TITLE II: IMPROVING GRANTS FOR STATES AND COMMUNITY PROGRAMS ON AGING

Jamie Kuhne, *Department of Veterans Affairs, Worthington, Ohio, United States*

There are several noteworthy changes to the Improving Grants for States and Community Programs on Aging's portion of the OAA. The reauthorization adds language requiring data collection on the needs of older adults and specifying additional populations on whom to focus outreach efforts, such as survivors of the Holocaust. The reauthorization also expands what States may fund with Supportive Services grants, adding screening for social isolation and traumatic brain injuries. The Act goes on extend Stated the option of funding programs to address both of these issues. The Act also requires the Assistant Secretary to study the supply and demand of home delivered and congregant meals and make recommendations to address the gap. Finally, there is expansion of the section on Caregiving, including a definition of caregiver assessment and the removal of a limit on funds States can use on support services to family caregivers.

AMENDMENTS MADE TO THE OLDER AMERICANS ACT TITLES III, IV, AND V

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This presentation discusses amendments made to the Older Americans Act titles III, IV and V through the most recent reauthorization. Title III reauthorizes Title IV programs, Title IV reauthorizes title V programs and Title V reauthorizes title VI programs. The reauthorizations each include a seven percent increase in fiscal year 2020 and a six percent increase per year for the next four fiscal years. New in title III are an amendment that allows projects that address traumatic brain injury among older adults to be included in grant programs, an amendment that improves an existing transportation grant program and an amendment that improves an existing grant program for multigenerational collaboration. Additionally, existing falls prevention and chronic disease self-management programs are codified within title III. New in title IV is an amendment that allows eligible previously incarcerated individuals to be considered a prioritized population for the Senior Community Service Employment Program.

TITLE VI: MODERNIZING ALLOTMENTS FOR VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES AND OTHER PROGRAMS

Taneika Duhaney, *Health and Aging Policy Fellowship, Springfield, Virginia, United States*

Of the many changes to the OAA, the Modernizing Allotments for Vulnerable Elder Rights Protection Activities and Other Programs section included notable changes. This bill specifies that Title VII programs will receive a 7% increase in 2020 and a 6% increase in the following four fiscal years. It extends the Supporting Grandparents Raising Grandchildren Act for an additional year. The reauthorization ensures that ombudsman representatives can be reimbursed for costs incurred through their services. The Act requires that the Government Accountability Office study federal programs for home modification assistance for older adults and individuals with disabilities. The Act directs the Administrator of the Administration for Community Living to continue the 2017 requirement of disseminating and soliciting feedback on the Principles for Person-directed Services and Supports during Serious Illness. This reauthorization updates home and community-based best practices; and elder justice activities, including community outreach and education to bolster community partnerships.

SESSION 6240 (SYMPOSIUM)

STATE VARIABILITY IN ASSISTED LIVING REGULATIONS, ACCESS, AND OUTCOMES FOR PERSONS WITH DEMENTIA

Chair: Kali Thomas

Approximately one million individuals, an estimated40% with a diagnosis of Alzheimer's disease-related dementias (ADRD), reside in assisted living (AL); yet, little is known about their experience or the quality of care provided in AL. Unlike other forms of long-term care (LTC), the licensing, operating, and enforcement requirements for AL falls to the states, which vary dramatically in their regulatory approaches. The overall objective of this symposium is to examine states' AL regulatory environments and understand if and how access to AL and the health outcomes of AL residents with ADRD are impacted by states' regulatory decisions. Presenters will highlight the state variability in the regulation, access, and outcomes of AL residents with ADRD. The first presentation will describe the within and between state differences in regulatory approaches as it relates to dementia care. The second presentation will describe the variation in Medicaid financing of services in AL and its potential impact on access to AL within those states. The third will present geographic disparities in access to specialized dementia care in AL. The fourth presentation will characterize differences in emergency department utilization among AL residents with ADRD across states. Finally, the fifth presenter will report on the effect of establishing or increasing state staffing requirements on outcomes of AL residents with ADRD. Results will ultimately inform policy-makers, organizational leaders, and clinicians as they seek the most effective ways to ensure equal access to AL and optimal outcomes for residents with ADRD. Assisted Living Interest Group Sponsored Symposium.

VARIATION IN ASSISTED LIVING REGULATIONS WITHIN AND ACROSS STATES

Paula Carder,[1] Lindsey Smith,[2] Taylor Bucy,[2] Jaclyn Winfree,[1] Wenhan Zhang,[3] and Kali Thomas,[3] *1. Portland State University, Portland, Oregon, United States, 2. PSU School of Public Health, Portland, Oregon, United States, 3. Brown University, Providence, Rhode Island, United States*

Assisted living (AL) regulations have been long recognized as being highly variable across states. A new approach developed by our team, Health Services Regulatory Analysis, allows for a more granular identification of within-state variation in AL regulation. We identified 172 licensing classifications from the 50 states and DC representing 58 primary license types, 48 sub-types, and 66 designations that can modify a primary or sub-license. Over two-thirds (72%)

of dementia-specific classifications require that all staff receive initial dementia training, compared to only one-third (33%) of general AL classifications. This trend is similarly reflected in cognitive-screening requirements, present in 67% of dementia-specific classifications and 42% of general AL classifications. Regulatory theory describes how licensing agencies respond to various forces and values. Within-state AL regulatory variation reflects a combination of oversight mandates, population-specific needs (e.g., people with dementia), historic policies, and provider influence, with implications for consumers, policy-makers and researchers. Part of a symposium sponsored by Assisted Living Interest Group.

THE INTERSECTION OF MEDICAID AND ASSISTED LIVING FOR RESIDENTS WITH DEMENTIA

Brian Kaskie,[1] Seamus Taylor,[1] and Lili Xu,[2] *1. University of Iowa, Iowa City, Iowa, United States, 2. University of Iowa, University City, Iowa, United States*

Medicaid has increasingly offered coverage to persons residing in assisted living (AL). However, the scope of coverage across states is unknown. We sourced 2019 state administrative regulations specific to Medicaid and AL and determined forty-five (45) states link Medicaid with AL. Twenty-seven (27) do so as part of their state plan, 32 use a §1915(c) waiver, and 11 use a §1115 waiver. Forty-four states limit Medicaid coverage to a specific population, 16 limit coverage to those with a diagnosed disability, and 1 state limits coverage to a specific geographic region. In addition, 33 states provide payment for room and board with 28 states upholding a payment cap. In regards to services, 13 states reimburse a limited range of services while 32 offer a more expansive range of services. As Medicaid programs have extended coverage to residents of AL, researchers must now consider the impact on AL access and residents' outcomes. Part of a symposium sponsored by Assisted Living Interest Group.

GEOGRAPHIC DISPARITIES IN ACCESS TO SPECIALIZED DEMENTIA CARE

Portia Cornell,[1] Wenhan Zhang,[2] Lindsey Smith,[3] Shekinah Fashaw,[2] and Kali Thomas,[2] *1. Providence VA Medical Center, Providence, Rhode Island, United States, 2. Brown University, Providence, Rhode Island, United States, 3. PSU School of Public Health, Portland, Oregon, United States*

With novel, previously undescribed data on the availability of dementia-specific assisted living communities (ALs), we analyzed variation among counties in the availability of this important service for persons with dementia. In twenty-one states, we identified 6,961 ALs (16%) with a dementia-specific license/certification. Counties with at least one AL providing dementia-specific care had substantially higher college attainment versus counties that had at least one AL, but no dementia-specific beds: 25% versus 18% ($p<0.01$). Counties with dementia care also had significantly greater median incomes ($54,000 vs. $46,400), and home values ($159,000 vs. $113,000), lower poverty rates (13.7 percent vs. 16.3 percent), and lower proportions of Black residents (7.8 percent vs. 8.7 percent). Our findings are suggestive of a mismatch in need and availability of residential care options for older adults with ADRD that are also low-income or racial/ethnic minorities. Part of a symposium sponsored by Assisted Living Interest Group.

STATE VARIABILITY IN EMERGENCY DEPARTMENT VISITS AMONG ASSISTED LIVING RESIDENTS WITH DEMENTIA

Cassandra Hua,[1] Wenhan Zhang,[2] Portia Cornell,[3] Momotazur Rahman,[1] David Dosa,[4] and Kali Thomas,[2] *1. Brown University School of Public Health, Providence, Rhode Island, United States, 2. Brown University, Providence, Rhode Island, United States, 3. Providence VA Medical Center, Providence, Rhode Island, United States, 4. Brown University, Barrington, Rhode Island, United States*

Emergency department (ED) visits are associated with poor outcomes; however, state variation in ED use among assisted living (AL) residents is not well understood. Using 2017 Medicare data, we identified a cohort of 88,880 beneficiaries with dementia residing in larger ALs (25+ beds) and calculated risk-adjusted rates of all-cause and injury-related ED use per 100 person years, by state, adjusting for demographics and chronic conditions. Risk-adjusted state rates of all-cause ED visits ranged from 129.5 visits/100 person-years (95%CI=114.6,148.2) in New Mexico to 246.1 visits/100 person-years (95%CI= 224.9,274.8) in Rhode Island. The risk-adjusted rate of injury-related ED visits ranged from 91.4 visits/100 person-years (95%CI=83.0,101.4) in New Mexico to 135.9 visits/100 person-years (95%CI=126.9,146.6) in Montana. Potential reasons for these state variations will be discussed. Part of a symposium sponsored by Assisted Living Interest Group.

THE IMPACT OF CHANGES IN DIRECT CARE STAFFING POLICIES AND OUTCOMES FOR ASSISTED LIVING RESIDENTS WITH DEMENTIA

Kali Thomas,[1] Portia Cornell,[2] Wenhan Zhang,[1] Paula Carder,[3] Lindsey Smith,[4] Cassandra Hua,[5] and Momotazur Rahman,[5] *1. Brown University, Providence, Rhode Island, United States, 2. Providence VA Medical Center, Providence, Rhode Island, United States, 3. Portland State University, Portland, Oregon, United States, 4. PSU School of Public Health, Portland, Oregon, United States, 5. Brown University School of Public Health, Providence, Rhode Island, United States*

We identified a cohort of 410,413 Medicare beneficiaries residing in 10,623 large (25+bed) assisted living (AL) communities between 2007 and 2017. We conducted linear probability models with a difference-in-difference framework to examine the association between hospitalization and changes in regulations pertaining to staff training (model 1) and staffing levels (model 2), adjusting for time trends, resident characteristics, and state-license fixed effects. During this 11-year period, six states changed their staff training requirements and two states introduced/increased direct care staffing levels. A change in regulations related to staffing levels was associated with a reduction in the probability of hospitalization during the month of -0.0056 percentage points (95%CI=-0.008,-0.003). A change in regulations related to staff training was associated with a reduction in the probability of hospitalization during the month of -0.0035 percentage points (95%CI=-0.006,-0.002). The policy effects represent clinically important differences of approximately 21% in the mean monthly hospitalization rate. Part of a symposium sponsored by Assisted Living Interest Group.