hypothesis and type 2 diabetes mellitus (T2D). Using a 5% sample of the total Medicare population we identify groups of individuals with AD/ADRD and i) hypertension, ii) T2D or iii) both. Each group is then propensity-score-matched to similar individuals with hypertension, T2D or both but without a diagnosis of AD/ADRD. The primary explanatory variable of interest is the medication possession ratio (MPR) calculated at 1-year intervals for prescribed diabetes and/or hypertension medications. MPRs were compared between the two groups using t-tests and standardized differences each year after baseline and until death/censoring. A Cox proportional hazard model was then used to estimate differences in survival between these two groups and across race/ethnicity-related strata. Reduced adherence with time and notable race/ethnicity-related differences were identified.

Session 1235 (Symposium)

EMBODYING THE AGING EXPERIENCE: HOW VIRTUAL REALITY IS TRANSFORMING MEDICAL AND NURSING EDUCATION
Chair: Marilyn Gugliucci Co-Chair: Pamela Saunders
Discussant: Erin Washington

Virtual reality (VR) has long been standard in healthcare education. Recent advances in VR hardware and software applications have coalesced to allow for higher fidelity, more highly realistic simulations that are also deployable at scale — not just in highly specialized, single location simulation labs. In tandem, there has been an examination in both the corporate and academic sectors around the efficacy of VR training and learning. While VR has been long proven to be effective in training students and workers in hard skills, its lack of realism has been a barrier to explore efficacy in simulations related to soft skills and emotional intelligence. This symposium will discuss the implementation of virtual reality “labs”, where learners embody in a live 360 film environment the first-person point of view of an older adult — interacting with gaze, voice, and natural hand motions — into four university’s medical and nursing curriculum. Lab outcomes include decreased ageism and stereotyping, and increased empathy, sensitivity, cultural competency, and disease knowledge. The first paper reports outcomes of increased understanding, comfort, compassion and empathy of students and informal caregivers after experiencing various labs. The second discusses comparative data on knowledge and attitudes of medical students experiencing the virtual labs individually vs. the group distance mode. The third reports the results of an initial study on how embodying an older adult with sensory impairment affects participant empathy using a standardized scale. The fourth discusses how one university transitioned to delivering immersive labs to nursing students remotely during COVID19.

THE EFFECTS OF A VR TEACHING TOOL ON UNDERSTANDING, COMFORTABILITY, COMPASSION, AND EMPATHY OF STUDENTS AND CAREGIVERS
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Empathetic care giving is associated with improved patient satisfaction, compliance and outcomes; clinical competence, career satisfaction, and burnout reduction; as well as diminished medical errors and litigation claims. Unfortunately, recent studies have shown erosion in empathy and compassion across the health professions. Virtual reality shows promise as a teaching tool to combat this decline as it has been dubbed the ultimate empathy machine, allowing users to vividly and viscerally experience any situation from any perspective. Embodied Labs allows users to virtually walk in the shoes of different patients, experiencing symptoms, family dynamics, support networks and various components of the health care systems. We have demonstrated that the high level of immersion and presence afforded by these virtual labs are effective pedagogical tools to increase understanding, comfortability, compassion and empathy within various populations including informal caregivers, high school students, health professional students and medical students.

VIRTUAL REALITY IS TRANSFORMING MEDICAL AND NURSING EDUCATION

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Georgetown University medical students have the option of selecting a two-week rotation in Geriatrics during their third-year. Since Fall 2019, the curriculum has included three immersive virtual reality (VR) labs: hearing & vision loss, Alzheimer’s disease, and end-of-life conversations created by Embodied Labs. The curricular goals include increasing empathy and sensitivity of learners to the perspective of older adults, decreasing ageism & stereotyping, and increasing clinical knowledge. In each lab, students are immersed in a live film, first-person point of view of an older adult. They interact with the immersive environment via gaze, voice, and natural hand motions. Pre-pandemic, students viewed the labs in-person using a commercial VR headset. Since the pandemic, March 2020, students accessed the VR labs through the virtual modality of Zoom. This abstract summarizes data on knowledge and attitudes examining differences in knowledge and attitudes pre and post-pandemic.

IMPACT OF VIRTUAL REALITY ON HEALTHCARE PROVIDER EMPATHY FOR OLDER ADULTS WITH SENSORY IMPAIRMENT
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Virtual reality (VR) is an innovative technology that can simulate dual sensory impairment so that healthcare providers and others can experience this affliction common in older adults. This study investigated whether VR simulation could increase empathy among healthcare workers. Healthcare providers experienced a 7-minute scenario from the viewpoint of “Alfred”, a 74-year-old with macular degeneration and high frequency hearing loss on a commercial VR headset (Oculus Rift). Using a one-group pre/post-test study design, we measured knowledge, changes in empathy, and assessed participants’ self-reported behavior change. Results showed that participants increased their knowledge and that 9 of 14 empathy items had statistically significant increases. Additionally, 97% of participants agreed or strongly agreed that they would utilize the information
learned in their work with patients. In conclusion, evidence suggests VR is an effective intervention to increase empathy and positively change behavior to support persons with sensory impairment.

REMOTE DELIVERY OF VIRTUAL REALITY PATIENT SIMULATIONS FOR NURSING EDUCATION
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In the midst of rapid transfers to online teaching for experiential learning opportunities in nursing clinical labs this past spring due to the pandemic, nursing simulations with immersive virtual reality (VR) in VR headsets were deemed impossible. In partnership with Embodied Labs, nursing faculty pivoted to facilitating VR using remote learning approaches in groups. In this new VR approach nursing students engaged in active learning, critical discourse, and reflection guided by faculty delivered VR scenarios remotely with in-session debriefing during discussion pause points. Complex scenarios focused on patient or family perspectives (e.g. during end-of-life care or navigating community and healthcare needs as a LGBTQ individual). These were valuable online learning opportunities for undergraduate nursing education. Student feedback was positive, and faculty perceptions indicated using VR remote learning offers rich, engaging discussion through complex topics important to nursing clinical practice.

Session 1240 (Paper)

END-OF-LIFE CARE POLICY

AN EVALUATION OF THE SERVICE INTENSITY ADD-ON PAYMENT POLICY REFORM IN THE MEDICARE HOSPICE BENEFIT
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In 2016, the Centers for Medicare & Medicaid Services (CMS) implemented the Service Intensity Add-On (SIA) payment, which incentivized skilled nurse and medical social worker (SN/MSW) visits in the last seven days of life. Little is known about the impact of this initiative. Using 100% Medicare hospice claims, we identified a 10% random sample of Medicare hospice beneficiaries utilizing routine home care service during calendar years 2012-2018. We compared the provision of SN/MSW visits on service dates before and after the SIA's implementation relative to beneficiaries' date of death. We also determined hospice providers' success in providing SN/MSW visits in the last days of life and categorized all providers into quintiles according to the average rate of these visits in the period prior to the SIA's implementation. Cumulative over the last seven days of life, we calculated an increase of 15.7 SN/MSW minutes (95% confidence interval [CI] 14.9-16.5 minutes) per beneficiary after the SIA was implemented. The per-minute increase was greatest on days nearer to death (4.0 minutes day of death, 95% CI 3.6-4.2). There was no detectable visit increase on days which were ineligible for the SIA. Additionally, those providers in the quintile providing the lowest rate of SN/MSW visits pre-SIA exhibited a 14-percentage point increase in rates of these visits, the third, fourth, and fifth quintiles exhibited little change over time. Further monitoring is needed to ensure beneficiaries receive adequate end-of-life care.

CHALLENGES IN IMPLEMENTING AN EXPLICIT PROTOCOL FOR LIVE DISCHARGE FROM HOSPICE
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A live discharge from hospice can occur when a patient stabilized under hospice care and no longer meets the life expectancy hospice eligibility criteria. In 2018, 220,000 hospice patients across the United States were discharged alive from hospice care, with 1 in 6 discharges due to stabilization, with a life expectancy exceeding hospice's six-month criteria. Hospice practitioners prepare patients and their caregivers upon enrollment for the possibility of a live discharge should their condition stabilize, however, there is no explicit discharge process available within hospice to guide practitioners in transitioning patients (and caregivers) out of hospice care. This transition process largely falls within the domain of hospice social workers, yet there is no research documenting the challenges and facilitators to conducting a live discharge from hospice. This study aimed to understand social workers' perspectives on the live discharge process. To better understand challenges and facilitators to the live discharge process, we conducted focus group interviews with hospice social workers at four hospice agencies across the U.S. We asked participants to discuss specific tasks associated with the live discharge process for a patient and their caregiver including identifying concrete services needed post-discharge; assessing the psychosocial and grief risk of patient and caregiver; and developing a post-discharge follow-up plan. Using constant comparison analysis we identified several themes including the need for clear professional roles during a live discharge, interprofessional education, and the need for dedicated time for live discharge follow-up. Policy implications and opportunities also will be discussed.

CONSTRUCTION AND PERFORMANCE OF THE HOSPICE CARE INDEX CLAIMS-BASED QUALITY MEASURE
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As part of the Medicare Hospice Benefit (MHB), hospices submit claims containing information that allows policy