may be modifiable means of reducing P&I in LTCFs. Funding provided by Sanofi Pasteur.

READMISSION FOR HEALTHCARE-ACQUIRED INFECTIONS: DOES PATIENT DISPOSITION MATTER?

Geoffrey J. Hoffman,[1] Lillian Min,[1] Haiyin J. Liu,[1] and Lona Mody[1], *1. University of Michigan School of Nursing, Ann Arbor, Michigan, United States*

Both common and preventable, healthcare-acquired infections (HAI) are nevertheless associated with high risk for hospital readmission. However, whether these infection-related readmissions are more common among older adults discharged from the hospital to a nursing facility as opposed to home is unknown. We used 2013-14 HCUP data and multivariable logistic regression models to retrospectively examine the relationship of patient disposition (home, nursing facility, home health care) with an unplanned readmission for the same HAI observed at the index admission, among older Medicare beneficiaries, controlling for patient sociodemographics, comorbidity score, and length of stay during index hospitalization. Of 8.4 million index admissions, 323,332 (3.9%) involved an index HAI, of which 15,870 (4.9%) resulted in a linked HAI readmission. HAI readmissions were more common for Clostridium difficile infections (4.0%) and urinary tract infections (UTI, 2.3%) than for ventilator-acquired pneumonia (1.4%) or surgical site infections (1.1%) (p<0.001). Being discharged home or to home health care, compared to a post-acute care setting, was associated with increased odds (OR: 1.63 and 1.62, p<0.001) of HAI readmission, particularly for patients with higher comorbidity scores. For home discharges, HAI readmission risk was doubled for patients with the most compared to fewest comorbidities while nursing facility discharges were equally protective across comorbidity levels. We conclude that Clostridium difficile and UTIs result in higher risk for readmission than other HAIs. Patients discharged to nursing facilities are protected from readmission. Further research into identifying modifiable mechanisms for HAI readmission, in order to improve post-hospital care of infection at home, is needed.

RESILIENCY PHENOTYPES FOLLOWING HIP FRACTURE IN OLDER ADULTS

Cathleen Colon-Emeric,[1] Heather E. Whitson,[1] Carl Pieper,[1] Richard Sloane,[1] Denise Orwig,[2] Kim Huffman,[1] Daniel C. Parker,[1] and Jay S. Magaziner[3], *1. Duke University Medical Center, Durham, North Carolina, United States, 2. University of Maryland, Baltimore, Maryland, United States, 3. University of Maryland Baltimore School of Medicine, Baltimore, Maryland, United States*

Defining common patterns of recovery after an acute health stressor (resiliency phenotypes) has clinical and research implications. We examined groups of patients with similar recovery patterns across 10 outcomes following hip fracture to determine the most important predictors of resiliency group membership. This study is a secondary analysis of three prospective cohort studies. Participants, community-dwelling adults aged >65 with recent surgical repair of a hip fracture (n=541), were recruited from eight hospitals near Baltimore and followed for up to one year. Self-reported function and activity measures were collected using validated scales at baseline, 2, 6, and 12 months. Physical performance tests were administered at all follow-up visits. Stressor characteristics, co-morbidities, psychosocial and environmental factors were collected at baseline, and latent class profile analysis was used to identify resiliency phenotypes and logistic regression models to identify associated factors. Three resiliency phenotypes had similar patterns across the 10 outcome measures and were defined as "high resilience" (n=163, 30.1%), "medium resilience" (n=242, 44.7%), and "low resilience" (n=136, 25.2%). Recovery trajectories for outcome measures were plotted for each resiliency group. Self-reported pre-fracture function was by far the strongest predictor of resilience group membership (AUC 0.84). Demographic factors, co-morbidities, stressor characteristics, environmental factors, and psychosocial characteristics were less predictive, but several factors remained significant in a fully adjusted model (AUC 0.88). These three resiliency phenotypes have immediate utility for clinical decision-making. They can be measured in future studies with a more parsimonious set of variables, and may prove useful for understanding mediators of physical resilience.

SESSION 4135 (PAPER)

ISSUES IN HOME CARE AND CAREGIVING

ARE MEDICAL FOSTER HOMES SERVING VETERANS WHO HAVE SIMILAR FUNCTIONAL IMPAIRMENT AS TYPICAL NURSING HOME RESIDENTS?

Cari Levy,[1] Kate Magid,[2] Chelsea Manheim,[3] Kali S. Thomas,[4] Leah M. Haverhals,[5] and Debra Saliba[6], *1. VA Rocky Mountain Regional VA Medical Center, Aurora, Colorado, United States, 2. Seattle/Denver Center of Innovation, VA Eastern Colorado Health Care System, Aurora, Colorado, United States, 3. Rocky Mountain Regional Medical Center, Aurora, Colorado, United States, 4. Providence VA Medical Center, Providence, Rhode Island, United States, 5. Seattle-Denver Center of Innovation, Denver, Colorado, United States, 6. RAND Corporation, Santa Monica, California, United States*

The Veterans Health Administration's (VHA's) Medical Foster Home (MFH) program was developed as a community-based alternative to institutional care. This study compares the clinical and functional characteristics of Veterans in the VHA MFH program to residents in nursing homes to understand whether MFHs substitute for nursing home care or serve a population with different care needs. All data were derived from Minimum Data Set (MDS) 3.0 assessments. Nurses collected MDS assessments from Veterans (n=92) in 4 MFHs between April 2014-December 2015. Data for nursing home residents were from a national nursing home dataset of residents with an annual MDS assessment in 2014 (n=818,287). We found that MFH Veterans were more likely to be male, have higher functional status, and perform more activities of daily living (ADLs) independently relative to nursing home residents (p<0.01 for all comparisons). Yet, a similar proportion of MFH Veterans and nursing home residents required total assistance in 9 of the 11 measured ADLs. Cognitive impairment, neurological comorbidity,