reasons may be unable to do so. To address this, a number of housing alternatives have been explored, including homesharing, or homesharing, an exchange-based shared housing approach with the potential to empower older adults to age in place by enabling them to obtain additional income, companionship, and assistance with completing household tasks in exchange for renting out a room in their home. An intergenerational homesharing pilot program was launched in Toronto, matching older adults (55+) with postsecondary students. With limited research in the area, a mixed methods research study was embedded within the pilot project with the goals of: 1) conducting a scoping review to map and synthesize the literature related to outcomes of homeshare participation for this population, 2) conducting in-depth interviews with homeshare participants (N=22) to learn about their experiences, and 3) conduct a full evaluation and exit survey to better understand the implications of the project. Results were organized around the following themes: (1) benefits and challenges of participating in homeshare for older adults; (2) intergenerational engagement as social exchange; and (3) the key role of agency facilitation as a determinant of the experience of homesharing for older adults. Results spoke to the unique benefits and challenges of participating in homeshare for this population. Findings were used to derive implications for policy and practice, as well as highlight areas for future research.

NO LONGER AGING IN PLACE: HOUSING DECISIONS AFTER 100
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The number of aging individuals is growing and, along with it, a subset of the oldest-old (those over 85 years), including centenarians. Although researchers have begun identifying issues and needs related to this population (Dunkle & Jeon, 2016), still little is known about decision-making processes as they relate to housing. In rural areas, in specific, centenarians are limited by few residential choices and lack of geographic mobility. In this study, decision-making processes are examined, with an emphasis on interactions between aging individuals and their rural family caregivers. In addition, since family caregivers typically experience a pattern of burnout over time (Yilmaz, Turan & Gundogar, 2009; Yikikan, Aypak, & Görgelioglu, 2015), a second focus of the study is caregiver stress. Data for the study are drawn from semi-structured interviews with a sample of family caregivers in the Midwest. All caregivers had a 100-plus family member recently placed, or in process of placement, at a residential long-term care facility. To meet criteria, all facilities were in towns of 4000 individuals or less. Data consisted of qualitative interviews with the primary family contact (female in all cases), and were analyzed according to Strauss & Corbin (1990). Decision-making themes centered primarily around work. Data are discussed in terms of family strengths, health and wellness, and the need for continued programming for family caregivers, particularly in rural areas.

PATTERNS AND PREDICTORS OF RESIDENTIAL CARE TRANSITIONS OVER TIME AMONG MEDICARE BENEFICIARIES
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Older adults prefer to age in place, but sociodemographic characteristics, health factors, and socioeconomic resources may influence their decision to move into other residential care settings (e.g., assisted living) or nursing homes. The characterization of residential care transitions and factors contributing to these transitions is limited. This study describes patterns and identifies predictors of transitions across community, residential care settings, and nursing homes among N=7076 Medicare beneficiaries in the National Health and Aging Trends Study, from 2011-2018. A discrete-time, multi-state Markov model was used to estimate the annual probabilities and hazards of transitioning across settings, adjusting for sociodemographic, health, and socioeconomic factors, mortality risk, as well as censoring from loss to follow-up. Most beneficiaries did not experience transitions: annual probabilities of remaining in the community, residential care settings, and nursing homes were 93%, 78%, and 73%, respectively. Being older, having dementia, being hospitalized in the last year, living alone, having multiomorbidity, and having some or any functional limitations were associated with higher hazards of transition from the community to residential care settings and nursing homes. Being on Medicaid was associated with a reduced hazard of transitioning from the community to residential care settings (hazard ratio [HR]: 0.57; 95% CI: 0.36-0.91), but a higher hazard of transitioning from the community to nursing homes (HR: 1.37; 95%: CI: 0.98-1.91). As long-term services and supports increasingly shift from institutional to home and community-based care, our results can inform the design of federal and state policies targeting transitions across the care continuum.

WHAT DOES IT MEAN TO AGE IN PLACE AS AN OLDER HOMELESS WOMAN? FACING AN ALTERED SENSE OF PLACE, BELONGING, AND IDENTITY
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The emergence of “aging in place” as social policy in the U.S and globally reflects a deepening understanding that a home is more than a physical domicile, it also represents a source of personal and social identity and offers one a sense of place and belonging. In this qualitative study we explore the question, What does “aging in place” mean to older homeless women navigating the shelter system and streets? Using a phenomenological approach, we conducted semi-structured interviews with fifteen chronically homeless women in their fifties using the shelter system. Our analysis process was inductive and iterative with the culminating phases being the generation and interpretation of themes. Our analysis revealed the links between place, sense of belonging, and identity. To be displaced from a physical home can present
challenges to defining one’s very existence. Specific themes emerging from the women’s narratives included the ways in which shelter and street life impacted their sense of personal control, privacy, security, health, and comfort as well as underscored that shelters are dehumanizing places that further diminish one’s sense of self and self-worth. The interviewed women sought to construct a positive sense of self through speaking about their past, present, and future roles as well as identities gained through social relations and place identity connections. Based on the findings, we suggest strategies by which shelters might better respond to unique needs of older women, including adopting ways that do not further disempower or stigmatize them but rather promote pathways out of homelessness.

SESSION 2851 (POSTER)

ALCOHOL AND ADDICTIONS

DIAGNOSED OPIOID USE DISORDER AMONG OLDER ADULTS: COMPLEX COMORBIDITY AND MANAGEMENT CHALLENGES

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In the face of a widespread opioid epidemic and many policy changes affecting opioid access and management, it is important to understand the prevalence and characteristics of diagnosed opioid use disorder in older people and their implications for effective management of this high-risk population. We examined these issues in an ~40% random sample of Medicare beneficiaries with Part D coverage. In 2017, 8% of beneficiaries ages 65+ were diagnosed with OUD (opioid abuse or dependence diagnoses), an increase from .5% in 2015. The late-2015 transition from ICD-9 to ICD-10 may have contributed to this change, but the rate also increased post-ICD-10 by 9.1% from 2016-2017. The profile of individuals diagnosed with OUD reveals a population with complex comorbidity and multiple health challenges: 45% were diagnosed with major depression, 7% with alcohol disorders, 45% with anxiety, 8% with hepatitis C, 26% with cancer, 38% with COPD and 19% with pneumonia (risk factors for opioid overdose), 56% with diabetes and 27% with heart failure. 97% were diagnosed with pain conditions, 85% received opioid prescriptions, and 38% received benzodiazepine prescriptions. These patients represent complex and potentially competing challenges in concurrent management of pain, opioid use disorder, multi-substance use and opioid use disorder. Development of effective, integrated care models to simultaneously address these interrelated problems in this high-risk population should be informed by a closer focus on their multiple needs and monitoring of the adequacy of health system response.

FOSTERING CONTINUITY OF CARE FOR MASSACHUSETTS LONG-TERM CARE RESIDENTS ON MEDICATION FOR OPIOID USE DISORDER

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In 2016, the CDC estimated that 2.1 million Americans had Opioid Use Disorder (OUD); about 1.8 million related to prescribed painkillers. Older adults are especially susceptible; SAMHSA estimates that 2.7 million older adults will misuse prescription drugs by 2020. The Massachusetts Department of Public Health (MDPH) issued a 2016 Circular Letter advising long-term care facility (LTCF) administrators that, if otherwise eligible for admission, facilities are expected to admit individuals diagnosed with OUD, and provide medication for OUD (MOUD) as prescribed. Yet, many facilities express concern for admitting residents with OUD. The MDPH and their partners are conducting a multi-faceted training/technical support (TS) program to foster best practices across the continuum of care, targeting LTCF. The 15-month program consists of in-person learning sessions, a comprehensive toolkit, on-site TS, weekly contact, and a peer-to-peer webinar. Pre-training data indicated that 24 of 42 recruited LTCFs had not admitted residents with OUD. Although licensed LTCF practitioners can obtain a waiver to prescribe certain MOUD, only 4 of the 28 LTCF medical directors interviewed had done so. Subject matter experts led topic-specific discussions in the first learning session to educate on OUD/MOUD, dispel myths, make community connections, and provide resources. Almost all participants agreed that the session met the objectives of understanding OUD as a chronic disease, recognizing the stigma of OUD, gaining knowledge of MOUD treatments, and obtaining strategies to enhance best practices across the continuum of care. All items on the pre/post-session assessments indicated a significant increase in understanding (37% versus 60%, respectively).

HAVING A CASINO IN THE COMMUNITY: IMPLICATIONS FOR OLDER RESIDENTS

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Casino-going has been acknowledged as a common leisure activity for older adults, but what having a casino in the community means for the local older population has been understudied. Previous research has focused on problem gambling among older adults, but little is understood about how older residents perceive having a casino nearby and further how it impacts relevant senior services. This mixed-methods study gathered perspectives from 14 senior center directors and older residents (N = 411) of communities in Massachusetts that surround Plainridge Park Casino, the first casino that opened in the state in 2015. We conducted qualitative interviews with senior center directors and distributed a quantitative survey to older residents of the surrounding communities and those who visited the casino during the study period. We found that while most senior centers did not engage in trips to this “hometown” casino, many had other creative interactions with the casino, such as using casino space to host senior center events or seeking funding support from the casino. Older residents exhibited low rates of problem gambling risk, preferred to go to casinos outside of the state as an excursion, and attributed their reasoning to go to casinos...