

means-tested program for health care coverage. There has been longstanding concern that wealthy older adults are taking advantage of the program by divesting assets in order to qualify for coverage. The existing research on the issue is somewhat dated, does not focus on the question of asset transfer, and often lacks a significant longitudinal view. Thus, questions remain about whether states need to tighten asset eligibility rules to prevent the wealthier older adults from accessing the program. This analysis explores longitudinal data from the Health and Retirement Study (1998 to 2016) to determine the extent to which wealthier Americans age 50 and older engage in asset transfer to access Medicaid. Our findings demonstrate that this may occur among a relatively small proportion of wealthy older adults, and that tightening Medicaid eligibility criteria would likely have a small to modest impact on the financial status of the program.

DIFFERENTIAL EFFECTIVENESS OF THE MINNESOTA SAFE PATIENT HANDLING ACT BY HEALTH CARE SETTING

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The Minnesota Safe Patient Handling (SPH) Act requires nursing homes, hospitals, and outpatient facilities to develop comprehensive SPH programs and acquire mechanical lifts. The law was designed to prevent the adverse outcomes of manual patient handling among workers (e.g., musculoskeletal injuries) and care recipients (e.g., falls, skin tears). Reducing manual handling is of particular concern in nursing homes where residents' care needs necessitate frequent lifts and transfers. To date, research has focused on the effects of SPH laws separately in nursing homes and hospitals. Our study aimed to assess whether change in worker injury rate differed between nursing homes and other health care settings following enactment of the 2007 Minnesota law. We used 2005-2017 claims data from a large workers' compensation insurer and assessed the effects of time, health care setting, and their interaction on claim rate using negative binomial regression models. The claim rate for patient handling injuries was highest in nursing homes (2.8/million payroll), followed by hospitals (1.4/million payroll), and outpatient facilities (0.04/million payroll). Across settings, patient handling claims declined by 38% (95% CI 19-53%) between pre-law (2005-2007) and post-implementation (2014-2017). The decline in claims over time did not differ by health care setting (Wald χ^2 for interaction=3.40, $p=0.758$). Our results suggest that nursing homes are successfully addressing the unique mobility needs of their residents in their mandated SPH programs. Future work should seek to describe the magnitude and nature of care recipient injuries caused by lifting and transferring and evaluate trends in care recipient injuries over time.

FAILING TO COMPLAIN: DO NURSING HOMES WITH MORE RESIDENTS WITH DEMENTIA HAVE FEWER COMPLAINTS?

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The majority of nursing home (NH) residents have Alzheimer's Disease or Related Dementias (ADRD). However, the association of ADRD prevalence and NH quality is unclear. The objective of the current study is to understand the association of NH characteristics, including the proportion of ADRD residents, with the prevalence of NH complaints as an indicator of quality of care and quality of life. We merged data from the ASPEN Complaints/Incident Tracking System with national NH data from the Certification and Survey Provider Enhanced Reports, the Minimum Data Set, the Area Health Resource File, and zip-code level rural-urban codes in 2017. Three groups of NHs were created, including those whose proportion of residents with ADRD was in the top decile (i.e., high-dementia NHs (N=1,473)) and those whose proportion of ADRD residents was in the lowest decile (i.e., low-dementia NHs (N=1,524)). Bivariate results revealed high-ADRD NHs had higher percentages of Medicaid-paying residents, were less likely to be for-profit and chain-affiliated, had lower staffing hours and lower percentages of Black, Hispanic, and Asian residents. Using NHs in the middle deciles as reference, negative binomial regression models showed that having a low proportion of ADRD residents was significantly associated with higher numbers of total complaints ($p<.001$) and substantiated complaints ($p<.001$), whereas having a high proportion of ADRD residents was significantly associated with lower numbers of substantiated complaints ($p=.001$). The findings suggest the proportion of residents with ADRD in NHs is associated with quality, as measured by complaints. Policy implications of these findings will be discussed.

MEANINGFUL ASSESSMENT OR MINIMUM COMPLIANCE: PASRR FOR NURSING HOME RESIDENTS WITH MENTAL ILLNESS

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The Omnibus Budget Reconciliation Act (OBRA) of 1987 included provisions for the Preadmission Screening and Resident Review (PASRR) program, which requires states to create and maintain systems to assess persons with serious mental illness (SMI) seeking NH care. The prevalence of SMI in NHs is increasing, and little is known about the effectiveness of the PASRR program intervention. We conducted 20 interviews with state and national PASRR stakeholders, including assessors, hospital discharge planners, mental health advocates, geriatricians and geriatric psychiatrists. Interview data were triangulated with state provided materials on PASRR collection and implementation. Based on these interviews, we identified four themes: 1) variation in the implementation of federal PASRR legislation across states and jurisdictions, 2) the need for investment in professional development and workforce capacity, 3) lack of usefulness of PASRR in ongoing care planning, and 4) the need to consider the role of age, race/ethnicity, and stigma on quality of care for NH residents with SMI. Stakeholders