

and psychiatric comorbidity were similar in both cohorts; however, MFH Veterans were more likely to have traumatic brain injury ($p < 0.01$), higher Patient Health Questionnaire (PHQ)-9 depression scores ($p = 0.04$) and less likely to have anxiety ($p = 0.05$). Our results suggest there are two distinct MFH populations, one with lower-care needs and another with Veterans completely dependent in performing ADLs. Given these findings, MFHs may be an ideal setting for both low-care nursing home residents with less functional impairment as well as residents with higher care needs who desire community-based long-term care.

FUNCTIONAL STATUS ASSOCIATED WITH RISK OF READMISSION DURING HOME HEALTH CARE FOR PATIENTS WITH DEMENTIA

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Approximately 14.0% of Medicare beneficiaries are re-admitted to a hospital within 30-days of home health admission. Individuals with dementia account for 30% of all home health care admissions and are at high-risk for rehospitalizations. Our primary objective was to determine the association between functional status and social support at admission to home health and 30-day potentially preventable readmissions (PPR) during home health care. We conducted a retrospective cohort study of 124,119 Medicare beneficiaries receiving home health (7/2013 – 6/2015) and diagnosed with dementia (ICD-9 codes). Approximately 65% of participants were over the age of 81, 61% were female, and 80% were Caucasian. The primary outcome was 30-day PPR during home health. OASIS items were used to create mobility, self-care, social support, and cognition categories. The overall rate of 30-day PPR was 7.6% (95% CI: 7.4-7.7) but varied by patient and health care utilization characteristics. After adjusting for sociodemographic and clinical characteristics, the odds ratios (OR) for the most dependent score quartile versus the most independent was 1.68(1.56,1.80 95% CI) for mobility, 1.78 (95% CI: 1.66-1.91) for self-care, and 1.10(95%CI: 1.03-1.17) for social support. The OR for impaired versus intact cognition was 1.12 (95% CI: 1.05-1.20). Impaired functional and cognitive status as well as limited social support at admission to home health care are associated with increased risk of PPR for individuals with dementia. Future research is needed to determine if strategies targeted at mobility and self-care can decrease PPR during home health for individuals with severe dementia.

HOME HEALTH CARE AS A PREDICTOR OF SURVIVAL AMONG PEOPLE LIVING WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

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Over the past 10 years, dementia care has been shifting to the community; however, there are significant regional and sociodemographic differences in the use of formal home health care services. Does the use of home health care improve survival and other outcomes among people diagnosed with dementia? The aim of the study was to determine the individual, societal, and health systems predictors of survival after a diagnosis of dementia. Using linked Medicare administrative, claims, and assessment data (N = 4,349,565); we found that home health care significantly reduced risk of death for males, but not females. This effect was strongest among older adults between the ages of 65 and 80. While men who were living alone or in a congregate/assisted living environment benefited the most (O.R. = 0.87) the effect was also strong for men living with a spouse or other caregiver (O.R. = 0.90). These findings suggest home health care may provide a survival advantage for men through the provision of rehabilitative and supportive services, as well as patient and family caregiver education. Further research is needed to understand if sex based survival differences are associated with the intensity of home health care services provided or social determinants of health.

SNF TO HOME: OUTCOMES OF THE SNF RE-ENGINEERED (RED) DISCHARGE PROCESS

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Re-engineered (RED) Discharge Process has been effective in hospitals but little tested in SNFs. This study tested the effect of an 18-month adapted RED implementation in four Midwestern SNFs on 30, 60, 180 day hospital, SNF, and emergency department (ED) readmissions. The sample included 1026 SNF residents discharged to the community during 2013 (n = 526) and 2015 (n = 500). We used Medicare claims Data and Minimum Data Set (3.0) File to identify SNF admissions and readmissions to SNF, acute care, or ED. Data were linked across all four facilities by year and compared using appropriate statistics for descriptive, comparison, and regression tests. Residents discharged in 2013 had statistically significantly higher Charlson Comorbidity Scores 4.65 vs 3.97 in 2015 ($p < 0.01$), while those discharged in 2015 had significantly worse cognitive status, mood, and ADL self-performance. Overall, rates and number of 30, 60-day, 180 rehospitalization, SNF re-admission, ED visits with rehospitalization were lower for all 2015 compared to 2013, but not statistically significantly different, except for the number of 180-day rehospitalizations in 2015. Likewise, the only statistically significantly different result was in the regression model was 180 day rehospitalizations. However, in the two facilities that had the best uptake of the intervention, numbers of readmissions were lower at 60 and 180 days ($p = .0106$ and $.0013$, respectively for regression results). SNF RED may be a useful tool for SNFs to use to reduce rehospitalizations after discharge; however, benefit depends on the degree of adoption of the intervention.