Session 3315 (Symposium)

TESTING IMPLEMENTATION OF FFC-AL-EIT
Chair: Barbara Resnick
Co-Chair: Marie Boltz

Residents in assisted living settings engage in limited amounts of physical activity and decline functionally more rapidly than peers in nursing homes. To address the persistent functional decline and increased time spent in sedentary activity Function Focused Care was developed. Function Focused Care involves teaching caregivers to evaluate residents’ underlying functional capability and physical activity and engage them in physical activity during all care interactions. Prior research has demonstrated that implementing function focused care improves or maintains function and increases physical activity, improves mood and decreases behavioral symptoms among residents. To optimize implementation of Function Focused Care a theoretically based implementation strategy, Function Focused Care for Assisted Living Using the Evidence Integration Triangle (FFC-AL-EIT), was developed. FFC-AL-EIT combines the social ecological model, social cognitive theory and the Evidence Integration Triangle. The social ecological model includes intrapersonal, interpersonal, environmental, and policy factors that influence behavior. Social cognitive theory guides the interpersonal interactions that motivate caregivers and residents to engage in function focused care. Lastly, the Evidence Integration Triangle facilitates systemic implementation of function focused care. A total of 85 facilities from three states were randomized (FFC-AL-EIT versus Education Only) and 794 residents consented. The Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) model was used to evaluate outcomes. This symposium will provide the implementation outcomes and value of the Evidence Integration Triangle, the effectiveness of FFC-AL-EIT on function and physical activity and the effectiveness on psychosocial outcomes and care interactions.

THE VALUE OF THE EVIDENCE INTEGRATION TRIANGLE
Barbara Resnick, University of Maryland School of Nursing, Baltimore, Maryland, United States

The Evidence Integration Triangle involved engaging stakeholders in the 12 month FFC-AL-EIT activities including identifying community specific goals, supporting the staff implementing the intervention, and intervening when champions or staff were not engaged in intervention activities. Ongoing participation of the stakeholder team occurred through monthly meetings. Evaluation of implementation was based on the Reach Effectiveness Adoption Implementation and Maintenance (RE-AIM) Model. Reach was based on 85 of 90 communities participating and 794 residents recruited. Effectiveness was based on less functional decline and more function focused care performed by residents. Adoption was based on evidence that monthly meetings were held, 77% of settings engaged as, or more than expected, and caregivers increased the amount of function focused care provided. The intervention was implemented as intended, knowledge was received, and environments and policies supporting function focused care were maintained. The Evidence Integration Triangle is an effective implementation approach for assisted living.

THE IMPACT OF FFC-AL-EIT ON RESIDENT AND SETTING OUTCOMES
Marie Boltz, Pennsylvania State University, University Park, Pennsylvania, United States

FFC-AL-EIT was implemented by a Research Nurse Facilitator working with a community champion and stakeholder team for 12 months to increase function and physical activity among residents. FFC-AL-EIT included four steps: (Step I) Environment and Policy Assessments; (Step II) Education; (Step III) Establishing Resident Function Focused Care Service Plans; and (Step IV) Mentoring and Motivating. A total of 85 communities and 794 residents were included. The age of participants was 89.48 (SD=7.43), the majority was female (N=561, 71%) and white (N=771, 97%). Resident measures, obtained at baseline, four and 12 months, included function, physical activity, and performance of function focused care. Setting outcomes, obtained at baseline and 12 months, included environment and policy assessments and service plans. Effectiveness was based on less decline in function (p<.001), more function focused care (p=.012) and better environment (p=.032) and policy (p=.003) support for function focused care in treatment sites.

THE EFFECTIVENESS OF FFC-AL-EIT ON PSYCHOSOCIAL OUTCOMES AND CARE INTERACTIONS
Elizabeth Galik, University of Maryland School of Nursing, Baltimore, Maryland, United States

This study included a subset of 59 communities and 550 residents from the full FFC-AL-EIT study. Participants were mostly white (98%), female (69%) and had a mean age of 89.30 (SD=7.63). Sites were randomized to the four step FFC-AL-EIT intervention implemented by a function focused care nurse facilitator working with a facility champion over 12 months versus education only. Resident measures included depression, agitation, resistiveness to care and the quality of care interactions and were obtained at baseline, 4 and 12 months. There was a significant positive treatment effect related to depression, agitation, resistiveness to care and quality of care interactions with either less decline or some improvement in these behaviors and symptoms and improvement in the quality of care provided between the treatment versus control group. The study suggests there is some benefit to implementing FFC-AL-EIT for psychosocial outcomes and care interactions among residents in assisted living communities.

Session 3320 (Symposium)

2020 EDITOR’S CHOICE ARTICLES FROM JGMS: FOCUS ON VULNERABLE POPULATIONS
Chair: Lewis Lipsitz
Discussant: Tamara Baker

This symposium will present four 2020 “Editor’s Choice” articles from the Journal of Gerontology Medical Sciences that focus on issues relevant to vulnerable older populations. Justin Golub and colleagues, in their article “Audiometric
Age-Related Hearing Loss and Cognition in the Hispanic Community Health Study”, broaden the scope of age-related studies on audiometric hearing loss by using a large Hispanic cohort, a community largely excluded from previous hearing loss studies. By examining audiometrically-defined hearing loss and cognitive measures, Golub found links between hearing loss and lower neurocognition. Janice Atkins and colleagues, in “Preexisting Comorbidities Predicting COVID-19 and Mortality in the UK Biobank Community Cohort”, challenge the practice of simple age-based targeting of older adults to prevent severe COVID-19 infections, and show that specific high-risk comorbidities are better indicators of hospitalization and mortality. “Comparison of Recruitment Strategies for Engaging Older Minority Adults: Results from Take Heart”, by Jessica Ramsay and colleagues, examines methods used to recruit older adults of color from primarily low socio-economic households for behavioral and clinical health research. Ryon Cobb and coauthors, in their article “Self-reported Instances of Major Discrimination, Race/Ethnicity, and Inflammation among Older Adults: Evidence from the Health and Retirement Study”, investigate whether self-reported lifetime discrimination is a psychosocial factor influencing inflammation in older adults. Tamara Baker, the discussant, will highlight commonalities and lessons learned from these studies, including links between racial, socio-economic, or disease-related vulnerabilities of older adults and their health status, as well as best practices to account for these factors in future clinical trials.

MAJOR DISCRIMINATION, RACE-ETHNICITY, AND INFLAMMATION AMONG OLDER ADULTS
Ryon Cobb,1 Lauren Parker,2 and Roland Thorpe, Jr.,2 1. University of Georgia, Athens, Georgia, United States, 2. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, United States

This study examines the relationship between self-reported instances of major discrimination and inflammation among older adults, and explores whether this relationship varies in accordance with race/ethnicity. Data from 2006/2008 Health and Retirement Study was used to collect measures of self-reported instances of major discrimination and high-risk C-reactive protein (CRP), which was assayed from blood samples. Modified Poisson regression with robust standard errors was applied to estimate the prevalence ratios of self-reported instances of major discrimination, as it relates to high-risk CRP (CRP ≥ 22 kg/m2), and test whether this relationship varies by race/ethnicity. Respondents who experienced any instances of major discrimination had a higher likelihood of high-risk CRP (prevalence ratio [PR]: 1.14, 95% confidence interval [CI] = 1.07–1.22) than those who did not report experiencing any instances of major discrimination. This relationship was weaker for blacks than whites (PR: 0.81, 95% CI = 0.69–0.95).

AUDIOMETRIC AGE-RELATED HEARING LOSS AND COGNITION IN THE HISPANIC COMMUNITY HEALTH STUDY
Justin Golub,3 Adam Brickman,1 Adam Ciarcleglio,2 Nicole Schupf,3 and José Luchsinger1 1. Columbia University, New York, New York, United States, 2. New York University, Washington, DC, District of Columbia, United States, 3. Columbia University, Mailman School of Public Health, New York, New York, United States

Studies associating age-related hearing loss (HL) with cognition have been limited by non-Hispanic cohorts, small samples, or limited confounding control. We overcome these limitations in the largest study of formal, audiometric HL and cognition to date using the multicentered Hispanic Community Health Study (n=5,277, mean age=58.4 [SD=6.2]). The main exposure was audiometric HL. The main outcome was neurocognitive performance. Adjusting for demographics, hearing aid use, and cardiovascular disease, a 20-dB increase (one-category worsening) in HL was cross-sectionally associated with worse performance in multiple neurocognitive measures: -1.53 (95% CI = -2.11, -0.94) raw score point difference on Digit Symbol Substitution Test, -0.86 (-1.23, -0.49) on Word Frequency Test, -0.76 (-1.04, -0.47) on Spanish-English Verbal Learning Test (SEVLT) 3 trials, -0.45 (-0.60, -0.29) on SELVT recall, -0.07 (-0.12, -0.02) on Six-Item Screener. Because HL is common and potentially treatable, it should be investigated as a modifiable risk factor for neurocognitive decline/dementia.

COMPARISON OF RECRUITMENT STRATEGIES FOR ENGAGING OLDER MINORITY ADULTS: RESULTS FROM TAKE HEART
Jessica Ramsay,1 Cainnear Hogan,2 Mary Janevic,3 Rebecca Courser,1 Kristi Allgood,3 and Cathleen Connell,3 1. University of Michigan School of Public Health, Detroit, Michigan, United States, 2. VA Ann Arbor Healthcare System, Ann Arbor, Michigan, United States, 3. University of Michigan School of Public Health, Ann Arbor, Michigan, United States

Few studies report best practices for recruiting older adults from minority, low SES communities for behavioral interventions. In this presentation, we describe recruitment processes and numbers for Take Heart, a randomized controlled trial testing the effectiveness of an adapted heart disease self-management program for primarily African American, low SES adults 50 years or older in Detroit. Community-based (CB), electronic medical record (EMR), and in-person hospital clinic (HC) recruitment methods were implemented. Within 22 months, 453 participants were enrolled, with an overall recruitment yield of 37%. The CB method had the highest yield (49%), followed by HC (36%) and EMR (16%). The average cost of recruiting and enrolling one participant was $142. Face-to-face interactions and employing a community health worker were particularly useful in engaging this population. Further research is needed to confirm these findings in other minority and low SES populations and share lessons learned about recruitment challenges and successes.

PREEXISTING COMORBIDITIES PREDICTING COVID-19 AND MORTALITY IN THE UK BIOBANK COMMUNITY COHORT
Janice Atkins,1 Jane Masoli,2 Joao Delgado,3 Luke Pilling,2 Chia-Ling Kuo,4 George Kuchel,4 and David Melzer2 1. University of Exeter Medical School, University of Exeter, England, United Kingdom, 2. University of Exeter, Exeter, England, United Kingdom, 3. University of Exeter Medical School, Exeter, England, United Kingdom, 4. University of Connecticut Health, Farmington, Connecticut, United States