of diabetes management, including poor glycemic control, episodes of very low or high blood sugar (hypoglycemia), insulin injections, or fingerstick pricks to check blood glucose. Few studies have examined how diabetes control contributes to behavioral symptoms of dementia. We conducted a retrospective study in VA nursing home (NH) residents aged 65+ with both dementia and diabetes, and a NH stay>45 days. We used the second assessment of the Minimum Dataset (MDS 3.0) to identify behavioral symptoms of verbal or physical outbursts during the prior 7 days. We conducted mixed-effects logistic regression, with clustering by NH facility. The 5060 residents were overwhelmingly male (99%), had an average age of 78, with mean HbA1c was 7.1 (standard deviation 1.6). The overall prevalence of any behavioral symptoms was 16.7%. Compared to residents with HbA1c < 6%, behavioral symptoms were slightly more common among residents with HbA1c 6-7%, 7-8%, and >9%, but not statistically significantly different. Behavioral symptoms were significantly more common in residents with HbA1c 8-9% (prevalence 19.6%) than in residents with HbA1c < 6% (prevalence 15.5%; odd ratios adjusted for NH facility: 1.35, 95% confidence interval: 1.05-1.75). Additional research is needed to determine which aspects of diabetes management may be contributing to excess risk of behavioral symptoms of dementia.

COSTS OF DEMENTIA CARE AND EARLY-STAGE PREVENTIVE NURSING: A COMPARATIVE BIG DATA STUDY IN OSAKA
XUJING HU1, Reiko Kanaya2, Ryoei Yamamoto3, Hiroshi Toki4, Yasushi Takeya1, and Miyae Yamakawa1, 1. Osaka University, Suita, Osaka, Japan, 2. Osaka University, Osaka, Osaka, Japan, 3. Health and Counseling Center, Suita, Osaka, Japan

Data show a substantial increase in the costs of dementia care nationally and globally. We assessed the factors increasing financial pressure, and found an association between the costs and the severity of dementia. We suggest that early diagnosis and preventive nursing care can reduce the deterioration associated with dementia, and therefore the overall costs of dementia care. The purpose of this study was to determine the relationship between the costs of dementia care and early-stage preventive nursing care in a sample of people with dementia aged 65 to 85 years, using the Medical Care Insurance and Osaka Prefecture Long-Term Care Insurance Database (N = 17973). We found that early care might have a significant effect on formal care costs in the early period of dementia but did not influence the medical care costs of dementia. During the first 5 years, the long-term care costs of people with dementia with an initial care level of Support 1/2 (one type of care level of Japanese long-term care insurance system, and the participants receive preventive services) were $4,389, while people with an initial care level of Care 1/2 (the other type of care level, and the participants receive nursing services) were $12,333. About 20% of people who received preventive care recovered, suggesting that preventive nursing care can restore the ability of people with early-stage dementia. This might be the reason for the reduction in long-term care costs. This research provides a basis for supporting preventive nursing care and extending healthy lifespans.

PAIN IN PERSONS WITH DEMENTIA AND APATHY IN NURSING HOMES
Yo-Jen Liao1, and Ying-Ling Jao2, 1. Pennsylvania State University, Pennsylvania State University, Pennsylvania, United States, 2. Pennsylvania State University, University Park, Pennsylvania, United States

Apathy and pain commonly occur in persons with dementia and significantly impact their quality of life. However, communication barriers in persons with dementia make pain assessment challenging. Apathy further complicates pain management in dementia due to decreased facial expression and verbal communication. This study aims to examine pain management in persons with dementia and apathy. This descriptive study included 13 residents with dementia and apathy from two nursing homes in Pennsylvania. Data on pain, pain-related diagnoses, and treatments were extracted from medical records. Participants’ mean age was 90 years old, and their mean apathy level was 54.6. All 13 participants had pain-related diagnoses with an average of 3.1 pain-related diagnoses (range=1-7). Four participants (30.7%) had pain reported in their medical records with osteoarthritis being the most common diagnosis (38.5%). Eight participants (61.5%) had pain-related diagnoses but did not have regular pain medication administered, and 3 of them (37.5%) had pain reported. In addition, five participants had one or more acute pain-related diagnoses, including surgery, fractures, and falls, and only 2 (40%) of them had pain reported. The average number of prescribed pain medications was 0.4 and 1.1 for regularly administered and as-needed medications, respectively. Acetaminophen was the most common administered medication. Overall, the results pointed out the potential issue that pain may be underrecognized and undermanaged in this population. More research is needed to examine the pain assessment and treatment in this population to promote pain management in persons with dementia and apathy.

REJECTION OF CARE AND AGGRESSION AMONG OLDER VETERANS WITH DEMENTIA WITH AND WITHOUT POSTTRAUMATIC STRESS DISORDER
Bada Kang1, Wei Pan2, Michele Karel3, Kirsten Corazzini4, and Eleanor McConnell5, 1. Yonsei University, Seoul, Seoul-t'ukpyolsi, Republic of Korea, 2. Duke University, Durham, North Carolina, United States, 3. VA Central Office, Washington, Washington, United States, 4. University of New Hampshire, Durham, New Hampshire, United States

Veterans with co-occurring dementia and posttraumatic stress disorder (PTSD) living in residential long-term care encounter a range of physical and social stimuli, which may trigger trauma-related distress that can be exacerbated and manifested with care rejection and aggression. Yet, it is largely unknown how PTSD influences manifestation of care rejection and aggression in older veterans with dementia. Guided by the need-driven dementia-compromised model, this study examined the moderation effect of PTSD on pathways from background factors, and interpersonal triggers to care rejection and aggression among veterans with dementia with and without co-occurring PTSD. In this secondary analysis study, a multi-group structural equation modeling was conducted using program evaluation data of 315 veterans with dementia from the STAR-VA behavioral intervention.
The relationship between dementia and neuropsychiatric symptoms is well documented. Yet, little is known about the prevalence of neuropsychiatric symptoms among diverse homebound persons living with dementia. Guided by an intersectionality framework we asked: 1) Is there an association between the presence of individual neuropsychiatric symptoms and racial and ethnic groups? 2) If so, do these symptoms differ by dementia stage among groups? We conducted a cross-sectional study of n=190 receiving skilled home healthcare in Utah, New York, and New Jersey and enrolled in the DSM-H trial. We prospectively measured symptom prevalence with the Neuropsychiatric Inventory Questionnaire and dementia stage using the Quick Dementia Rating System. We performed Chi-square tests to determine the association of individual symptom prevalence with race and ethnicity and cross tabs to descriptively stratify individual symptom prevalence by dementia stage among groups. Participants were 11.9% Hispanic, 28% non-Hispanic Black, 56.1% non-Hispanic white (white). The prevalence of delusions was significantly higher in Hispanic and non-Hispanic Black groups than whites (41.7% & 41.8% vs. 22.5%) and elation/euphoria in Hispanic and non-Hispanic Black groups than whites (20.8% &12.7% vs. 5.4%). Delusions were most prevalent in non-Hispanic Black groups with mild dementia (53.8%) and Hispanics with moderate dementia (50.1%), while elation/euphoria was most prevalent for Hispanics with severe dementia (33.3%). Other neuropsychiatric symptoms showed no significant differences. These findings expand our knowledge of differences in neuropsychiatric symptoms among racial and ethnic persons living with dementia, which can inform future studies and targeted interventions that address disparities and improve care.

DEMENTIA CARE IN THE LAST YEAR OF LIFE: EXPERIENCES IN A COMMUNITY PRACTICE

Mairead Bartley1, Jennifer Manggaard2, Karen Fischer2, Diane Holland2, and Paul Takahashi2, 1. Mayo Clinic Rochester, Rochester, Minnesota, United States, 2. Mayo Clinic Rochester, Rochester, Minnesota, United States

Objectives: People with dementia often have high care needs at end of life. We compared care delivery in the last year of life for people living with dementia in the community (home/assisted living facilities, ALF) to those in skilled nursing facilities (SNF).

Methods: This was a retrospective study of people who died with a diagnosis of dementia in the community compared with SNF between 2013 and 2018. Primary outcomes of hospitalizations/ED visits in the last year of life were measured. Secondary outcomes included advance care planning (ACP) completion, hospice enrollment, provider visits and ICU admissions.

Results: Of 1203 people with dementia, 581 (48.3%) were living in a SNF and 622 (51.7%) in the home/ALF. At least one hospitalization was recorded for 70.7% in the home/ALF compared with 50.8% in the SNF (p<0.01), similar to ED visits (80.2% versus 58% in home/ALF and SNF groups, respectively, p<0.01). People in the SNF had more provider visits (median 9 (IQR 6, 12) compared with 5 (IQR 3,9) in the home/ALF group (p<0.01). There was no ACP for