care preferences among older adults in the U.S. Using data from the 2012 National Health and Trends Study (n=1798, aged 65 to 101), we identified four levels of ACP engagement: None (28%), Informal ACP conversation only (12%), Formal ACP only (14%), and Both informal and formal ACP (46%). Older adults with None showed the highest prevalence of having cognitive impairment (17%), followed by those with Formal ACP only (15%) and the other two (6%, 6%). The results of Multinomial Logistic Regression showed that, compared to those without, respondents with cognitive impairment had 143% increased relative risk of having None (RR = 2.43, CI: 1.58-3.73) and 81% increased relative risk of completing Formal ACP only (RR = 1.81, CI: 1.11-2.95) relative to completing Both informal and formal ACP. In addition, respondents with None were more likely to prefer to receive all treatments available nearing death than those with any ACP engagement. Achieving high quality care at the end of life can be more challenging for older adults with cognitive impairment and their family caregivers due to the limited capacity. Although encouraged, informal ACP conversation with loved ones does not necessarily occur before the formal ACP, especially, for those with cognitive impairment. Therefore, they may merit more attention such as early ACP engagement.

FACTORS PREDICTING SHORT LENGTH OF STAY IN HOSPICE PATIENTS WITH A PRIMARY DIAGNOSIS OF STROKE
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Stroke is the second leading cause of death globally among people aged 60+, yet only 9% of hospice decedents have a primary diagnosis of stroke and little research has examined their end-of-life care experiences. Late referral and admission to hospice is an indicator of poor end-of-life care quality. This project identified factors predicting short stays in hospice, defined as a length of stay (LOS) of 14 days or less, via chart review of 100 hospice patients with a primary diagnosis of stroke. Of the 98 patients with complete data, 89% died in hospice; 11% were live discharges. Most patients were female, married, and referred to hospice from a hospital. Only 21% of patients entered hospice with a completed advance directive. Approximately 75% (n=73) of patients had a short LOS. Binary logistic regression indicated that gender, race, marital status, and having an advance directive at hospice admission were unassociated with LOS. Controlling for demographics, patients referred from home were 74% less likely to have a short LOS (OR=.26, CI=.08-.83) compared to those referred from a hospital, with a mean LOS of 44 and 13 days, respectively. Including Palliative Performance Scale (PPS) score in the model attenuated the effect of referral location. For every ten percent increase in PPS, participants were 85% less likely to have a short LOS (OR=.15, CI=.07-.32). Advance care planning should be more widely promoted among patients at high risk for stroke. There are opportunities for earlier referral to hospice for patients with a diagnosis of stroke.

HOME HOSPICE VERSUS OTHER PLACES OF DEATH AND CAREGIVER STRESSES
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As of 2017, more individuals in the U.S. die at home than in any other location. Hospice care was designed to provide support for people who are dying and their families. However, dying persons may have rapidly emerging needs that home hospice does not immediately meet, thereby, exposing family members to be “first responders.” Thus, home death may result in distress and burden for dying individuals’ family members, even when hospice is involved. This study uses multivariable regression analysis to explore the relationship between place of death and stressful end-of-life experiences in a sample of 185 patients with advanced cancer. We also analyze which end-of-life experiences are associated with death location. Compared to home hospice death, we found dying in a hospital was associated with fewer caregiver exposures to, and reports of fearfulness and helplessness in response to, stressful end-of-life events. Compared to home hospice death, hospital death was associated with decreased frequency of choking, falls, confusion/delirium, and feeling the patient has had enough. It was also associated with less fearfulness about choking and falls and less hopelessness about falls, the patient having enough, and thinking the patient was dead. Our results suggest home death with hospice care, often involves undesirable experiences that result in more caregiver fear and helplessness than dying in a hospital without hospice care. Research is needed to understand how to best support family members through stressful end-of-life experiences even when supported by home hospice services.

HOW WILL I BE REMEMBERED? REFLECTION ON VIRTUES IN SELF-DEFINING MEMORIES ACROSS ADULTHOOD
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Reflection on memorialization may differentially influence nomination and narration of self-defining memories across the lifespan, including the extent to which positive character strengths (i.e., virtues) are represented. We investigated characteristics of self-defining memories across adulthood and in the context of being memorialized after death. Young, middle-age, and older adults were randomly assigned to narrate a memorialization-based self-defining memory (a memory to describe you after you are gone; n = 103) or current self-defining memory (a memory to describe your current self; n = 99). Participants rated qualities of their memory (e.g., personal significance) and the extent to which the memory represents them as virtuous (e.g., courageous, empathic, etc.). There were no age or condition differences in personal significance of the memory narrative (p = 0.43). However, there was an age-by-condition interaction for representations of virtue described in the self-defining memory, F(2, 199) = 3.94, p = 0.002. Young adults rated their self-defining memories as more virtuous in the memorialization condition than in the current self condition (p = 0.001).
Middle-age (p = 0.95) and older (p = 0.94) adults rated their self-defining memories as portraying similar levels of virtue across conditions. Unlike their middle-age and older counterparts, young adults report embodiment of virtue differently in unique contexts. Findings are discussed in the framework of how individuals’ views of the self as virtuous change in relation to time lived and time left to live.

LESSONS FROM WHAKAPAPA AND FILIAL PIETY: CAN SOCIAL WORK CAPITALIZE ON THE CONNECTION THAT SURVIVES DEATH?
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Ageing is part of life, and so is death. Although death will involve all of us over time, it is often regarded as a taboo topic, and bonds with the dead are seldom acknowledged in contemporary times. The paper presents selected insights on the connection that survives death, learned from a qualitative study on two indigenous knowledges—whakapapa (genealogical connections in Maori) and filial piety (respect/care for ancestors). Data were collected from interviews with 49 key informants (Maori=25; Korean=24) in 2018/19 in New Zealand and South Korea. The research findings indicate that the connectedness with ancestors or deceased loved ones is a significant part of the participants’ mental and social lives. Māori (the first nation people of New Zealand) have established the unwritten convention of whakapapa as the core value that places whānau (family) at the centre of social relationships. In Korean culture, its filial piety/ancestor veneration tradition has emphasised the connection between deceased and living family members. Criticism about the traditions of whakapapa and filial piety was also raised by a few participants. The significance of this study is situated in the innovative perspective that the post-mortem relationship can be embodied, not only by the living who practise memorial respect for the dead, but also by those older people who establish after-life legacy before death. To help capitalise on this whakapapa connection, the so-called concept of “memorial social work” is presented as a potential area of social work practice. In contemporary times, the core value that places whānau (family) at the centre of social relationships. The paper presents selected insights on the connection that survives death, learned from a qualitative study on two indigenous knowledges—whakapapa (genealogical connections in Maori) and filial piety (respect/care for ancestors). Data were collected from interviews with 49 key informants (Maori=25; Korean=24) in 2018/19 in New Zealand and South Korea. The research findings indicate that the connectedness with ancestors or deceased loved ones is a significant part of the participants’ mental and social lives. Māori (the first nation people of New Zealand) have established the unwritten convention of whakapapa as the core value that places whānau (family) at the centre of social relationships. In Korean culture, its filial piety/ancestor veneration tradition has emphasised the connection between deceased and living family members. Criticism about the traditions of whakapapa and filial piety was also raised by a few participants. The significance of this study is situated in the innovative perspective that the post-mortem relationship can be embodied, not only by the living who practise memorial respect for the dead, but also by those older people who establish after-life legacy before death. To help capitalise on this whakapapa connection, the so-called concept of “memorial social work” is presented as a potential area of social work practice, which has critical implications in the ageing/end-of-life related fields.

MEANING MAKING AS A CENTRAL MECHANISM OF DIGNITY THERAPY FOR OLDER ADULTS WITH CANCER
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Nearly 500,000 older Americans die a cancer-related death each year (National Vital Statistics Report, 2018). Following a diagnosis of a serious illness like cancer, maintaining a sense of dignity is central to a patient’s wellbeing. Dignity Therapy (DT) was recently introduced as an intervention to enhance dignity for terminally ill patients (Chochinov et al., 2005).

This therapy provides patients opportunities to foster a sense of dignity though making meaning of their lives (Hack et al., 2010). To date, whether meaning-making actually occurs as a central mechanism of effective DT has not been tested. The current study investigates (i) how often and in what forms meaning-making occurs during DT, and (ii) how patients’ baseline feelings of dignity relate to meaning-making during DT. Participants were 25 male and female cancer outpatients (M age = 63.08; SD = 5.72). They completed the Patient Dignity Inventory (Chochinov et al., 2008) and then participated in Dignity Therapy with a trained provider. Sessions were audio recorded, transcribed, and reliably content-analyzed for meaning-making using an established coding scheme (Park & Folkman, 1997). Content-analysis revealed that all patients made meaning of past life events at least once (range: 1-12 occurrences). Multiple forms of meaning-making emerged, with Finding Benefit and Personal Growth most common. Patients reporting more dignity-related distress prior to DT showed greater meaning-making during the DT session (r = .46, p < 0.05). This study provides foundational evidence that meaning-making is a key mechanism of Dignity Therapy, helping older adults with cancer enhance dignity at end-of-life.

RELIGIOSITY, COGNITION, AND ENGAGEMENT IN ADVANCE CARE PLANNING AMONG OLDER ADULTS
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Advance care planning (ACP) is an important process of discussion and documentation that may help older adults receive the end-of-life care they prefer. Although existing literature predominantly finds greater self-reported religiosity to decrease the rates of ACP, a clear consensus is not yet evident. Data from 3,182 adults aged 55 and older participating in the 2012 wave of the Health and Retirement Study were used to investigate this association and examine the moderating role of cognition. Participants reporting at least one of two ACP behaviors (written instructions and assigning a health care proxy) were categorized as formal planning only, engaging in only informal discussions was categorized as informal planning, and those who completed both or none were categorized accordingly. Cognition was measured using self-reported memory change over the last two years and with objective cognitive testing scores. Using multinomial logistic regression, three forms of ACP behaviors were regressed on a religiosity/spirituality scale, the two cognition measures, and demographic and psychosocial covariates. Greater religiosity was associated with a lower likelihood of engaging in both plans compared to none (OR=0.91, 95%CI=0.84-0.97), however this effect was no longer significant with the inclusion of race. Higher cognitive scores were associated with greater odds of engaging in informal-only (OR=1.07, 95%CI=1.04-1.10) and both plans (OR=1.04, 95%CI=1.01-1.06); subjective memory change was not associated with ACP. Neither cognitive measure significantly moderated the negative association of religiosity on ACP, suggesting that the awareness of worsening memory does not undermine the tendency to avoid planning among the highly religious.