In 2008, Doll and colleagues assessed the scope of sexual behaviors, staff perceptions of and responses to such behaviors, and whether facilities had a sexual policy in place in SNFs in the state of Kansas (Doll, 2013). In the present study, an online survey was distributed to the same population to provide an updated assessment of sexual behaviors, policies, and practices. Of 60 survey respondents, 62.7% reported knowledge of individual sexual acts (e.g., masturbation) within the past year and 34.5% reported interactional (between two or more residents) sexual acts. When encountering a sexual event, staff were most likely to report the incident to an administrator (76.7%) and treat residents with respect (70.0%), while 35.0% and 41.7% were expected to respond with embarrassment and discomfort, respectively. Only 40% of administrators reported having a policy related to sexual expression. Findings indicate that staff are likely to respond differently to LGBTQ residents due to discomfort and those living with cognitive impairment due to concerns related to consent. The proportion of facilities in Kansas with policies related to sexual expression has increased from 26% to 40% in the past 12 years, but there remains a need for greater specificity of sexuality-related policies and trainings.

THE ROLE OF MINORITY STRESS AND SOCIAL RESOURCES IN THE HEALTHCARE UTILIZATION OF AGING LGBT ADULTS

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Research suggests that minority stress can influence the healthcare utilization of aging LGBT adults, and that social resources can buffer the effect of stress on healthcare utilization. Using data from Aging with Pride: National Health, Aging, and Sexuality/Gender Study (N = 2,560), multiple logistic regression assessed the associations between minority stress (i.e., internalized stigma and LGBT identity disclosure) and healthcare utilization (i.e., health screenings, emergency room use, routine checkups, and regular provider). We also examined the moderating effect of social resources, including social network size, social support, and LGBT community belonging, in these associations. Internalized stigma was negatively associated with having a routine checkup in the previous year (OR = 0.82, p = .038). Disclosure was positively associated with having a health screening within the past 3 years (OR = 1.52, p = .000) and having a regular provider (OR = 1.33, p = .021). Further, we found that social support moderated the association between disclosure and health screenings (OR = 1.52, p < .001); thus, having higher levels of social support and disclosure in tandem increased the likelihood of getting a health screening in the last three years. Health and human service professionals should provide information about internalized stigma and LGBT identity disclosure to educate their clients about the ways in which these minority stressors can impact their healthcare experiences. Providers should assess the social support of their aging LGBT clients and inform them about the added benefit that social support can have in their healthcare experiences.

Session 2155 (Symposium)

TRANSFORMING DEMENTIA CARE: IMPLEMENTATION CHALLENGES MOVING EVIDENCE-BASED PROGRAMS TO HEALTH CARE

Chair: Laura Gitlin
Co-Chair: Kenneth Hepburn
Discussant: Sara Czaja

Although evidence for dementia care programs continues to grow, families and health providers do not have ready access to programs, nor have they been widely disseminated and routinized in healthcare. Understanding implementation considerations when embedding evidence-based programs in healthcare systems can inform ways to effectively transform dementia care. This symposium will examine similarities and differences in implementation challenges encountered and strategies used when implementing four evidence-based programs being tested in different healthcare environments using distinct study designs. Dr. Gaugler et al., will discuss implementation challenges encountered with a staff-delivered intervention (ADS Plus) to support caregivers in adult day services that is being tested using a mixed methods hybrid trial design in >50 sites nationally. Dr. Hodgson et al., will discuss adaptations and their measurement to COPE, a home-based dyadic support program being embedded in 10 PACES of a large healthcare system using a noninferiority trial testing staff training strategies. Dr. Forester et al., will examine implementation of the Care Ecosystem for dementia patients in a high-risk, integrated care management program using a pilot embedded pragmatic trial. Dr. Hepburn et al., will explore tactical challenges of implementing Tele-Savvy, an online caregiver psychoeducation program, within the context of a pilot pragmatic clinical trial. Drawing upon implementation science, themes discussed include balancing adaptations and fidelity, measurement of implementation outcomes and organizational readiness, and staff training implications. Also highlighted are research design considerations. Dr. Czaja, an expert in the design and implementation of dementia care interventions from in-person to technology-based will be the discussant.

ADDRESSING TACTICAL CHALLENGES IN EMBEDDING TELE-SAVVY IN A PILOT PRAGMATIC TRIAL

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This presentation describes how we plan to address the challenges of testing an evidence-based caregiver program in a real-world setting without the infrastructure and personal contact of a typical RCT. Instead of screening participants for eligibility, clinic staff will pre-identify participants whom clinicians then confirm. Each clinic will include Tele-Savvy as standard of care; we will thus be able to obtain IRB approval for a waiver of consent. By securing agreement from each clinic to incorporate a small set of standard instruments (e.g., Pearlin Caregiver Competence scale) into their standard operating procedure of routinely collecting caregiver data.