validity of MEDSAIL for use with nursing home residents. Participants were twenty-four residents of a Veterans Health Affairs nursing home. Exclusion criteria were cognitive impairment too severe to complete the protocol, diagnosis of serious mental illness or developmental disability, inability to hear, and inability to communicate verbally. Participants completed two assessments: the MEDSAIL interview administered by a research assistant and the criterion standard capacity interview administered by a geriatric psychiatrist. We examined internal consistency, convergent validity, divergent validity, and criterion-based validity. Five of seven MEDSAIL scenarios approximated acceptable levels of internal consistency (α>0.70). MEDSAIL scores were positively correlated with the criterion standard (r=0.88, p<0.001), and the Wilcoxon Rank Sum Test statistic was also statistically significant (p<0.001). MEDSAIL has promise as a user-friendly brief screening tool in nursing homes to understand resident capacity for SAIL and to inform development of discharge plans to keep the resident safe and independent in the community.

VALUE-BASED PURCHASING FINANCIAL OUTCOMES AMONG MINORITY-SERVING SKILLED NURSING FACILITIES
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Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) ties post-acute payments to readmissions performance. Minority-serving SNFs tend to be poorly resourced and understanding the financial implications of SNF-VBP is important. Our study examined VBP payments and penalties among minority-serving SNFs. We conducted cross-sectional analysis using public data sources. We defined minority-serving as SNFs with >50% of residents who are African American (AA)/Black (n=764) or with >50% of residents who are Hispanic/Latino (n=164). Majority-White SNFs (>50% residents who are White) were the reference group (n=11,002). Outcomes examined were: being in top 20% of performance rankings; receiving a bonus; receiving a bonus that was above the median bonus dollar amount; being in bottom 20% of performance rankings; receiving a penalty; receiving a penalty that was below the median penalty dollar amount. Logistic models estimated the likelihood of experiencing each performance outcome for AA/Black-serving and Hispanic/Latino-serving SNFs in reference to majority-White SNFs. Results show that minority-serving SNFs not only perform worse but also experience greater negative financial impacts. Among those penalized, Hispanic/Latino-serving SNFs had the largest average penalty amounts: $32,575 compared to approximately $26,000 for both AA/Black- and White-serving SNFs. Hispanic/Latino-serving SNFs had 1.69 times the odds of receiving larger than median penalties and AA/Black-serving SNFs had 27% lower odds of receiving higher than median bonus payments. Average penalties approximate the average salary for a certified nursing assistant, the primary direct care worker in this setting. Results from this study raise concerns over long-term impacts. Alternative approaches to encouraging quality should be considered.

SESSION 2849 (POSTER)
ELDER MISTREATMENT: PREVENTION, PROGRAMS, PRACTICE, AND POLICY
AN ORPHAN NEEDING A CHAMPION—BARRIERS TO EVALUATIONS OF DECISION-MAKING CAPACITY
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Impaired decision making capacity is common in medical and community settings, often coexistent with functional impairment and dementia. Though the legal system determines competence, deciding if guardianship is appropriate often relies on a medical assessment of decision making capacity. Physicians conduct cognitive evaluations but are often unaware of a person’s functional impairments and are unfamiliar with their role in pursuing guardianship. Despite the individual roles of the legal system, medical system, and community agencies (e.g. Adult Protective Services (APS)) in such cases, no agency claims responsibility for ensuring this process’s fidelity. As numbers of older citizens in the US increase along with associated increasing numbers of cases involving impaired decision making capacity, ensuring this processes’ fidelity is essential. We sought to identify the barriers (recognized by each of these parties) in determining decision making capacity of persons for whom guardianship is being considered. Surveys were conducted with professionals in the legal, medical, and APS arenas, to identify barriers to obtaining capacity determinations. Common themes identified amongst these entities included needing to include functional status in this evaluation, and the need for clear communication between the legal system, medical system, and APS. Unique concerns identified in the survey included APS caseworkers challenges in finding physicians willing to complete capacity evaluations, judges’ concerns about evaluations’ failure to address safety issues and need for immediate action, and physician’s concerns about liability and compromising the physician-patient relationship. Continued collaboration between these systems could overcome these barriers.

APPLYING EVIDENCE-BASED VIOLENCE PREVENTION STRATEGIES TO ELDER ABUSE IN PUBLIC HEALTH
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Elder abuse is a growing problem with significant public health implications. Because elder abuse shares root causes with other types of violence (e.g., suicidal behavior, intimate partner violence), awareness of elder abuse as a violence prevention priority is rising among public health professionals. Major limitations, however, affect delivery of effective population-level primary prevention for elder abuse, necessitating increased community partnerships. In Washington State, the Department of Health’s Injury and
Violence Prevention Section and the Department of Social and Health Services Adult Protective Services Division are leveraging existing strategies to increase identification and reporting of potential elder abuse from falls and injury prevention partners (i.e., opioids, suicide). We describe: (1) challenges and opportunities in creating unique cross-program collaborations, (2) the combined education and outreach efforts of this partnership, and (3) strategies for sustained collaboration. Additionally, we share results of a scoping literature review on evidence-based violence prevention strategies applicable to elder abuse between 2015 – 2019. In the Pubmed and Academic Search Complete databases, the following terms were searched: elder abuse prevention, primary prevention, shared risk and protective factors. Only six articles were identified that addressed primary prevention efforts. Researchers note that primary prevention of elder abuse is poorly understood and challenges exist in applying methods from other types of violence. Education for key community members on identification of abuse is a promising intervention targeting shared risk and protective factors for public health to pursue. Cross-sector community partnerships and rigorous evaluation of primary prevention approaches are needed.

CAREGIVER RESILIENCE AS A PROTECTIVE FACTOR FOR ELDER ABUSE
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This study examines the protective function of caregiving resilience and caregiving self-efficacy for elder abuse. A convenient sample of 600 family caregivers of community dwelling older Chinese in Hong Kong were individually interviewed. Participants were assessed on the caregiving context, care recipient physical functioning and behavioral problems, perceived caregiver stress, neurotic personality, caregiving self-efficacy and resilience. Past year elder abuse was assessed using Revised Conflict Tactic Scale and Older Adult Financial Exploitation. Elder abuse is common in this sample: 7.5, 11.5, 24 per cent reported physical, psychological, and financial abuse respectively. Injuries were reported in 2.3% of the sample. Hierarchical linear regression analysis was conducted. Number of co-residing days and hours of care provided per week were entered into Model One; Care recipient physical functioning, behavioral problems, and caregiver stress were entered into Model Two; Caregiver resilience and caregiving self-efficacy were entered into Model Three. Care recipient behavioral problems and caregiver stress were prominent factors associated with abuse across all models. With the exception of physical abuse, caregiver resilience buffered the effects of care recipient behavioral problems and caregiver stress on all forms of elder abuse. No such effect was observed for caregiving self-efficacy. Intervention efforts aiming at fostering caregiver resilience could potentially prevent elder abuse.

COMPARING ELDER AND CHILD ABUSE PREVENTION APPROACHES IN JAPAN: STRATEGIES FOR REDUCING ELDER ABUSE
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This paper examines trends in elder abuse cases (types of abuse, traits of abusers, victims and their relationships, levels of disabilities and dementia of victims, etc.) by using longitudinal data (2012-2018) collected by Japan’s Ministry of Health, Labour and Welfare since its enforcement. Considering these trends, this paper compares the Elder Abuse Prevention Law to the Child Abuse Prevention Law to assess differences in policy and program provisions and how these relate to successful prevention outcomes. For example, while reports for both elder abuse and child abuse cases have been increasing, governmental actions taken in response have varied. The Child Abuse Prevention Law has been modified 6 times since its enactment based on abuse cases, but no amendments have been made for Elder Abuse Prevention Law based on case or evaluation data. Moreover, there have been many public awareness campaigns for child abuse prevention, but none for elder abuse prevention. These efforts appear to have positive outcomes including increased reporting of child abuse to police. This analysis aims to compare abuse data, abuse laws and public health efforts for children and older adults in Japan. Findings seek to identify disparities and areas where the public approach to child abuse can inform and strengthen elder abuse policies and programs.

ELDER ABUSE AND NEGLECT: TRAINING FIRST RESPONDERS IN RURAL ARKANSAS TO RECOGNIZE, RESPOND, AND REPORT
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As the incidence of elder abuse and neglect continue to rise and plague our country’s older adults, it is imperative that their plight is recognized, reported and elicits an appropriate response. At least 1 out of 10 older adults suffer from at least one type of abuse each year (DOJ, 2020) and only 1 in 24 cases of elder abuse is ever reported to authorities (National Center on Elder Abuse, 2019). Since 41% of Arkansas’ population live in rural areas, reaching and educating first responders who work in these areas is a priority, yet has been a challenge. It has been ascertained that virtually no elder abuse or neglect related training for first responders occurs in Arkansas. In 2015, the Arkansas Geriatric Education Collaborative (a HRSA Geriatric Workforce Enhancement Program) developed an education program and mobilized it to multiple first responder groups including the AR State Police, multiple city and county paramedics’ organizations, EMTs, local police officers and fire fighters. The program was further enhance late in 2019 when the training was made available on-line in conjunction with dementia training. The content and methods of training and test results revealing knowledge gained will be reviewed. Follow-up stories from first responders who have put their training into action in the field will be told as they reveal how they have used their training to identify potential abuse, neglect and self-neglect cases and how they have recognized, reported and addressed specific cases.