the 0.1% level. Based on these results, we find that SIA utilization varied by certain characteristics. As a result, CMS should continue to monitor rates of SIA utilization to better understand whether any patient groups appear to be underserved at the end of life.

LIVE DISCHARGE FROM HOSPICE WITH DEMENTIA: CHALLENGES TO SUPPORTING THE PATIENT-CAREGIVER DYAD
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A live discharge from hospice disrupts care continuity and results in burdensome transitions for individuals with a life-limiting illness and their caregivers. In 2019, hospices served more than 1.6 million people across the United States, with nearly 63% of Medicare decedents age 85 or older. Of these patients, nearly 350,000 (20.9%) had a principal diagnosis of Alzheimer’s Disease/Dementia/Parkinson’s Disease. Research demonstrates that hospice care improves end-of-life outcomes for adults with Alzheimer’s Disease and related dementias (ADRD), yet with eligibility limited to a six-month prognosis, hospice is not structured to meet longer-term needs. The result is a live discharge from hospice. In 2019, 17.4% of hospice patients were discharged alive from hospice, with 6.5% discharged due to being ‘no longer terminally ill.’ The majority of live discharges are either hospice-initiated due to patient stabilization (extended prognosis resulting in a situation in which a patient no longer meets the life expectancy hospice eligibility criteria) or are patient-initiated (revocation) where a patient or proxy chooses to leave hospice care, typically to access disease-directed therapies or inpatient hospitalization. Both present unique challenges and opportunities for hospice providers. Informed by over 10 years of practice experience and research, this presentation will discuss the impact of live discharge from hospice and the unique impact for patients and primary caregivers of individuals with ADRD, the service gaps that exist for this population, and our recommendations for policy reform.

BUILDING A PROTOCOL FOR LIVE DISCHARGE FROM HOSPICE: UNDERSTANDING THE APPROACHES, CHALLENGES, AND OPPORTUNITIES
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A live discharge from hospice can occur when a patient stabilized under hospice care no longer meets the life expectancy hospice eligibility criteria. In 2019, 278,400 hospice patients across the United States were discharged alive from hospice care, with 18,096 (6.5%) discharged due to being ‘no longer terminally ill.’ For these individuals and their caregivers, the result is a disruption of care continuity and an often burdensome transition. Hospice care improves end-of-life outcomes for some patients, and a live discharge results in lost access to important supportive services and resources, while the patient remains ‘terminal.’ Further, an increased burden is placed on primary caregivers who may be unprepared for this transition. Currently, there is no explicit discharge process available within hospice to guide practitioners in transitioning patients and their caregivers out of hospice care. This study aimed to garner a deeper understanding of current approaches and accompanying challenges to inform the development of an explicit live discharge protocol. Focus group interviews with hospice social workers at four hospice agencies across the U.S. were conducted. Using thematic analysis, four key themes emerged, including the logistical (n=13) and psychosocial (n=9) approaches, the need for clear professional roles during a live discharge (n=12), and specific challenges (n=14), such as needed services and desired discharge timeline to best support the patient-caregiver dyad. Findings demonstrate the complexities of conducting a live discharge, the uniqueness of each hospice agency, and the need for more research to support a standardized and reimbursable discharge process.

THE RELATIONSHIP BETWEEN PHYSICIAN VISITS AND ADVANCE CARE PLANNING
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Some studies have shown that advance care planning (ACP), discussions about future care given a serious illness, are associated with improved quality of death and better end-of-life care. Studies also have found that physicians play an important role in ACP. In fact, in 2016 CMS began reimbursing physicians for ACP discussions. However, little is known about the relationship between the number of physician visits and engaging in ACP. This study investigated the association between outpatient physician visits and ACP engagement. Only respondents over 65 were included in our study. We conducted logistic regressions using the 2016 Health and Retirement Study. We used ACP engagement (n=9838), advance directive (AD; eg, living will) completion (n=9746), and healthcare power of attorney (e.g., proxy) assignment (n=9724) as outcome variables. In addition to the frequency of physician visits, we controlled for basic demographics (age, gender, marital status, race, and socioeconomic status), number of chronic conditions, and self-rated health in our models. For each additional physician visit, the probability of having an ACP conversation, (p<.001), AD completion (p<.001), and healthcare proxy assignment (p<.001) increased by 1.6%,1.4%, and 1.9% respectively after controlling for covariates. Number of chronic conditions also was independently and positively associated with ACP-related activities. Additionally, greater perceived health was associated with higher odds of AD completion (OR= 1.08, p<.05) and healthcare proxy assignment (OR= 1.07, p<.05). This study found that frequent encounters with physicians are associated with higher rates of ACP engagement even after controlling for health conditions.

DO DIFFERENT ADVANCE DIRECTIVES CREATE CONFUSION ON A PATIENT’S WISHES? (MOLST VERSUS FIVE WISHES)
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Introduction. The objective of this study is to compare perspectives of young adults toward advance directives (ADs) and their preferences for life-sustaining treatment and care options. Methods. Participants include graduate students (n=30) attending a New York State university. Data were collected using a structured survey questionnaire, the Medical Orders for Life-Sustaining Treatment (MOLST) form and the Five Wishes form. Summary statistics were performed to address the study aim. Results. Of the participants, the average age was 24 years (60% were female, 60% White, and 27% Black). In Five Wishes, participants who are close to death, 70% wanted all or some forms of life support; when in a coma (47%), or with permanent and severe brain damage (36.6%) chose similar options. In MOLST, without pulse and/or breathing, 87% want CPR; while with pulse and breathing, 96% want artificially administered fluids and nutrition, 90% want mechanical ventilation, 67% want to be hospitalized, 67% want antibiotics, and 53% want unlimited interventions. Conclusion. (1) The majority of participants had not previously completed an AD; however, they were capable of making decisions about their life-sustaining treatments. (2) The discrepancies in treatment preferences may be due to the language of advance directives. Further studies in this respect are warranted.

EXPLORING FIVE WISHES AND END-OF-LIFE CARE PLANNING IN YOUNG ADULTS
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Introduction. Advance care planning (ACP) allows individuals to plan ahead and express their preferences for medical treatment and care options to health care providers, family, and loved ones before they are no longer able to make or voice decisions due to the event of a serious illness or injury. Advance directives (ADs) allow individuals to record their preferences. While unintentional injuries are the leading cause of death among young adults, limited studies focus on ACP, ADs, and end-of-life treatment and care. Our study aims to (1) examine the perspectives of young adults towards Five Wishes, and (2) measure their preferences related to personal, emotional, spiritual, and medical values in end-of-life care planning. Methods. Data were collected using Five Wishes and a one-time questionnaire. Participants include graduate students (n=30) at a New York State university. The average age was 24 years old (60% were female, 60% White, and 27% Black). In Five Wishes, participants who are close to death, 70% wanted all or some forms of life support; when in a coma (47%), or with permanent and severe brain damage (36.6%) chose similar options. In MOLST, without pulse and/or breathing, 87% want CPR; while with pulse and breathing, 96% want artificially administered fluids and nutrition, 90% want mechanical ventilation, 67% want to be hospitalized, 67% want antibiotics, and 53% want unlimited interventions. Conclusion. (1) The majority of participants had not previously completed an AD; however, they were capable of making decisions about their life-sustaining treatments. (2) The discrepancies in treatment preferences may be due to the language of advance directives. Further studies in this respect are warranted.