PERCEPTIONS OF LONG-TERM CARE RESIDENTS AND THEIR FAMILY MEMBERS ABOUT USING THE CONVERSATION STARTER KIT
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The need for a palliative approach in long term care (LTC) is widely recognized. However, advance care planning (ACP) is still rare. The purpose of this study was to explore the perceptions of LTC residents and their families about using an ACP tool called The Conversation Starter Kit (CSK). This study utilized a mixed methods approach. Data was collected in four LTC homes in Ontario, Canada from 31 residents and family members during an interview after they had completed the CSK. Data was analyzed using thematic analysis and descriptive statistics. All participants read all sections but only 73% completed all sections of the toolkit. Participants spent an average of 36 minutes discussing it with their family members and/or LTC staff. Participants reported: a better understanding of ACP after using the tool (80%), that the tool helped clarify the available resources and/or choices (53%), and that they felt less apprehensive about ACP after using the tool (60%). Qualitative findings revealed many strengths (e.g., usefulness, ability to start difficult conversations, content and clarification), and weaknesses of the tool (e.g., redundant information, difficulty understanding the content and lack of information regarding medically assisted dying). Family members noted that the toolkit would have been helpful to receive earlier on in their family members’ disease trajectory, perhaps before being admitted into LTC. These study findings support the CSK for residents and family members to have ACP discussions in LTC. Future work is needed to evaluate the effectiveness of the tool with a larger sample.

LGBTQ PROGRAMMING AT SENIOR CENTERS IN MASSACHUSETTS
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LGBTQ seniors have some different needs for programs and services, are at a higher risk of social isolation, and are often underserved in the community. Senior centers serve as a hub of resources in a community and are purposefully situated to address the needs and interests of all seniors in a community; they are a natural outlet for targeted programming for LGBTQ seniors. The purpose of this project is to demonstrate what municipal senior centers across Massachusetts are doing to meet the needs of their LGBTQ seniors. A total of 24 senior centers were identified by the Massachusetts Association of Councils on Aging (MCOA) as providing LGBTQ programming. Semi-structured interviews were conducted with 14 senior center directors or programming staff from different communities across Massachusetts to learn more about their specific programming. For almost all senior centers in this study, the main LGBTQ-specific programming was a congregate meal with an activity. Activities included both recreational activities like a film-screening and educational engagements such as guest speakers or specialists on housing, legal services, and health promotion. Distinguishing characteristics included whether or not programming had an intergenerational component, type of recruitment methods, and geographic clustering of programs. For example, two regions emerged as having shared activities for LGBTQ seniors. Results from this study will be used to illustrate models of best practice when it comes to LGBTQ programming for older people.

LTSS IS LOCAL, EVEN IN COUNTRIES WITH NATIONAL LTSS PROGRAMS
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This study reports the results of a cross-national qualitative assessment of how different countries structure their provision of long term services and supports (LTSS). It emphasizes the universality of the local role, even in countries that offer some form of universal coverage for LTSS. At minimum, countries devolve the responsibility for administration and eligibility determination to sub-national units, variously called provinces, départements, Länder, or other terms. However, many countries do much more than that: sub-national units can be responsible for the safety net welfare programs that pick up the costs that the universal programs do not cover. They may also run other programs that affect the ability of people with LTSS needs to live good lives, such as housing and health programs; again, the role of sub-national governments often focuses on those least able to pay. In addition, in some countries, local governments have a role in helping to finance the national program as well. Differing abilities to support these responsibilities across regions can result in geographic disparities in access to care – so, too, can differences in administration and eligibility determination, resulting in many of the same issues that we in the US confront regarding access to LTSS through the Medicaid program. Thus, even countries with strong national programs for LTSS experience many of the same tensions between national and sub-national units of government that we in the US do.

DISPARITIES IN ACCESSING DIFFERENT TYPES OF LONG-TERM CARE SERVICES IN TAIWAN
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A growing body of evidence documents pervasive social and demographic factors relating to disparities in long-term care (LTC). In 2007, Taiwan implemented its Ten-year Long-Term Care Plan version 1.0 (TLTCP 1.0) that aimed to develop a home-and community-based (HCBS) LTC system. In 2016, Taiwan began to implement TLTCP 2.0. To continue providing effective LTC, this study aimed to assess the disparities in access to LTC services using Taiwan’s LTC claim database from 2010 to 2013. A total of 87,438 older adults who had applied for LTC services from the TLTCP 1.0 were included. The study assessed LTC disparities related to five sociodemographic factors, including age, gender, living status, urbanization, and income status. Sixteen types of LTC services, including HCBS, home-based professional
care, meal services, transportation, and institutional services were assessed. After controlling for the level of disability, we found that those who were older-old (age 80+ over), male, and low-income were less likely to use HCBS, but more likely to use institutions services (p < 0.001). We also found that those who lived in the city were more likely to use HCBS and transportation services (p < 0.001). Yet, older adults living alone were more likely to use home care and meal services but not other types of LTC services (p < 0.001). In conclusion, the social disparities in access to LTC services in Taiwan remains, suggesting LTC 2.0 should continue monitoring and placing the LTC equity issue on the top priority.

ADVANCE DIRECTIVES: STATE REQUIREMENTS, PRACTICES, AND PREVALENCE IN ADULT DAY SERVICES CENTERS

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Advance directives (ADs) are documents that express a person’s healthcare preferences if he/she is unable to make decisions. Adult day service centers (ADSC) may serve as an entrée to advance care planning for many people. This study examined the relationships among: 1-state requirements on ADSCs to provide information on ADs; 2-ADSC’s awareness of their state requirement; 3-ADSC’s practice in providing AD information; and 4-the percentage of ADSC participants with an AD. From the 2016 National Study of Long-Term Care Providers, 3,300 ADSCs reported that they maintained documentation of ADs in participants’ files. Nine states required ADSCs to provide information on ADs; 22% of ADSCs were located in these states. About 24% of ADSCs did not know if their states had requirements; among the 76% of ADSCs that reported knowing, 62% were correct and 37% were incorrect. About 80% of ADSCs provided AD information to their participants, while 41% of ADSC participants had an AD on file. Regression models controlled for size, chain and profit statuses, Medicaid-licensing, medical or social care model, electronic health records use, and Census region. Having state requirements was not independently associated with ADSCs’ practice of providing AD information or with the percentage of participants with an AD. Instead, ADSCs that thought their state had a requirement had greater odds of providing information on ADs, regardless of state requirements. Similarly, ADSCs that thought their state had a requirement and that provided AD information had a higher percentage of participants with an AD, independent of state requirements.

STATE VARIATION IN NURSING HOME CIVIL MONEY PENALTY ENFORCEMENT ACTIONS FOR QUALITY DEFICIENCIES

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States vary in their overall rates of nursing home deficiency citations as well as deficiencies for actual harm or jeopardy (Harrington et al., 2018). Civil Money Penalty (CMP) fines collected by the Centers for Medicare and Medicaid Services (CMS) are one enforcement action imposed to promote nursing home compliance with regulations. Collected CMP funds are redistributed to states for the sole purpose of improving nursing home resident care and quality of life through reinvestment in quality improvement projects. Using CASPER data available for US skilled nursing homes in 2015 and 2016 through the CMS QCOR database, we examined the distribution of quality of care (QOC) and quality of life (QOL) deficiencies and CMP enforcement action across states. Guided by the systems framework for evaluating nursing home quality (Unruh & Wan, 2004), we further explored how contextual factors such as state spending for nursing home care, structural characteristics of facilities in states, and inadequate care processes indicated by deficiencies contribute to CMP enforcement actions and fines. Findings indicate that 27% of enforcement actions resulting in a CMP between 2015 and 2016 were imposed for a QOL deficiency while 61.7% represented QOC deficiencies. QOL deficiencies represented only 8% of the highest severity deficiency category but 81.7% of enforcement actions for QOC were for those causing immediate harm or jeopardy. QOC deficiencies are a focus of enforcement actions as they represent critical care processes influencing resident basic needs for hydration, ambulation, skin integrity and care for other special physical and behavioral needs.

ANTICIPATED NEED FOR NURSING HOME PLACEMENT AMONG LESBIAN, GAY, BISEXUAL ADULTS AGES 50-64: FINDINGS FROM THE HRS

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By 2030, the population of LGBTQ older adults is expected to exceed 6 million. Yet little is known about the expected use of nursing homes (NH) among LGBTQ older adults. Prior research has found NHs lack cultural sensitivity, and that LGBTQ NH residents are going “back into the closet” and not disclosing their sexual orientation due to discrimination and quality of care concerns. Using data from 2016 HRS, we describe bivariate differences between the LGB and heterosexual population, ages 50 to 64, and conduct a linear regression to determine the impact of LGB status on self-reported chance of moving to a NH in the future. Compared with the heterosexual population (n=4,049), these LGB adults (n=158) had a higher mean self-reported chance of moving to a NH (p<.01), fewer children (p<.01) and reported a slightly higher health rating (p<.05). LGB adults ages 50-64 also were more likely to be unmarried (71%, p<.001), white (59%, p<.001) and have a college degree (51%, p<.001). After controlling for sociodemographic variables, there were no significant differences between LGB and heterosexual adults’ self-reported chance of moving to a NH. Although anticipated chance of moving to a NH is no different for LGB adults ages 50-64 when controlling for their sociodemographic profiles, as a group they have a higher anticipated chance than heterosexual adults. These findings support the need for improved education, training, and structural changes within long-term care settings to better serve the growing older adult LGB population.