PRE-LOSS GROUP THERAPY FOR FAMILY CAREGIVERS OF PERSONS WITH DEMENTIA: TRANSLATION INTO PRACTICE

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We developed Pre-Loss Group Therapy (PLGT) for dementia caregivers at risk for Complicated Grief (CG). PLGT is a manualized ten-session multi-modal group therapy that includes elements of cognitive behavior therapy, motivational interviewing, exposure therapy, memory revisiting, meaning-making, and self-care. We implemented and evaluated three PLGT cohorts in three long-term care facilities with family caregivers at-risk for CG whose care recipient had a life expectancy of 6 months or less and resided in a long-term care facility (NT = 24). Evaluation of participant preparedness for the death of the persons with dementia (PWD), self-care and grief outcomes showed significant improvement across multiple domains between pre and post-group, notably a statistically significant decrease in grief as measured by the Inventory of Complicated Grief score from baseline (M = 25.67, SE=1.80) to post-group (M = 14.41, SE=1.65) $t(21)= 6.280$, $p<0.001$. Clinician-rated grief severity declined (N=22, $\beta = -0.472$, SE = 0.018, $p < 0.001$) per week and grief improvement increased (N=22, $\beta = 0.259$, SE = 0.023, $p < 0.001$) per week, as assessed on the Clinician Global Impressions Scale. We subsequently trained two LCSWs to conduct PLGT, and both clinical outcomes and treatment fidelity and skills measures achieved performance levels of master clinician-trainers. Family caregivers at risk for CG may benefit from group therapy targeting preparedness and pre-loss grief experience, as we provide with PLGT. Manualized PLGT is suitable for implementation by LCSWs in the settings of hospice and long-term care.

RURAL-URBAN DIFFERENCES IN SURVIVAL AND NURSING HOME USE AMONG MEDICARE BENEFICIARIES DIAGNOSED WITH DEMENTIA

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There is poor understanding as to how survival and healthcare utilization vary among older adults living with Alzheimer's disease and related dementias (ADRD) in rural versus urban areas of the United States. This prospective cohort study used 2008-2015 Medicare claims linked with nursing home and home health assessment data to describe differences in survival and healthcare utilization in the six years following a new ADRD diagnosis between rural and urban populations. The sample consisted of 1,203,897 Medicare fee-for-service beneficiaries who were diagnosed with ADRD in 2008 or 2009. 77% (n=921,853) resided in metropolitan counties, 14% (n=162,857) in micropolitan counties, and 10% (n=119,187) in rural counties. Rural residents were on average about six months younger than metropolitan residents at diagnosis. Metropolitan residents survived a mean of 1211 days after diagnosis. Adjusting for individual characteristics, beneficiaries in rural and micropolitan counties survived 29.2 fewer days (95% CI -34.0,-24.4) and 31.9 fewer days (95% CI -36.1,-27.7) than metropolitan residents, respectively. Compared to metropolitan residents, rural residents spent 59.8 more days (95% CI 56.7, 63.0) in nursing homes. We found similar patterns in nursing home use for micropolitan vs. metropolitan residents, though the magnitude of the differences was smaller. Differences between groups became more pronounced the greater the time from diagnosis. These findings demonstrate that urban-dwelling older adults with ADRD are significantly more likely to remain in the community and less likely to use nursing homes than individuals in rural and micropolitan counties, particularly in later disease stages.

THE IMPACT OF CHANGING THE CMS NURSING HOME COMPARE 5-STAR RATINGS ON THE USE OF ANTIPSYCHOTICS

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Due to their potential to increase falls and death in people with dementia, antipsychotic medications (APMs) have been the subject of several federal efforts to reduce their use in nursing homes (NHs). In 2015, the Centers for Medicare & Medicaid Services added inappropriate APM use to their NH 5-star quality ratings. We examined the impact of this policy decision on NH residents with dementia by race/ethnicity. Using a quasi-experimental study design and Minimum Data Set (MDS) 3.0 assessments, we examined long-stay NH residents with dementia. We examined changes in APM use quarterly (2013-2016) using interrupted time series analyses, stratified by race/ethnicity. There were about 1 million NH residents per quarter. Baseline use of APMs among persons with dementia was 29.1% for Whites, 29.2% for Blacks, and 33.7% for Hispanics. All three races experienced significant declines in APM use prior to the addition of AP use into the quality rating ($p<0.001$). During the first quarter of rating system changes, there were significant declines in APM use for all three races: Blacks, 0.48%; Hispanics, 1.0%; Whites, 0.49%. Subsequent rates of decrease in APM use did not differ from the baseline rate of decline ($p> 0.5$). The policy change did result in a one-time, significant drop in APM use, but did not alter the rate of decline already in place, presumably stemming from the National Partnership instituted in 2012. Hispanics started with the highest rate of APM use and experienced the greatest decreases over time and with the new star rating measure.

SESSION 2830 (PAPER)

LONG TERM CARE: RESIDENTS, STAFFING AND ORGANIZATIONAL ISSUES

ADVERSE CONSEQUENCES OF UNMET IN-HOME MOBILITY CARE NEEDS AND RISK OF HOSPITAL STAY AMONG OLDER ADULTS IN THE UNITED STATES

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Mobility limitations are the most prevalent late life disability and are strongly associated with negative health

outcomes. Research suggests that 1 in 5 older adults with limitations in activities of daily living report needing more help than is received. The objective of this study is to address a gap in the literature by directly examining the relationship between adverse consequences (e.g. home-bound, bedridden) of unmet in-home mobility care needs and hospital stay for a national sample of community-dwelling older adults. Data was analyzed from round eight (2018) of the National Health and Aging Trends Study (NHATS), an epidemiologic panel study of nationally representative Medicare beneficiaries ages 65 and older living in the communities (n = 4,344). Community dwelling adults with one or more adverse consequence due to in-home mobility limitation had 1.931 times odds of hospital stay in the last 12 months, compared to the counterpart with no in-home mobility limitation (OR = 1.931, SE = 0.153, $p < 0.05$), after adjusting for the covariates. Community-dwelling older adults who have adverse consequence due to unmet in-home mobility care needs are more likely to be immobile and are more likely to have hospital stays. By addressing the needs of this population, the rate of hospitalization can be decreased resulting in fewer stressful events and better quality of life. Policies to improve long-term services and supports and reduce unmet need could benefit both older adults and those who care for them.

CHARACTERIZATION OF SKILLED NURSING FACILITY RESIDENTS ADMITTED WITH SUBSTANCE USE DISORDERS

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For reasons including the opioid epidemic and more widespread substance use across all ages, the prevalence of individuals meeting preadmission criteria for skilled nursing facility (SNF)-level care and who have substance use disorders (SUDs) is growing. However, little is known about this population. We characterized a sample of residents with SUDs in two SNFs that target admission of difficult-to-place individuals in Hartford, Connecticut. Residents admitted between June 1, 2018 and May 31, 2019 and had an SUD per Pre-Admission Screening and Resident Review (PASRR) were included. Using retrospective chart review, we collected data including demographics, physical and mental health conditions, psychiatric medications, and participation in SNF-provided SUD counseling. Of 163 residents admitted with an SUD, all were admitted following an acute hospitalization. Residents' average age was 49.9(SD=11.7) years (range 21-79). They were 61% male and racially diverse; 56% Caucasian, 27% Hispanic, 16% Black. SUDs on admission included opioid use disorder (48%), alcohol use disorder (33%), unspecified psychoactive SUD (26%), cocaine use disorder (25%), and Other (20%). Of these, 18% and 16% were taking methadone or suboxone, respectively and 25% were taking an antipsychotic medication. Comorbidities such as bipolar disorder (15%) and viral hepatitis (26%) were prevalent. A total of 40 (25%) residents participated in SUD counseling; none of the aforementioned factors was associated with participation. This is the first study to characterize a sample of residents from SNFs that target individuals with SUDs. Improved understanding of this unique and growing subset of the SNF population may help optimize their treatment.

DEVELOPING LIFE STORIES FOR NURSING HOME RESIDENTS AND EXAMINING THE IMPACT ON RESIDENTS AND STAFF

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A life story program was implemented in 16 nursing homes (NHs) in Ohio with partners including a company specializing in life story work and a gerontological institute. The aim was to evaluate the impact of the life story program on residents and staff. NH sites were selected from an urban/suburban and a rural county using sampling procedures ensuring variation in auspice, quality star ratings and bed size. A longitudinal design was used to conduct in-person interviews with residents at baseline (prior to the life story interview), immediately after the interview, and approximately a month after most life story books were delivered to a NH. Resident eligibility criteria included being age 60 or older, Medicaid-eligible, long-stay and having no to moderate cognitive impairment. Residents' (n=238) average age was 77 years, 66% were female, and 52% had resided in the NH for 1-5 years. Cognitive scores declined over time, but depressive symptomatology improved significantly. Residents had very high levels of satisfaction with care, enjoyed telling their life stories and would recommend the program; these findings did not change. A pre-post study design was used with staff (n=198), who included nurse aides, nurses, administrators, social workers and activity staff. Their average age was 44 years. Although staff job satisfaction did not change significantly, the vast majority enjoyed learning about residents' life stories and used them in care planning. The findings demonstrate that life story work may be useful in promoting person-centered care, although further testing is needed with a more generalizable sample.

VALIDATION OF THE MEDSAIL TOOL TO SCREEN FOR CAPACITY TO LIVE SAFELY AND INDEPENDENTLY IN NURSING HOME RESIDENTS

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Capacity for safe and independent living (SAIL) refers to an individual's ability to solve problems associated with everyday life and perform activities necessary to live independently. Little guidance exists on the assessment of capacity for SAIL among nursing home residents. As a result, capacity for SAIL is not fully considered in the development of discharge plans to ensure safety and independence in the community. The Making and Executing Decisions for Safe and Independent Living (MEDSAIL) tool was developed to screen for capacity for SAIL among community-dwelling older adults. In this cross sectional pilot study, we tested the