staffing (nurses reluctant to take temporary jobs) and investment in establishing programs (building EMR components, changing workflows, creating inpatient processes in an outpatient setting). Programs adapted to uncertainty in multiple ways: 1) operating parallel waiver and non-waiver programs; 2) seeking to operate/ calculate the HaH value for their institution; 3) determining which patients would benefit most from HaH; and 4) seeking additional health system financing options beyond the CMS reimbursement (new programs) or relying on existing contracts with payers (existing programs). Implementing HaH is a complex and resource intensive process. Greater clarity from CMS regarding the waiver’s future state will encourage programs to invest the resources that they need to establish their programs long-term. Waiver extension/permanence would also enable programs to develop and test measures of value, making rigorous evaluations possible to optimize different HaH components.

EXPLORING QUALITY AND COVID MEASURES OF NEW YORK STATE LONG-TERM CARE FACILITIES INVOLVED IN THE SAFE STAFFING LAWSUIT
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In April 2021, New York’s “Safe Staffing” law capped Long-Term Care Facility (LTCF) profits. LTCFs with “excess profits” are now challenging the law in court. This study examined how LTCFs involved in the lawsuit differed from other NY state LTCFs before and during the COVID-19 pandemic. LTCF “Safe Staffing” lawsuit data were obtained from Long Term Care Community Coalition, then linked with Centers for Medicare and Medicaid Services COVID-19 and Small Business Association Paycheck Protection Program (PPP) data. First, we tested for differences across quality measures. We found that, compared to LTCFs not involved in the lawsuit, LTCFs in the lawsuit were more likely to be located outside of a hospital, report more certified beds and higher occupancy rates, and have higher overall quality scores. LTCFs in the lawsuit also reported lower staff ratings and staffing hours, which have previously been identified as a determinant of higher mortality in LTCFs. To create valid comparisons given these systematic differences, we specified “Doubly Robust” Augmented Inverse Probability Weighted regression models and tested if lawsuit involvement was associated with COVID-19 outcomes. Despite finding higher rates of admitting patients infected with COVID-19 in “excess profit” LTCFs, we did not find that COVID-19 deaths differed by lawsuit involvement. Finally, lawsuit involvement was associated with a higher probability of receiving a PPP loan. Before and during the pandemic, LTCFs with “excess profits” appeared fundamentally different than other NY LTCFs. How these differences impact the health of older adults receiving long-term care beyond the pandemic remains unknown.

FACTORS ASSOCIATED WITH THE AVAILABILITY OF SPECIALIZED RESOURCES TO TACKLE OBESITY IN HIGH MEDICAID NURSING HOMES
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The purpose of this research is to explore the factors associated with the availability of specialized resources required to care for obese residents in high Medicaid nursing homes (NHs) (85% or higher). Due to the vagaries of payment models—Medicaid payments lag other modes of NH reimbursements—high Medicaid NHs typically report poorer quality and financial performance. Operating in a financial perilous environment, and with obesity among the elderly on the rise, high Medicaid NH may particularly struggle to obtain the appropriate resources essential to cater to obese residents’ needs. Utilizing the resource-dependent theory, we hypothesized that occupancy rate, acuity index, and payer mix may be positively associated with the availability of obesity related specialized equipment in high Medicaid NHs. The study was conducted by merging survey and secondary data sources for the year 2017-2018. Obesity related data was collected via mail surveys sent to Directors of Nursing in high Medicaid NHs. The survey data was merged with the following secondary data sources: Brown University’s LTCF Focus, Area Health Resource File, and the Medicare cost reports. The dependent variable was the summative obesity score that ranged from 0-19 with the larger number indicating greater availability of obesity-related equipment/services. An ordinary least square regression with propensity score weights (to adjust for potential non-response bias), and appropriate organizational/market level control variables were used for our analysis. Results suggest that payer mix (Medicare residents) and acuity index were positively associated with the summative obesity score (p < 0.05). Policy and managerial implications are discussed.

INFORMATION SHARING TO SUPPORT CARE TRANSITIONS FOR PATIENTS WITH COMPLEX MENTAL AND BEHAVIORAL HEALTH NEEDS
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Information sharing practices between hospitals and skilled nursing facilities (SNFs) are insufficient to effectively support patient handoffs. Information needs are even greater for SNFs that admit patients with complex behavioral needs. It is unclear whether these needs have prompted hospital investment in enhanced information sharing with these SNFs, and what strategies these facilities are using to meet informational needs. We use data from a 2019 nationally representative SNF survey (N=265, response rate 53%) designed to gather information on information sharing practices with hospital partners. 122 SNFs (57% of respondents) report accepting at least two of the following complex conditions: serious mental illness, substance use disorder, or medication assisted treatment. Using logistic regression models that adjust for facility ownership and rurality, SNFs that accept complex patients are significantly more likely to receive information on behavioral, mental, and functional status compared to facilities who accept none or only one type of complex patient (odds ratio=2.42; p=0.023). Unadjusted models indicate that facilities that accept complex patients lag in IT-facilitated access to hospital information, and report more difficulty securing timely access to information. The significance of these findings do not persist after adjustment, suggesting structural differences in the types of SNFs.
that hospitals are partnering with to improve information sharing. We conclude that while SNFs that accept complex patients are mostly keeping pace or even doing slightly better in terms of access to hospital information that supports transitional care, further investment is needed to improve hospital information sharing behaviors.

**REBALANCING LONG-TERM CARE: THE ROLE OF MEDICAID-MANAGED LONG-TERM SERVICES AND SUPPORTS**

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From 2018 to 2020, Pennsylvania conducted a phased implementation of a mandatory Medicaid managed long-term services and supports program called Community HealthChoices (CHC). The new program covers people receiving Medicaid financed long-term services and supports (LTSS) in nursing homes and home and community-based settings. The three participating MCOs are incentivized to serve people in the community. This study took advantage of the phased implementation to generate causal estimates of the effect of the new program on both the extensive margin (the proportion of people receiving HCBS vs. nursing homes), and the intensive margin (the type and amount of HCBS services). Medicaid claims data for the years 2013 to 2020 were analyzed to examine pre-program trends and program effects. There was a long-term pre-program trend away from nursing homes. The implementation of managed care did not appear to accelerate this trend, however, analysis of data from 2020 is complicated by the COVID-19 pandemic. However, MLTSS did appear to control growth in hours of personal care per person both in the aggregate and longitudinally within the same individuals over time. There were decreases in the use of adult day services and home delivered meals. However, the decline in home delivered meals was more than offset by an increase in uptake of the supplementary nutritional assistance program (SNAP). This is the first causal analysis of the effects of managed care on use of long-term services and supports. The findings have implications for other states that are considering implementing similar policies.

**SESSION 3670 (SYMPOSIUM)**

**TECHNOLOGY DESIGN AND IMPLEMENTATION TO PROMOTE EQUITY, INCLUSION, AND DIVERSITY**

Chair: Walter Boot

The design of technology and technology-based solutions for the challenges many older adults face must consider principles of equity, inclusion, and diversity, or there is a risk of exacerbating digital divides in our society. This session focuses on the design, evaluation, and implementation of technologies to support older adults considering the diversity of the older adult population with respect to factors such as race and ethnicity, income level, health conditions, and cognitive status. M. Harris will discuss the facilitators and barriers identified by Black older adults related to the use of wearable devices for health monitoring. J. Chung will present on the development of a smart speaker application to support wellness among low-income senior housing residents. C. Berridge and E. Sanders will discuss designing technology solutions related to diversity with respect to cognitive status, with Berridge discussing preferences of older adults with mild Alzheimer’s disease for a technology-delivered planning tool, and Sanders presenting technology-based solutions to support the prospective memory of older adults with diverse cognitive impairments. Finally, Schiaffino will present a study examining the acceptability of community-based telehealth programs among vulnerable older adults as a function of health, language, and ethnicity. General themes of inclusive design to ensure that all older adults can benefit from existing and emerging technology-based solutions will be highlighted.

**EXPLORING THE POTENTIAL OF WEARABLE DEVICES FOR HEALTH MONITORING: A FOCUS ON BLACK OLDER ADULTS**

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Chronic diseases are some of the top conditions leading to death in the United States. Management of these chronic diseases could benefit from monitoring risk factors, such as physical activity. Wearable devices (e.g., Fitbit) have the capability to track and give information to allow the individual to take control of their health. However, wearables are typically advertised to young, physically active, and individuals who belong to racial groups with the highest population. As such, the purpose of this study was to understand Black adults’ opinions and attitudes towards wearable design to support usage, focusing on both users and non-users. Participants were interviewed to explore their wants and needs towards wearables to support usage (e.g., aesthetics) and to overcome barriers (e.g., usability concerns). The findings from the thematic analysis will be presented to illustrate these facilitators and barriers identified by Black adults. These insights can guide future inclusive design.

**ENGAGING LOW-INCOME SENIORS IN PARTICIPATORY DESIGN OF SMART SPEAKER APPLICATIONS FOR WELLNESS**

Jane Chung1, Jodi Winship1, Tracey Gendron2, Rachel Wood1, Natalie Mansion3, and George Demiris4, 1. Virginia Commonwealth University, Richmond, Virginia, United States, 2. Virginia Commonwealth University College of Health Professions, Richmond, Virginia, United States, 3. Bon Secours Mercy Health System, Cincinnati, Ohio, United States, 4. University of Pennsylvania, Philadelphia, Pennsylvania, United States

Low-income senior housing (LISH) residents are at a high risk of unmanaged health conditions, loneliness, and limited healthcare access. Smart speakers have the potential to improve wellness in LISH settings. We conducted a user-centered process with primarily African American, LISH residents (N=25) to develop prototypes of smart speaker applications for wellness and social connections. Five focus groups were conducted to elicit feedback about challenges with maintaining wellness and attitudes towards smart speakers. Participants expressed their desires for using the technology for safety and health. Through design workshops,