

resource, and service needs. We compared the service needs and utilization patterns of 334 co-resident grandmothers who were participants in two independent NIH-funded studies of grandmothers raising grandchildren, conducted 10 years apart (2008-2009:n=145 and 2018-2019:n=189). Researchers asked both samples whether they received or had an unmet need for 16 types of services (ex: financial, legal, substance abuse, respite care). There were statistically significant differences between the samples on 8 of 16 services received, and 15 of 16 unmet, but recognized, service needs, with our current sample reporting higher usage and need. The largest percentage increases in need were financial assistance (31.5%), respite care (29.9%), exercise/fitness (26.4%), and family therapy (25%). Although there is a 7% increase in legal services received between the samples, 48.1% of the 2018-19 sample still report unmet legal needs, compared to 16.6% of the 2008-09 sample. We observed a significant difference in an unmet need for help to families dealing with drug and alcohol abuse, with 23% of current participants reporting unmet need, compared to 9% in the prior study. Our results highlight a gap in resources available to grandfamilies and highlight the need for intervention and evaluation research targeting service needs to inform policy change.

#### EVALUATING A CONSUMER-DIRECTED HEALTH CARE PILOT FOR OLDER PEOPLE IN THE COMMUNITY

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In an ageing society with a policy focus on community (Oireachtas 2017), providing choice and self-determination in home care provision for older people is fundamental. Consumer directed care has increased in popularity in many countries (Low, Yap & Brodaty, 2011). In 2016, planning began in Community Healthcare Organisation 3 to pilot a CDHC pilot for community based older people. This study presents the findings of this pilot project. The study used the Moore et al.'s (2015) evaluation approach. Data collection methods were via descriptive questionnaires with qualitative investigation of stakeholder experiences as well as an economic review. Findings demonstrated the need for additional clarity in understandings of the CDHC. Care recipients and caregivers did report satisfaction with care, however, it was the accessibility of care rather than choice that was considered important. There were also issues related to capacity to manage the CDHC as well as capacity to give a choice of providers, particularly in rural areas. Although, broadly cost-neutral, processes and structures also require additional alignment to enhance both effectiveness and efficiency. Empowering care recipients and enabling greater choice, flexibility and autonomy in care organisation and delivery was a central focus of the CDHC pilot. However, additional consumer awareness and programme enhancement is needed to fully realize the potential of the CDHC. Study recommendations focus on areas of increased clarity about the CDHC, implementation enhancement, complementarity and incorporation of CDHC with existing home support service provision arrangements

#### WHY DON'T OLDER ADULTS USE SENIOR CENTERS? EVIDENCE FROM A SAMPLE OF MASSACHUSETTS ADULTS AGE 50 AND OLDER

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Senior centers are an integral community resource, providing programs and services intended to meet the vast range of needs and interests of older adults. There is a growing literature describing senior center participants and benefits to participation, but little is known about those who choose not to participate at a local senior center. This presentation uniquely characterizes non-users of senior centers, based on a sample of community-dwelling adults aged 50+ from seven communities in Massachusetts (N = 9,462). To date, this is the largest data set that describes senior center usage. Most of the sample were women (60%) and in the 60-69 age group (36%). More than three quarters of the sample do not use the local senior center (77%). The most common reasons for non-usage were lack of interest (27%) and not feeling old enough (26%). There are significant differences in reasons of non-usage among age groups and gender ( $p < .001$ ). Younger age groups' (50-69) most popular reasons for non-usage were not feeling old enough, not having time, inconvenient senior center hours, and not knowing what is offered. In contrast, older age groups (80+) more frequently reported having no interest or using programs elsewhere. Men were more likely to report not being interested and not being familiar with what is offered. Women were more likely to report not having time, inconvenient hours of programming, and using programs elsewhere. Based on results from this study, this presentation will outline implications for the future of senior centers and their programming.

#### MANAGING MANAGED CARE: PERSPECTIVES FROM KEY STAKEHOLDERS IN SKILLED NURSING FACILITIES

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In recent years, Medicare Advantage (MA) plan enrollment has increased, a trend that is expected to continue. Many skilled nursing facilities (SNFs) rely on MA managed care insurer referrals to maintain their census in a market with high competition for post-acute care patients. This study used semi-structured interviews to describe the relationship between MA plans and SNFs from the perspective of key decision-makers in SNFs. Twenty-three interviews were conducted with key stakeholders from 11 Denver Metropolitan area SNFs. A combined purposive-snowball sampling approach was used to identify and recruit select staff from the participating facilities. Interviews focused on the relationship between MA plans and SNFs, including mechanisms of

control, power dynamics, and preferences for MA versus Fee-for-Service (FFS) Medicare patients. Key findings included: 1) challenges SNF staff had navigating MA plans' case management processes, a key mechanism used by MA plans to influence the behavior of SNF decision-makers; 2) MA plans exercising power over beneficiaries' length of stay, potentially leading to early discharge and heightened risk for rehospitalization; 3) SNF preference for admitting Medicare FFS over MA patients due to higher rates of Medicare FFS reimbursement and greater control over patient care. SNFs are increasingly reliant on MA plans for patient referrals and revenue. The themes suggest that this growing reliance may place SNFs at odds with MA plans on how best to manage overall patient care. It is therefore important that future research investigate how MA plans' influence over care affects patient outcomes in SNFs and other post-acute settings.

#### MANAGING DEATH IN THE FIELD: HOW EMERGENCY MEDICAL SERVICES TEAMS PROVIDE END-OF-LIFE CARE

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Emergency medical services (EMS) providers respond more frequently to calls for older adults with serious illness than for people in other age groups. Recent legislation that makes it possible to document healthcare decisions has facilitated an era of choice in end-of-life care. EMS teams make time-sensitive decisions about care, resuscitation and hospital transport that influence how and where a seriously ill older adult will die and how his/her family will experience the death. Yet, EMS providers' perspectives on urgent decision-making and how they work with families are unknown. The purpose of this study was to explore the decision-making process that occurs how EMS teams respond when someone is dying from a serious illness (vs. an injury). In-depth in-person interviews were conducted with 50 EMS providers (24 emergency medical technicians [EMTs] and 26 Paramedics) from four ambulance services. Participants' ages ranged from 21-57 (M=37.9) and 70% were male. Qualitative data was coded using Atlas.ti software. Three themes illuminated participants' experiences with end-of-life calls: (1) How legally binding documents (e.g. Do Not Resuscitate [DNR] orders, Medical Orders for Life Sustaining Treatment [MOLST]) inform care; (2) Decision-making about foregoing or halting resuscitation (e.g. no hospitalization, death at home); and (3) Family care, support and education. The results suggest that EMS providers have critically important roles in upholding the wishes of seriously ill older adults and helping caregiving families through the end-of-life transition. Implications: Discussions about the meaning of legally binding documents (e.g. DNR, MOLST) and EMS calls are important in advance care planning.

#### PRELIMINARY YEAR-ONE RESULTS OF A 5-YEAR PROJECT TO DEVELOP AND IMPLEMENT PATIENT- AND FAMILY-CENTERED CARE MODEL

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**Objective.** The overarching goal of this 5-year study is to develop and evaluate an innovative patient- and family-centered care (PFCC) model to address the challenges of quality care and high cost care in Changhua County, Taiwan. The year-1 study examines the baseline differences on selected outcomes between Changhua County and the comparison group (nationally). **Methods.** Five-year longitudinal study. **Participants:** stroke patients (n=2,931) from Changhua County Hospitals. Year-1 baseline discharge registry data (2018) for stroke patients obtained from Changhua Health Bureau. Summary statistics and bivariate analysis performed. **Providers:** care provider [n=28] were interviewed through five focus groups for the support needed to begin implementing PFCC. **Results.** The year-1 results show the stroke incidence rate was 3.8%. Sixty-three percent of stroke patients were 65+ with an average age of 69, and 60% were male. Compared to the Taiwan national average, the stroke patients in Changhua County had a longer length of stay in acute and postacute care settings (41.1 days vs. 29.3 days;  $p < 0.001$ ), and higher hospitalization cost (US\$7,815 vs. US\$5,905;  $p < 0.001$ ). The focus group data found lack of effective tools and platforms to facilitate the provider-to-provider communication necessary for PFCC. **Conclusion.** These findings suggest that stroke patients in Changhua County had a longer average length of stay and higher healthcare costs compared to stroke patients nationally. To address these discrepancies, our year-2 program will focus on PFCC intervention program development and pilot testing, which include a Taiwan-specific PFCC tool and platform, followed by three years of intervention implementation and evaluation.

#### MEETING SOCIAL NEEDS TO IMPROVE HEALTH OUTCOMES: PARTNERSHIPS BETWEEN COMMUNITY-BASED ORGS AND HEALTH CARE

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Unmet social needs negatively affect individual and population health, and better integration of community-based supports and health systems is a promising approach to improve health outcomes and avoid unnecessary health care use. Community-based organizations (CBOs) such as Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs), as providers and coordinators of social services, are well-positioned within their communities to coordinate care and provide for unmet social needs. Partnerships between CBOs and health care entities have clear potential to improve health care outcomes while also reducing expenditures. This paper will present a cross-sectional analysis of a national survey of AAAs, CILs, and other CBOs at two time points (2017: n=593; 2018: n=763) to understand the extent,