stratified results were presented if the interaction term was p≤0.10. A sex/gender*weight loss assignment interaction was observed for SPPB (p=0.07), with women experiencing greater weight loss-associated improvement in SPPB score (WL: 0.42±0.08 versus NWL: 0.10±0.09; p=0.02) compared to men (WL: 0.30±0.11 versus NWL: 0.30±0.13). A sex/gender*weight loss amount interaction was observed for grip strength (p=0.05), with no difference observed across categories in women; however, greatest grip strength improvement was seen in men experiencing moderate weight loss compared to high loss and weight gain/stability categories. Weight loss-associated improvement in SPPB score is greater in women than men; grip strength gains in men are greatest among those achieving moderate weight loss.

THE ASSOCIATION OF SUBCLINICAL HYPERTHYROIDISM WITH FRAILTY

Nalini S. Bhalla,1 Karyne Vinales,1 Janet Fawcett,1 Ming Li,1 Richa Bhattarai,2 and Sherman M. Harman1. 1. Phoenix VA Health Care System, Phoenix, Arizona, United States, 2. Banner University Medical Center-Phoenix, Phoenix, Arizona, United States

The relevance of subclinical hyperthyroidism in the elderly has not been clearly defined. We studied whether the reported association of low TSH with frailty is an indicator of subclinical hyperthyroidism as assessed by free T3 levels. In a retrospective chart review of patients seen between January 2017 and December 2018 at the Phoenix VA Medical Center, we identified 100 patients aged ≥60 years with at least 2 low TSH measurements (<0.5 mIU/ml) and a free T3 measurement within 6 months of the measured TSH and 50 sex- and age-matched controls (TSH 0.5-5.0 mIU/ml). Patients with exogenous or clinical hyperthyroidism were excluded. We used a deficit accumulation approach evaluating 31 factors, to create a frailty index between 0 and 1 for each patient. The higher the FI, the more likely that patients had expired in the interim. Patients with low (0.31±0.11 mIU/mL) vs. normal (1.84±0.84 mIU/mL) TSH had higher mean FI compared to controls (0.25±0.12 vs. 0.15±0.07, p<0.001). TSH significantly predicted frailty score (p<0.0001) independent of age. However, lower TSH was not associated with higher free T3 or free T4 levels. There was a nonsignificant inverse association of free T3 levels with FI (P = 0.09), which disappeared when adjusted for age. Similar to prior studies, low TSH predicted frailty. However, neither free T3 nor free T4 predicted low TSH or frailty index, suggesting that the association of low TSH with frailty is not due to subclinical hyperthyroidism, but perhaps to effects of comorbidities on TSH secretion.

SESSION 3330 (POSTER)

HEALTH AND MENTAL HEALTH CARE: USE AND ACCESS

A FRAMEWORK FOR CARE TRANSITIONS FOR OLDER ADULTS WITH COMPLEX HEALTH CONDITIONS

Paul Stolec,1 Jacob B. Elliott,1 Kerry Byrne,1 Joanie Sims-Gould,2 Catherine Tong,1 Bert Chesworth,3

GSA 2019 Annual Scientific Meeting

Mary Egan,4 and Dorothy Forbes5. 1. University of Waterloo, Waterloo, Ontario, Canada, 2. University of British Columbia, Vancouver, British Columbia, Canada, 3. Western Health Sciences, London, Ontario, Canada, 4. University of Ottawa, Ottawa Ontario, Canada, 5. University of Alberta, Edmonton, Alberta, Canada

For older adults with complex health conditions, transitions between care settings are common and a major risk to quality of care and patient safety. Care transition interventions have shown positive impacts on continuity of care and health service use, however, most require additional human resources (e.g., transition coach), focus on one transition or “handoff”, and provide support for individual patients without addressing underlying challenges of health system integration. We sought to develop a framework for system-level enhancements to care transitions for older adults. We report a secondary framework analysis of an ethnographic investigation (the “InfoRehab” project) of care transitions for older persons who had experienced a hip fracture. The ethnographic study involved interviews, observations, and document reviews for 23 patients, 19 family caregivers, and 92 health care providers. Data were collected at each transition point (1-4/patient) along the care continuum, at three Canadian sites (large urban, mid-size urban, rural). Our framework analysis followed the approach described by Gale et al. (2013), using as cases 12 peer-reviewed papers which had reported InfoRehab results. Two researchers coded findings from each paper, then developed an analytical framework of eight themes by consensus; these include: patient involvement and choice, family caregiver involvement, patient complexity, health care provider coordination, information sharing, documentation, system constraints, and relationships. NVivo 11 was used to index findings into these themes and to generate a matrix. We are working with system stakeholders, including patients and caregivers, to apply this framework in the development of improved systems for care transitions.

DECISION-MAKING AND DISPARITIES IN QUALITY OF CHOSEN PLANS AMONG RACIAL-ETHNIC GROUPS IN MEDICARE ADVANTAGE

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Limited research regarding decision-making in Medicare Advantage (MA), which now disproportionally serves racial and ethnic minorities (~45% Hispanics and 30% African-Americans), has been conducted. Without understanding the extent to which vulnerable groups select low quality plans with high out-of-pocket costs (OOPC) and what factors influence this selection, these beneficiaries could continue to be adversely affected. The objective of this study is to understand plan choice decision-making process and differences in quality and OOPC of chosen plans between racial and ethnic minorities enrolled in MA. We used 2015 national data from Medicare and conducted in-depth interviews with 25 MA enrollees. African-Americans were enrolled in plans with higher drug deductibles and lower OOPC. In addition, Hispanics and African-Americans enrollment in high quality
Primary care may be the best place within the health system to coordinate care for older persons, but at present, it is poorly equipped to do so. Effective models for complex patients require appropriate targeting, patient/caregiver engagement, and care coordination. A large national project aims to co-design and implement a model in primary care that includes risk-stratification, patient engagement and care coordination techniques for older adults. This presentation focuses on the process of implementation in primary care. Grounded in the Consolidated Framework for Implementation Research, researchers worked with nine primary care sites in three Canadian provinces. Project implementation was completed in two phases. Pre-implementation: Interviews with providers (n=25) and older adults (n=8) were conducted to understand current practices and plan for implementation. Implementation: Researchers worked with sites to train staff and support implementation. Monitoring of the implementation process included interviews with providers (n=20) and field notes. Data were analyzed using directed coding, following the framework. A number of learnings emerged: buy-in was required from the entire team, teams provided meaningful information to guide implementation, contributing to a sense of ownership, and it was important that intervention components were tailored to the needs at each site. Ongoing and frequent discussions with the team was necessary. Scheduling meetings and training sessions for providers was challenging due to the length of time away from direct patient care. A new primary care model for older adults living with frailty was implemented. Lessons from this project will be used to guide future implementation and spread.

TRANSGENDERED OLDER ADULTS IN LONG-TERM CARE: PREPARING FOR THE RISING TIDE
Jean Henry,1 and Susan K. Patton1
1. University of Arkansas, Fayetteville, Arkansas, United States

Gender non-conforming older adults are more likely to be without traditional support systems in place; many may need to turn to nursing homes for long-term care (LTC). Little information is available about the experiences of LGBT older adults in these settings. Research questions: What is known about the experiences of transgender (TG) older adults in LTC? What evidence-based recommendations exist to guide LTC administrators in providing quality care to TG residents? What are key future research areas? Method: Systematic review of extant literature, using databases: PubMed, Medline, Psych Info, CINAHL, Academic Search Complete, and ProQuestCentral. Key Results:RQ1) Published research in transgender healthcare consists primarily of case reports, and retrospective and cross-sectional studies; minimal literature specifically on TG individuals; combining LGBT carries risk of minimizing or equating the TG experience to that of gays and lesbians. RQ2) Recommendations: take proactive approach; focus on awareness of relevant laws and regulations; establish non-discriminatory and inclusive environments, policies, and procedures; regular staff training, monitoring, and evaluation. RQ3) Need exists for quantitative and qualitative research into all aspects of the TG experience in LTC. Key areas include: lived experience of the TG in LTC; beliefs, attitudes, values and practices of LTC staff; administrative challenges and responses. Conclusions: Transgender and gender non-conforming individuals frequently experience

IMPLEMENTING A NEW MODEL IN PRIMARY CARE FOR OLDER CANADIANS LIVING WITH FRAILTY
Jacobi B. Elliott,1 Joanie Sims Gould,1 Susie Gregg,1 Catherine Tong,1 and Paul Stolee,1 1. University of Waterloo, Waterloo, Ontario, Canada, 2. University of British Columbia, Vancouver, British Columbia, Canada

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