transformation in independent living facilities and transformation of education in undergraduate nursing programs.

REFRAMING OLDER ADULTS’ VIOLENCE TOWARD STAFF AS SELF-PROTECTION
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One of the first studies on workplace violence in nursing homes was published in 1985. Forty-five (45) years later, resident violence against staff continues to increase in incidence and severity. At the request of a state senator, a New Hampshire psychiatrist formed a research group to conduct the first New Hampshire survey on staff experience of workplace violence. Study questions focused on experiences of workplace violence and incident reporting, and the availability and benefit of workplace violence training programs. Results were consistent with recently published literature: violence is an expected, normalized element when providing care; potential repercussions and perceived resident lack of intent were major reasons for incident non-reporting. Analysis of study results and review of the literature led to the question: Are older residents’ violent behaviors towards staff an act of self-protection?

IMPROVING POLICY AND LEGISLATION RELATED TO HEALTHCARE WORKPLACE VIOLENCE
Our group conducted the first known New Hampshire survey on healthcare staff experience of workplace violence. Study questions focused on experiences of workplace violence, incident reporting mechanisms, and the availability and benefit of workplace violence training programs. Results were consistent with recently published literature: violence against healthcare workers remains a serious public health problem that is under-reported, understudied, “tolerated and largely ignored.” We will discuss the aspects of policy and legislative responses to workplace violence that have been insufficient to address this problem. We also will present some strategies that, if implemented, could lead to improved policy and legislation that may be more proactive in reducing such violence.

Most older adults with serious illness, including Alzheimer’s Disease and Related Dementias (ADRD) reside in community-based settings. These individuals and their care partners rely on Long Term Supportive Services (LTSS) including nursing home, home health, hospice, and adult day centers to provide support. LTSS are often under-resourced and reimbursed however, with significant regulatory restrictions on the care they can provide. These issues combined with other systemic factors in our healthcare system and society, including racism and poverty, lead to substantial inequities. Even preceding the use of LTSS, ADRD is diagnosed later in non-white individuals and access to high-quality services, including palliative care is severely limited. Moreover, few palliative care interventions address ADRD and even fewer have been specifically tailored to address the needs of our multi-cultural, racially and ethnically diverse society. This symposium will therefore utilize data from several nationwide data sets collected as part of routine care for clinical, billing, and/or regulatory purposes to assess inequities that exist across LTSS sites related to ADRD and palliative care. The individual abstracts show a clear pattern of inequities that stem from endemic systems failures towards people of color in the United States that must be addressed through a multipronged approach. This research shows that policies must be changed to require adequate collection of social determinants of health, to target policies that allow sub-standard or limited access to care, and research and clinical reform to produce a more culturally sensitive approach to care for those with ADRD and other serious illnesses.

ASSOCIATIONS BETWEEN DEMENTIA, RACE-ETHNICITY, AND INTENSIVE AND PATIENT-CENTERED END-OF-LIFE CARE
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A retrospective cohort analysis of Medicare administrative claims data from 2016-2018 compared intensive and patient-centered end-of-life care measures in persons with and without dementia, including the moderating effects of race/ethnicity. Over half (53%) of 483,209 Medicare decedents had a dementia diagnosis. Decedents with dementia were 31-34% less likely to receive intensive end-of-life care (hospital death 95%CI: 0.64-0.67; hospitalization in last 30 days 95%CI: 0.68-0.70) and 50% more likely to receive timely hospice care (95%CI: 1.48-1.52). The association between dementia and end-of-life care varied by decedent race/ethnicity. Compared to non-Hispanic white decedents without dementia, non-Hispanic Black, Hispanic and Asian decedents with dementia were significantly more likely to receive intensive end-of-life care. Non-Hispanic Black decedents with dementia were 23% more likely to receive timely hospice care (95%CI: 1.11-1.36). Additional research is needed to understand why persons with dementia receive less intensive end-of-life care and why differences exist based on racial/ethnic status.

NATIONWIDE INEQUITIES IN NURSING HOME PALLIATIVE CARE SERVICES
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