratory qualitative study was to identify the PA preferences of HCBS clients including mode, duration, implementation strategy, and frequency, as well as barriers and motivators to PA. We recruited participants from the Illinois' Department on Aging Community Care Program. We conducted semi-structured interviews in participants' homes which were audio recorded, transcribed, and analyzed using Dedoose (version 7.0.23). We derived semi-structured interview questions from the Health Belief, Social Cognitive, and Health Action Process Approach framework. We used a structured coding approach using conventional content analysis to derive codes from the text, then applied these codes to each interview and examined the frequency to determine themes. The most frequently referenced theme was barriers to PA, primarily co-morbidities. The primary motivator was social support by a peer or instructor. The preferred PA program components were walking 2-3 days per week with duration varying from 20 minutes to 2 hours. Clients also preferred individualized PA instruction versus a passive strategy such as pamphlets or videotapes. Our findings show that individual-level factors most significantly influence PA participation and should be addressed among Medicaid HCBS clients. We recommend Medicaid HCBS consider a personalized approach of PA implementation with their clients.

WHAT CAN COUNTY-LEVEL EMERGENCY MEDICAL SERVICES DATA TEACH PUBLIC HEALTH ABOUT OLDER ADULT FALLS

Carolyn R. Ham,[1] Xinyao deGrauw,[1] and Scott Dorsey[2], *1. Washington State Department of Health, Washington, United States, 2. Snohomish County Fire District 7, Snohomish County, Washington, United States*

Fall-related injuries in older adults contribute to an increasing number of deaths, hospitalizations and Emergency Medical Services (EMS) responses. In Snohomish County, the third largest county in Washington State, EMS agencies with electronic health records cover 96% of the county's population. This EMS data contains unique information on falls, which can estimate costs and clarify intervention priorities. We analyzed 2018 data from EMS in Snohomish County. Fall incidents were summarized by count, frequency, and rate per 1,000 population. Costs for transferring patients to emergency departments (ED) were estimated using 2015 Snohomish Community Paramedic Analysis, and direct medical costs averted by implementing a single intervention were estimated based on prior research by Stevens and Lee (2018). There were total 38,910 incidents in older adults, of those 4,777 incidents were caused by falls (1606 in males and 2906 in females). The mean age (SD) was 81.0 (±8.9). The incidence rate was 45.6 per 1000 (55.8 in females and 30.6 in males). There were 573 repeated falls (12%). Most of the falls happened at home (54.85%), followed by assisted living and nursing homes (27.84%). 85.53% of the falls were transferred to ED, at an estimated cost of 3.15 million dollars. We calculated that one million dollars in medical cost could be averted by implementing home modifications delivered by an occupational therapist (OT). This research demonstrates the utility of EMS data for describing fall injury and determining interventions. Fall prevention programs should focus on preventing repeated falls and addressing home safety risks.