

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