very old age, but there is less evidence for its effect on frailty progression. We used the Newcastle 85+ Study, a longitudinal cohort of people born in 1921 and aged 85 at first assessment in 2006, and followed up at 18, 36, and 60 months. Of the 845 participants at baseline, the Fried frailty status (FFS) was available for 696 participants at baseline of whom 60% (n=414) were women. The effects of SEP in early, mid (occupation) and late-life (area deprivation) on frailty transitions between age 85 and 90 were investigated in multistate models. We found no significant effect of education on any frailty transitions. However those living in less deprived areas were less likely to die when frail (HR: 0.60, 95%CI: 0.40-0.89), and this remained significant after further adjustment for education and morbidity count.

EARLY-LIFE SOCIOECONOMIC POSITION AND ACCUMULATION OF HEALTH-RELATED DEFICITS IN MIDLIFE
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Improved understanding of predictors of frailty is key to delaying its onset. Yet, few studies have examined whether early-life socioeconomic position (SEP) predicts frailty in midlife. In the 1958 British Birth Cohort (n=7601), we examined (i) associations between early-life SEP and frailty at 50y and (ii) whether associations were due to continuities in disadvantage into mid-adulthood. Frailty was measured using an index composed of 37 health-deficits. Associations between early-life SEP and frailty were examined using linear regression. Lower early-life SEP was associated with higher frailty, e.g. compared to professional/managerial class, the frailty index was higher by 3.09% (95% CI: -0.65%, 6.84%) for skilled non-manual, 10.8% (8.20%, 13.4%) for skilled manual and 14.2% (11.1%, 17.2%) for partly skilled/unskilled. After adjustment for adult disadvantage, the trend remained, albeit weaker. Findings suggest that interventions in mid-adulthood targeted to those exposed to early-life disadvantage could reduce the risk of developing frailty when entering later life.

HOW DOES SOCIAL DEPRIVATION INFLUENCE END-OF-LIFE FRAILTY TRAJECTORIES? EVIDENCE FROM ELECTRONIC HEALTH RECORDS
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Recent research has highlighted inequalities in frailty status, driven by social deprivation over the life course. However, little is known about the interaction between deprivation and frailty over clinically relevant timescales. We used an electronic frailty index, generated automatically in health records at monthly intervals for one year in 13,000 people age >75 who died (cases), matched to 13,000 people with no record of death (controls). We used Index of Multiple Deprivation deciles and latent growth curve models to investigate the impact of deprivation on frailty trajectories. Greater deprivation was associated with higher baseline frailty, but did not influence the rate of change in frailty.

We observed greater deprivation driven differences in frailty at baseline in controls than in cases, suggesting that a degree of convergence occurs as people near end-of-life. We discuss these results in light of end-of-life care policy and planning.

SOCIO-DETERMINANTS OF FRAILTY: HAVE THEY CHANGED OVER TIME?
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Socioeconomic inequalities are important drivers of negative health outcomes. This study investigates the effect of social determinants on health using frailty from two studies 20-year apart and examines whether socio-economic differences are widening. A 30-item deficit accumulation score from the baseline data from the two Cognitive Function and Ageing Studies, 1991 (n=7,635) and 2011 (n=7,762) was calculated. For each of the two cohorts separately, binomial regression investigated the relationship between frailty and social determinants. Deprivation was most strongly associated with frailty among the other social determinants. The effect of high deprivation, when compared the lowest tertile, increased in CFAS II (CFAS I: RR=1.21, 95%CI:1.11-1.31; CFAS II: RR=1.47(95%CI: 1.36-1.59). Inequalities in frailty have increased over time, particularly in terms of deprivation. This has important implications for health policy as focusing policies including specific interventions and resources in more deprived areas could greatly improve health outcomes for those areas.

SESSION 1205 (SYMPOSIUM)

LEVERAGING COMMUNITIES AS NETWORKS TO REDUCE MALNUTRITION IN OLDER ADULTS
Chair: Tina Sadarangani, New York University Rory Meyers College of Nursing, New York, New York, United States
Co-Chair: Jeannette Beasley, New York University Langone Health, New York, New York, United States
Discussant: Shannon E. Jarrott, The Ohio State University, Columbus, Ohio, United States

Malnutrition in older adults, while ubiquitous, remains largely underrecognized and undertreated. In community-dwelling older adults, 25% of those at risk of over or under nutrition do not receive any dietary interventions; routine screenings for malnutrition are not typically required in community-based settings. In this interdisciplinary symposium, we explore issues focused on the delivery of evidence-based nutrition interventions to meet the needs of community-dwelling older adults. Using national survey data, we begin by underscoring the importance of treating the complex needs of adults at risk of malnutrition by examining health sequelae, specifically hospitalizations, in community-dwelling adults receiving home-delivered meals. We subsequently examine approaches to malnutrition screening in community-based settings, focusing on the utility of the DETERMINE checklist. We explore barriers and facilitators of providing person-centered nutrition to ethnically diverse
Asian American older adults in the adult day healthcare setting. Finally, we shift our focus to overnutrition, discussing the dissemination of a telehealth diabetes prevention program, BRIngeDiabetes (BRIDGE) among older adult meal program recipients. Older adults in community-based health settings are at risk of malnutrition, and among them, those who are prone to social isolation, are at highest risk for adverse outcomes. While congregate settings can facilitate social interaction, honoring food preferences and facilitating choice to address undernutrition, is challenging. Conversely, telehealth interventions may present a feasible approach for addressing overnutrition. We conclude by discussing how current and future research can inform innovative person-centered community-based approaches to identify and treat malnutrition.

BARRIERS AND FACILITATORS TO DELIVERING PERSON-CENTERED NUTRITION FOR ASIAN AMERICANS IN ADULT DAY HEALTH SETTINGS

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Malnutrition is a growing problem in community-based long-term care settings. Delivering person-centered nutrition is particularly important in congregate settings serving ethnically diverse older adults who have strong culturally-derived preferences around food. We conducted in-depth semi-structured multi-stakeholder interviews (N = 13) in an adult day health center (ADHC) serving Asian immigrants to explore the ADHC’s capacity to deliver person-centered nutrition interventions. Thematic analysis showed ADHCs successfully promoted social interaction at mealtime. However, participants had limited choice and restrictions on additives, like sodium, making it difficult to honor participants’ cultural preferences. Lack of flavor, limited choice, and rushed mealtimes, driven by center policies and procedures, disproportionately affected persons with dementia. Among those with dementia, clinicians disagreed whether nutrition should be used to manage chronic illness or whether a more palliative approach was warranted. One potential way to address this challenge would be to enable greater choice within a supportive ADHC mealtime environment.

PARTNERING WITH NUTRITION SERVICES PROGRAM PROVIDERS TO DISSEMINATE EVIDENCE-BASED PROGRAMS USING TELE-HEALTH

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Among adults ≥ age 65, 48% have prediabetes and are eligible to participate in the Medicare-covered Diabetes Prevention Program (DPP). We conducted a six-week pilot study to evaluate the feasibility and acceptability of a telehealth-adapted DPP for Nutrition Services Program (NSP) older adult meal program recipients. We enrolled NSP recipients (n=16) from a New York City senior center. These DPP participants attended weekly interactive DPP webinars and completed questionnaires covering lifestyle, physical activity, quality of life, and food records, and wore physical activity trackers. Retention was 75%; attendance averaged 80%; and weight loss was 2.9% (p=0.001). Our six-week pilot data suggest that a tele-adapted DPP intervention can achieve the Medicare reimbursement goals for attendance and 5% weight loss. We are surveying NSP recipients, who receive home-delivered meals, to evaluate the acceptability and feasibility of conducting a larger scale tele-adapted DPP intervention trial among NSP participants.

MENTAL HEALTH AND HUNGER: RISK FACTORS FOR HOSPITALIZATION AMONG HOME-DELIVERED MEAL PARTICIPANTS

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Home-delivered meals (HDMs) provided through the Older Americans Act (OAA) are intended to reduce hunger, promote socialization, and maximize wellness. However, HDM recipients are at increased likelihood of being hospitalized due to their complex health needs and risk for social isolation and depression. Drawing data from the OAA-HDM National Survey, we evaluated the predictors of hospitalization among HDM recipients in 2017. From our sample (n = 578), we conducted random forest classification analyses to identify the most important risk factors related to HDM recipient hospitalization. Our random forest model yielded an accuracy rate of 66.3% with risk factors most indicative of hospitalization being attributed to number of co-morbidities, depressive symptoms, and feelings of social isolation. These findings indicate that although HDMs may help alleviate hunger among older adults, innovate strategies are warranted to address the unmet mental health needs of HDM recipients.

ASSESSING NUTRITIONAL RISK IN ADULT DAY SERVICES: UTILITY OF THE DETERMINE CHECKLIST

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Older adults attending adult day services (ADS) often possess risk factors for malnutrition, such as chronic disease, physical disability, and cognitive impairment. We explored the utility of administering to ADS participants the DETERMINE Checklist - a measure of nutritional status. Among eleven participants (M age=77.3 years), 82% (n = 9) presented high nutritional risk. The three most common risk factors were: difficulty shopping, cooking, and/or feeding themselves (100%), making health-related dietary changes (63.7%), and taking three or more daily medications (63.7%). Our preliminary findings indicate that ADS participants may be at moderate-high risk of malnutrition; however, the DETERMINE Checklist may require modification for an ADS population. For example, the checklist may be more reliable if completed jointly by a participant and informal caregiver. We present recommendations for adaptations based on our pilot data as well as implications for ADS staff and clinicians.