

aging systems are summed to create a single score. These studies indicate that frailty is associated with adverse aging outcomes (e.g., mortality, dementia). We employ a data-driven approach to detecting and differentiating emerging frailty phenotypes and examine their associations with non-demented cognitive aging trajectories. Participants ( $n = 653$ ;  $M$  age = 70.6, range 53-95) were community-dwelling older adults from the Victoria Longitudinal Study. Participants contributed (a) baseline data for 30 frailty-related items representing deficits across 7 domains (e.g., instrumental and cardiovascular health) and (b) longitudinal data for latent variables of executive function, speed, and memory. For each participant, we calculated the proportion of deficits present in each frailty-related domain and submitted these data to a latent profile analysis (LPA; Mplus 7.0). We used latent growth modeling (LGM) to test these frailty phenotypes for prediction of cognitive performance and decline. LPA results revealed three profiles, one large normal low-frailty profile and two emerging frailty phenotypes. Whereas the latter represented profiles of individuals with respiratory-type frailty (i.e., marked impairment in respiratory function; 7%) and mobility-type frailty (i.e., marked impairment in mobility function; 9%), the former featured limited impairment across frailty domains (83%). Findings from LGM indicated that these profiles were differentially related to cognitive performance and decline. Data-driven approaches can help detect early differentiation of frailty profiles and contribute to personalized intervention.

#### SOCIAL ISOLATION AND FALLS RISK AMONG COMMUNITY DWELLING OLDER ADULTS: THE MEDIATING ROLE OF DEPRESSION

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Relatively little is known about the relationship between social isolation and the risk of falls among older adults. Yet, a considerable amount of research demonstrates that lack of sufficient social relationships, broadly defined, represents a modifiable risk factor for many indicators of well-being in later life. This study examines the association between two types of social isolation and the risk of falls. The study also examines whether depression mediates the association between social isolation and risk of falls. Longitudinal data from the Health and Retirement Study (2006-2012) were collected from community-dwelling participants aged 65 and older ( $N=8,464$ ). The outcome variable was number of falls self-reported over the observation period. Independent variables included perceived isolation (feeling lonely, perceptions of social support), social disconnectedness (e.g., having no friends or relatives living nearby, living alone), and number of depressive symptoms. Results from regression models indicated that social disconnectedness was associated with a 5% increase in the risk of falls (IRR=1.05, 95% CI=1.01-1.09). Perceived social support was associated with a 21% increase in the risk of falls; when examined together, perceived social support and loneliness were associated with a combined 37% increase in falls risk. Depression was associated with a 47% increase in falls. Depression mediated the association between perceived isolation and falls. Further, perceived isolation mediated

the association between social disconnectedness and falls. Reducing perceived social isolation and social disconnectedness may be an avenue for designing interventions to reduce the risk of falls, especially for older adults with depression.

#### FEASIBILITY OF A LOW-DOSE FRAILTY PREVENTION INTERVENTION AMONG OLDER AFRICAN AMERICANS

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Older African Americans (OAA) are at high risk for becoming frail in later life. Interventions can reverse or delay frailty, yet OAA have largely been excluded from frailty intervention research. Many interventions are also time and resource intensive, making them inaccessible to socially disadvantaged OAA. We present results of a feasibility trial of a low dose frailty prevention intervention among 60 community-dwelling, pre-frail OAA aged 55+ recruited from a primary care clinic between June 1st and October 31st 2018. Using a 2-arm RCT, participants were assigned to the intervention, which was delivered by an occupational therapist (OT) and comprised of four sessions over four months (an OT evaluation, and sessions on healthy dietary practices, increasing physical activity, and maintaining a healthy lifestyle), or enhanced usual care (publicly available information about healthy lifestyle, home safety, and local elder services). Feasibility criteria were set a priori at 75% for participant retention (including attrition due to death/hospitalization), 80% for session engagement, 2 participants/week for mean participant accrual, and 90% for program satisfaction. Participants were 65% female with an average age of 76.58 years, 51.67% of which lived alone and 51.67% lived off of less than 15K per year. Feasibility metrics were met. The study recruited 2.5 participants per week and retained 75% of participants who attended 95% of scheduled sessions. Mean satisfaction scores were 93%. The intervention was feasible to deliver. Qualitative findings from exit interviews suggested changes to the program dose, structure, and content that could improve it for future use.

#### AM I FRAIL, LOVE? YES, I SUPPOSE I AM: WHAT 10 OLDER PEOPLE CAN TELL US ABOUT LIVING WITH FRAILTY

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We sought to explore what matters in later life with frailty from an older persons perspective. Between March and May 2018, we recruited ten people, purposively sampled from the CARE75+ ageing cohort study. Interviews took place at the participant's own home in two sittings, each 45 minutes long. Interviews were semi-structured, used narrative techniques based on a topic guide developed with a patient representative. We used systematic analysis of the narrative experience to identify meaning in the context of an individual's time, space and history. Participants had a mean age of 84 years (range 77 to 93), half were women, and three were interviewed with their care-givers. All had moderate or severe frailty: mean frailty index 0.36 (range 0.25 to 0.47); mean Fried score 4 (range 3 -5). Half knew hunger as children; most grew up in large families and left school early; two survived TB in early life; all lived through or were affected by war. The term frailty was: never voluntarily used; described negatively and in value laden terms; seen better in others

than themselves. Decision making was best delegated to doctors who knew you and your family over time. Narratives focused on health events of a spouse; symptoms featured more than diagnoses. Survivorship, reciprocity and community were sustaining values. To engage elders in shared decision making we learnt to consider influences of cohort, of people closest to them; and to describe rather than declare someone to be frail, in terms that are real to them.

## SESSION 1365 (POSTER)

### GERONTOLOGY AND GERIATRICS EDUCATION

#### INTERPROFESSIONAL SOCIALIZATION AND VALUING SCALE FOR HEALTH PROFESSIONAL STUDENTS WORKING WITH OLDER ADULTS

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Interprofessional education allows students from two or more professions the opportunity to collaboratively practice patient centered care. Given the importance of interprofessional education in helping individuals become effective team members and understanding their value to a healthcare team, there is a need to evaluate the experiences. The Interprofessional Socialization and Valuing Scale (ISVS), aims to measure self-perceived experiences with interprofessional collaborative teamwork, including the ability, value, and comfort in working with others. The Wayne State University Interprofessional Team Visit (IPTV) program is an older adult home visit program that places pharmacy, social work, occupational therapy, nursing, and medical students in teams. Students form teams of 3 different disciplines and interview the older adult to assess various aspects of health and wellbeing. In order to evaluate the interprofessional educational experiences of the students, they are given a pre- and post- survey utilizing the ISVS tool. 18 questions pertaining to perceptions of what students have learned about working with professionals from other disciplines. Students respond to each statement using a 7-point scale with 1 = "Not at All" and 7 = "To a Very Great Extent." Statistical analysis is conducted in order to compare pre- to post-surveys and also assess differences between groups. It is found that ISVS scores increase from pre- to post-survey, second year medical students and third year pharmacy students feel more comfortable working in teams, and teams consisting of these two have higher average scores.

#### INTERDISCIPLINARY CURRICULUM FOR THE CARE OF OLDER ADULTS: CREATING NETWORKS OF COLLABORATIVE LEARNERS

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Serving older adults with multiple chronic conditions and variable social, emotional, or physical support effectively within the primary care setting requires an interdisciplinary approach to care. Our GWEP program has developed an

interprofessional education center that educates and prepares students and professionals from social work, medicine, nursing, dentistry, pharmacy, and community health partners, to function within a transformed integrated patient-centered geriatric primary care and community-based service delivery system. Learners from multiple disciplines attend a face-to-face Interdisciplinary Case Management Experience (ICME) session lasting 2.5 hours. Sessions include learners from each discipline and, if possible, at least one community practitioner in small groups of 6–8 learners at each table facilitated by 1 faculty member. Approximately 1,200 learners have received the curriculum. To evaluate the program, Kirkpatrick's Training Evaluation Model was used to determine if learners were satisfied with the content, skilled, and confident in their abilities to utilize the curriculum. Learners completed a satisfaction survey after taking each module, along with an interdisciplinary geriatric care knowledge test and self-efficacy test before and after taking each module to measure learning outcomes. Analysis showed that learners, irrespective of discipline, were satisfied with the program. All disciplines showed a significant increase from pre- to posttest for all 5 online modules achieving a mean post-knowledge score of 85% across all 5 online training modules. All disciplines experienced significant differences in their self-efficacy with working on interdisciplinary teams from pre to post ICME. Implications for future interprofessional curriculum will be discussed.

#### PROVIDER AND SYSTEM IMPACTS OF THE UW ECHO IN RURAL AND FRONTIER CARE TRANSITIONS

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Background: The Project ECHO model utilizes a hub and spoke approach through which a team of experts co-mentors local providers in the management of complex cases while disseminating information about best practices and evidence-based care. Project ECHO is a promising model for improving patient care through transformation of the care delivery system. The UW ECHO in Rural and Frontier Care Transitions created an online community of practice comprised of local care coalitions dedicated to improving care transitions in Wyoming and Montana. This ECHO network provided a unique opportunity to support system- and provider-level implementation of best practices in care transitions. Methods: Semi-structured interviews were conducted with thirty ECHO attendees following participation in an ECHO session as either a participant or case presenter. Thematic analysis was used to analyze interview data. Results: Two overarching themes emerged 1) impact of the ECHO on the provider or healthcare team and 2) impact on the system. Participants indicated that the impact on the provider/healthcare team included an increased sense of community, increased awareness of community resources, increased knowledge of care transition strategies, and increased confidence in implementing best practices. Additionally, providers indicated increased utilization of community resources. Systemic impacts included increased involvement of interprofessional team members in patient care and utilization of ECHO recommendations