A DELPHI STUDY ON DEMENTIA CARE TECHNOLOGY USE AND HOW TO MITIGATE RISKS: DESIGN TO IMPLEMENTATION
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What information is needed to navigate person-centered technology use in dementia care? The threefold aim of this Delphi study was to learn which technologies will be most prevalent in dementia care in 5 years, understand benefits and risks, and identify specific options to mitigate risks. Twenty-one interdisciplinary domain experts from academia and industry in aging and technology in the U.S. and Canada participated, an 84% response rate. Technologies rated most likely to cause value tensions were also predicted to be most prevalent and will be described, along with the identified risks. Suggestions to mitigate the risks are categorized as follows: intervene during design; make specific technical choices; build in choice and control; require data transparency; place restrictions on data use and ensure security; enable informed consent; and proactively educate users. The specific recommendations that are relevant to designers, clinicians, researchers, ethicists, and policy makers will be presented and discussed.

SESSION 7140 (SYMPOSIUM)

LESSONS LEARNED FROM THE FUNCTION AND BEHAVIOR FOCUSED CARE TRIAL: FROM EFFICACY TO IMPLEMENTATION
Chair: Elizabeth Galik
Discussant: Marie Boltz

Long term care residents with dementia are sedentary, experience rapid functional decline, and frequently exhibit behavioral and psychological symptoms of dementia. Our prior cluster, randomized controlled trial among 336 residents with moderate to severe dementia in 12 nursing homes demonstrated that it is possible to increase time spent in physical activity and decrease resistiveness to care through a theory based intervention, Function and Behavior Focused Care (FBFC). FBFC is based on the Social Ecological Model and Social Cognitive Theory and focuses on having long term care staff cue, model, and assist residents with dementia to engage in physical activity and perform functional tasks. Learning from prior work, it was noted that future implementation of FBFC would benefit from de-implementing inaccurate care practices, such as restricting resident mobility and providing custodial care and also by engaging a full stakeholder team in intervention activities. Additionally, there were measurement issues, such as the use of actigraphy with a sedentary, cognitively impaired population, and the need to assess the quality of care interactions between residents and staff. This symposium will review lessons learned from the FBFC trial and will discuss 1) facilitators and barriers to the implementation of the FBFC intervention within long term care settings; 2) measurement opportunities and challenges with a cognitively impaired long term care population; and 3) adaptation of the FBFC intervention to be appropriate for a dissemination and implementation trial that incorporates the Synthesis Model of De-Adoption and the Evidence Integration Triangle implementation strategy.

MEASUREMENT OPPORTUNITIES AND CHALLENGES WITH LONG-TERM CARE RESIDENTS WITH DEMENTIA
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Measuring clinical outcomes among older adults with moderate to severe dementia present practical and psychometric challenges. Proxy report surveys, direct observations, chart abstraction, and objective measures, such as actigraphy are frequently used with this population. The purpose of this paper is to describe issues related to measurement in the FBFC trial. Challenges to actigraphy included the resistance of residents and removal of devices, inability to detect limited movement and/or the type of activity performed. The combined use of the three measures to optimize understanding of physical activity will be addressed. Behavioral outcome measures included the Cornell Scale for Depression in Dementia, the Cohen Mansfield Agitation Inventory, and the Resistiveness to Care Scale. Despite the use of these multiple measures, limited behaviors were identified due to timing of assessments and items included within the measures. Optimal ways in which to capture behavioral symptoms will be reviewed.

FACILITATORS AND BARRIERS TO THE IMPLEMENTATION OF FUNCTION AND BEHAVIOR FOCUSED CARE
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Function and Behavior Focused Care (FBFC) is a two tiered intervention based on the Social Ecological Model and Social Cognitive Theory that focuses on training long term care staff to cue, model, and assist residents with dementia to engage in physical activity and perform functional tasks. FBFC was implemented by a Research Nurse and a facility based Champion for 12 months and involved a four step approach: (1) Environment and Policy Assessments; (2) Staff Education; (3) Establishing Resident Care Plans; and (4) Mentoring and Motivating of Staff and Residents. Facilitators of implementation included administrative support, an identified champion, and supportive environments and policies. Challenges and barriers included the fear of...
falls, fear of behavioral symptom exacerbation, competing priorities, and lack of facility specific goals. Innovative approaches to overcoming these barriers will be reviewed.

IMPLEMENTATION OF FUNCTION AND BEHAVIOR FOCUSED CARE
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There are many challenges to engaging long term care residents with dementia in physical and functional activities. Resident factors include age, comorbidities, cognitive impairment, motivation, sedation and polypharmacy. Facility factors include the environment, policies and culture within the setting such as a focus on safety versus function. Commonly used non-evidence based interventions include discouraging residents from walking by repeatedly telling them to sit down, and limiting recreational activities to seated positions. De-implementation to remove inaccurate care practices and implementation approaches are needed to facilitate implementation of Function and Behavior Focused Care. This paper will describe the use of the Synthesis Model for the Process of De-Adoption and the Evidence Integration Triangle implementation strategy in the development of the Function and Behavior Focused Care intervention to alter behavior among staff and cognitively impaired residents and optimize function and physical activity in long term care.

SESSION 7145 (SYMPOSIUM)

LEVERAGING EXISTING DATA FROM CMS-LINKED COHORT STUDIES FOR THE ADVANCEMENT AND TRANSLATION OF FRAILTY RESEARCH
Chair: Qian-Li Xue
Co-Chair: Kristine Ensrud
Discussant: Shari Lin

As population aging is accelerating rapidly, there is growing concern on how to best provide patient-centered care for the most vulnerable. Establishing a predictable and affordable cost structure for healthcare services is key to improving quality, accessibility, and affordability. One such effort is the “frailty” adjustment model implemented by the Centers for Medicare & Medicaid Services (CMS) that adjusts payments to a Medicare managed care organization based on functional impairment of its beneficiaries. Earlier studies demonstrated added value of this frailty adjuster for prediction of Medicare expenditures independent of the diagnosis-based risk adjustment. However, we hypothesize that further improvement is possible by implementing more rigorous frailty assessment rather than relying on self-report of ADL difficulties as used for the frailty adjuster. This is supported by the consensus and clinical observations that neither multimorbidity nor disability alone is sufficient for frailty identification. This symposium consists of four talks that leverage data from three CMS-linked cohort studies to investigate the utility of assessment of the frailty phenotype for predicting healthcare utilization and costs. Talk 1 and 2 use data from the NHATS cohort to assess healthcare utilization by frailty status in the general population and the homebound subset. Talk 3 and 4 use data from the MrOS study and the SOF study to investigate the impact of frailty phenotype on healthcare costs. Taken together, their findings highlight the potential of incorporating phenotypic frailty assessment into CMS risk adjustment to improve the planning and management of care for frail older adults.

PHYSICAL FRAILTY, COGNITIVE IMPAIRMENT, AND HEALTHCARE UTILIZATION IN LINKED COHORT AND CLAIMS DATA
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Accurate prediction of healthcare utilization is an important issue for Medicare managed care organizations. We hypothesized that physical frailty and cognitive impairment increase the risk of healthcare utilization in older adults receiving Medicare coverage, independent of age and multimorbidity. We used the marginal means/rates model to investigate the association between baseline cognitive impairment with/without frailty (using the physical frailty phenotype), vs. frailty alone, in NHATS and the number of incident non-ER-related hospitalizations and emergency room (ER) visits within 12 months in linked Medicare claims data (N=3,915). After covariate adjustment, physical frailty alone was predictive of both non-ER-related hospitalizations (HR=1.77; p=0.012) and ER visits (HR=1.75; p=0.001). Cognitive impairment with or without frailty was only associated with ER visits (HR=1.53, p=0.002; HR=1.30, p=0.001). Our findings support the value of physical frailty and cognitive impairment assessment above and beyond multimorbidity to improve the prediction of care utilization for vulnerable subgroups of Medicare beneficiaries.

ARE ALL HOMEBOUND OLDER ADULTS FRAIL?
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Seven million adults in the United States are homebound and suffer the negative, powerful synergies of multiple chronic conditions, functional impairment, social stressors, and limited social capital. The prevalence of frailty in this vulnerable homebound population is unknown. Using representative data from the National Health and Aging Trends study (NHATS) study linked to Medicare claims (n=4756) we sought to assess the prevalence of frailty in the homebound population (n=361). Among the homebound, 68.5% met the frailty criteria compared to 12.3% of the non-homebound population. The frail homebound had lower educational attainment, were more likely to live alone, self-reported poorer health and more chronic physical and mental health conditions than the non-frail homebound (p<0.05 for all). Frail