Oregon was the first state to legalize medical aid-in-dying (MAID), in 1994. Since then, eight states and Washington, DC, have legalized MAID through legislation. Despite literature exploring the legal and ethical aspects of MAID, very little research examines MAID policy at the federal level. This study aimed to 1) examine the objectives of MAID legislation introduced to the US Congress, and 2) investigate whether these bills increase or decrease access to MAID. This study used the congress.gov website to search for bills related to MAID introduced by the US Congress between 1994 and 2020. From the 98 bills identified, we excluded bills that were not directly related to MAID or were introduced in subsequent congresses. In total, 23 bills were retained and analyzed. The greatest number of bills aimed to restrict funds for MAID, followed by bills that sought to regulate the drugs used for MAID. Other bills prohibited the development of policies supporting MAID, regulated penalties for practitioners related to the drugs used for MAID, and restricted legal assistance for accessing MAID. These bills intended to block or limit patient access to MAID by restricting drugs, funds, health care services, legal assistance, policy, and research. These findings suggest that the federal approach is incongruent with the growing numbers of states that have legalized MAID. Federal policymakers must develop policies to 1) prevent discrimination against vulnerable groups, 2) support funds to study MAID, and 3) build a system to allow eligible individuals to access MAID equally.

ASSISTED LIVING ADMINISTRATORS’ VIEWS OF PALLIATIVE CARE

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As many older adults with progressive chronic conditions choose to age-in-place in assisted living (AL) communities, external healthcare workers (e.g., those who provide palliative care) increasingly support AL staff in caring for residents with complex health needs. Palliative care is a branch of healthcare dedicated to preserving quality of life by attending to the physical, mental, and spiritual needs of individuals with chronic, life-threatening diseases and is well suited to manage AL residents’ progressive medical conditions. However, AL residents and their care partners often face barriers to accessing palliative care. Using data from a larger 5-year NIA-funded study, we examined AL administrators’ knowledge and use of palliative care in seven AL communities around the Atlanta metropolitan area that were racially, ethnically, and socioeconomically diverse. Findings from thematic analysis of semi-structured interviews with 16 administrators indicated that 15 of 16 administrators were familiar with palliative care. A minority of administrators clearly distinguished palliative care from hospice services and conceptualized it as a “bridge” to hospice services. Administrators emphasized how palliative care assists communities in caring for health concerns in-house rather than having to send residents to the hospital. Despite their positive view of palliative care, administrators described infrequent use of palliative services in their communities. Findings show that although none of the AL communities integrate palliative care with their service offerings, AL administrators see value in palliative care for their residents. We provide recommendations for improving palliative care access and quality of life for AL residents at end of life.

DO STATE AGENCY ON AGING STRATEGIC PLANS INCLUDE TERMS RELATED TO MALNUTRITION?

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Demand for federal nutrition assistance programs is increasing as the older population grows and further accelerated with the COVID-19 pandemic. Older adult nutrition programs are based on federal nutrition guidelines that have traditionally focused on healthy populations, yet many older adults have multiple chronic conditions/advanced age. Some guidelines are changing; the 2020 Dietary Guidelines for Americans recognize older adults’ risk for malnutrition and also need for adequate protein to prevent lean muscle loss with age. The 2020 Older Americans Act (OAA) reauthorization included reduction of malnutrition in OAA’s official purpose and added program participant screening for malnutrition. The OAA requires State Agencies on Aging submit multiyear strategic plans to receive program funding, but it is unknown how the plans address risks for malnutrition, including overweight, underweight, and muscle loss (sarcopenia/frailty). We searched 51 State Agency on Aging strategic plans posted at advancingstates.org to determine their frequency of mentioning nutrition, malnutrition/underweight/undernutrition, obesity/overweight, frail/frailty, sarcopenia, and dietary supplements/oral nutrition supplements (DS/ONS)/meal replacements. Every state plan included nutrition but less than a third included malnutrition. There was wide variability in how nutrition and malnutrition were incorporated into state goals and strategies. Very few plans included obesity, frailty, and DS/ONS terms; none included sarcopenia. Although there has been some movement, there is need for many State Agencies on Aging plans to address all aspects of malnutrition including overweight, underweight/other factors related to muscle loss (sarcopenia/frailty) that adversely impact healthy aging. Wide disparities in plan structure/use of terms create opportunities for more common approaches/definitions.

DOES CLOSING THE DONUT HOLE REDUCE FINANCIAL BURDENS AMONG MEDICARE PART D BENEFICIARIES?

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The Medicare Part D donut hole has been gradually closed since 2010. But it is still unclear how it has impacted the beneficiaries’ relative financial burdens, especially in the later stage of the closing plan. The measurement of catastrophic health expenditure induced by prescription drugs (CHE-Rx)
reflects the relative financial burdens to beneficiaries’ household income, which bears more information than the measure of dollar-value expenses or the absolute poverty line used in prior studies. Using the Medical Expenditure Panel Survey 2008-2017 longitudinal national representative data and the method of difference-in-differences, this study found that the donut hole closing policy was associated with more usage of prescription drugs (β=2.84, p=0.023) and a higher likelihood of experiencing CHE-Rx (β=2.4%, p=0.011) among those who fell in the donut holes. Besides, the results show that the donut hole closing policy did not generate any immediate effects on prescription drug usage, CHE, and CHE-Rx. For the first time, this paper examined both the aggregated and marginal impact of the policy implementation, which had closed by an additional 35% between 2013 and 2017, on the relative financial burden among the beneficiaries.

HOME- AND COMMUNITY-BASED SERVICES USE PATTERNS AND FUNCTIONAL IMPROVEMENT AMONG OLDER CARE RECIPIENTS IN TAIWAN

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The new version of Taiwan’s 10-Year Long-Term Care Plan launched in 2016 aims to reinforce the integration of home- and community-based services (HCBS). The underlying HCBS use patterns and effectiveness of functional improvement among care recipients merit investigation. The purpose of the study was to examine the association of HCBS and changes in ADLs among care recipients with different levels of disabilities in Taiwan. We accessed the sub data of Taiwan’s Long-Term Care Services Management Online System. Samples were aged 65 and over and had completed records of baseline and reassessment information during 2018 (N = 4787). Latent class analysis and multivariate linear regression were applied to examine the formation during 2018 (N = 4787). Latent class analysis and multivariate linear regression were applied to examine the relationship of HCBS and functional changes. Four HCBS subpatterns were found: home-based personal care services (home-based PS) (59.16%), home-based reablement services (home-based RS) (23.90%), home-based multiple services (home-based MS) (11.93%), and community-based services (5.01%). In the cases with mild disabilities at baseline, recipients receiving home-based RS had higher probabilities of improving in ADLs among four HCBS subgroups (for example: β = 2.65, SE = 1.19 in comparison to home-based PS). Care recipients with moderate-to-severe disability at baseline, ADLs improvement was only found in home-based PS (β = 1.63, SE = 0.82 in comparison of home-based MS). In the cases with profound disabilities, home-based PS showed positive effects on ADLs improvement (β = 2.45, SE = 0.80 in ADLs, compared to home-based RS). The study suggested that HCBS subpatterns had different impacts on older adults with different disability levels.

LEADERSHIP AMONG DIRECTORS OF SOCIAL WORK

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Long term care facilities (LTC) provide ongoing care for seniors and chronically ill. To maximize the quality of the care, LTC staff must be properly trained to respond to patient care crises and communicate across departments. Although researchers have studied the leadership styles, strategies, and interactions of facility administrators and nursing directors, little was known about the leadership styles and strategies employed by the director of social worker (DSW). The aim of this phenomenological study was to explore how DSW influenced leadership policies, prepared subordinates for crisis intervention and management, perceived that social workers influenced patient care decisions, and believed that communication amongst SNF staff about patient care could be improved. The conceptual framework was based on the multilevel leadership model construct, the situational leadership model construct, and the complex adaptive leadership model construct. Participants included a purposive sample of 10 DSW working in a large, corporate SNFs in Virginia. Data were collected via in person, semi structured interviews consisting of open-ended questions. Data were analyzed via Hykner’s phenomenological approach. Findings from this investigation helped clarify roles and responsibilities of DSW, thereby improving the leadership they provide to subordinate social workers. Findings may be used to improve communication across professionals within SNFs and in their role in patient decisions.

LEADERSHIP AMONG DIRECTORS OF SOCIAL WORK IN LONG TERM CARE FACILITIES

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Long term care facilities (LTC) provide ongoing care for seniors and chronically ill. To maximize the quality of the care, LTC staff must be properly trained to respond to patient care crises and communicate across departments. Although researchers have studied the leadership styles, strategies, and interactions of facility administrators and nursing directors, there is a substantial gap in the literature on the leadership styles and strategies employed by Directors of Social Work (DSW). The aim of this phenomenological study was to address this gap in research by exploring how DSW influenced leadership policies, prepared subordinates for crisis intervention and management, perceived that social workers influence decision making in patient care, and believed that communication amongst LTC staff about patient care could be improved.

PREPARING EFFECTIVE INTERPROFESSIONAL TEAMS TO MEET THE NEEDS OF OLDER ADULTS IN INTEGRATED HEALTHCARE SETTINGS

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Background: Gerontology education has evolved from focusing primarily on the individual practitioner outcomes to promoting integrated, inter-professional team approaches to integrated care. Practicum training and service learning are effective pedagogy for paraprofessionals in integrated care settings to support clinicians and advance their effectiveness in meeting the needs of older adults. Interprofessional education (IPE) aims to enhance the capacity of practitioners to work collaboratively as integrated team members. Yet, little is