health using grip strength defined sarcopenia cut-points was higher in sarcopenic obesity (OR 1.87 [1.50,2.32]), sarcopenia (OR 1.79 [1.50,2.14]), and obesity (OR 1.24 [0.99,1.56]). Using the Grip divided by BMI cutpoints, we found the odds of low self-reported health in sarcopenia was OR 1.38 [1.12, 1.59]. Conclusions: Both sarcopenia and sarcopenic obesity are associated with an increased odds of decreased self-reported health.

SOCIAL DETERMINANTS AND FRAILTY IN HIGH-NEED, HIGH-RISK VETERANS

Kiranmayee Muralidhar,[1] Willy Marcos Valencia,[2] Fei Tang,[2] and Stuti Dang,[2] *1. University of Miami, Miami, Florida, United States, 2. Miami VA Healthcare System, Miami, Florida, United States*

The VA Geriatrics and Extended Care Data Analysis Center uses national predictive modelling to identify High-Need High-Risk (HNHR) Veterans, to provide targeted services and reduce hospitalization and institutionalization risk. To learn the needs of Miami VA HNHR Veterans, we mailed a needs-assessment survey to 2124 Veterans, of whom 634 responded (29.8% response rate). The average respondent age was 70.5±9.2. Among them, 127(20%) were <65 years old, 326(51.4%) were 65-74, and 179(28.2%) were ≥75; 389(61.4%) White, 225(35.5%) Black/African Americans; 515(81.2%) were Non-Hispanic, 111(17.5%) Hispanic/Latino; 173(27.3%) were high school graduates, 350(55.2%) had at least some college credit, 39(6.2%) had a master's degree or more and 536(84.5%) were health literate. As per Morley's FRAIL scale, 266(42%) were frail, 242(38.2%) were pre-frail and 87(13.7%) were robust. Social risk factors possibly associated with frailty were analyzed using ordinal logistic regression. Univariate analysis showed significant association with poor health literacy, having a caregiver, social isolation, transportation trouble, delayed or missed doctors' appointments due to transportation, a negative perception of aging, likelihood of depression, being homebound, inability to use the internet, lack of technology for video conferencing and lack of email use (p≤0.01). Through multivariate ordinal logistic regression analysis, adjusting for patients' age and Jen Frailty Index, we found that the same social risk factors other than internet use showed significant association with frailty (p≤0.01). HNHR Veterans have complex social needs with a limited ability to manage their chronic conditions, necessitating interventions that address not only their medical issues but also their access barriers and social support.

THE ASSOCIATION BETWEEN SELF-REPORTED AND OBJECTIVELY MEASURED ENERGY LEVEL IN OLDER ADULTS

Qu Tian,[1] Nancy Glynn,[2] Rebecca Ehrenkranz,[2] Briana Sprague,[2] Andrea Rosso,[3] and Caterina Rosano,[2] *1. National Institute on Aging, Bethesda, Maryland, United States, 2. University of Pittsburgh, Pittsburgh, Pennsylvania, United States, 3. School of Public Health, University of Pittsburgh, Pittsburgh, Pennsylvania, United States*

Energy is an important concept in human health and diseases. Self-reported energy has been described as "the individual's potential to perform physical and mental activity" and "the individual's energy availability". However, little empirical data exists on whether self-reported energy level is related to objectively measured energy level. Prior research suggests that more energy availability is associated with higher physical activity level. It remains unclear whether self-reported energy availability would be associated with objectively measured energy level, such as active energy expenditure and total energy expenditure. Using data from the Health, Aging and Body Composition Study, we identified 94 participants (mean age=86.2±2.4 y/o, 46%blacks, 52%women) with concurrent data on self-reported energy (scale 0-10) and objective energy level by the SenseWear Armband. We examined cross-sectional associations of self-reported energy with objectively measured energy and physical activity levels using Spearman correlation. Greater self-reported energy level was associated with higher daily active energy expenditure in kcal (r=0.30,p=0.004), higher METs (r=0.33,p<0.001), more minutes of physical activity (r=0.35,p<0.001), and more step counts (r=0.36,p<0.001). Self-reported energy was not associated with total energy expenditure (p=0.87) or estimated resting metabolic rate (p=0.53). Self-reported energy may reflect an individual's activity energy expenditure but not total energy expenditure. It further supports the hypothesis that energy availability even by self-report connects to physical activity behavior. Whether self-reported energy correlates with other health outcomes warrants further investigation.

THE ELECTRONIC FRAILTY INDEX AND AREA DEPRIVATION INDEX: INDEPENDENT CONSTRUCTS IN RISK STRATIFICATION

Kathryn Callahan,[1] Kristin Lenoir,[2] and Nicholas Pajewski,[1] *1. Wake Forest School of Medicine, Winston-Salem, North Carolina, United States, 2. Wake Forest University Health Sciences, Winston-Salem, North Carolina, United States*

Frailty and social determinants of health (SDOH) have been associated with mortality for older adults. Given time limitations, passive electronic tools such as the eFI and publicly available data such as the Area Deprivation Index (ADI) hold appeal for targeting limited resources to support at-risk older adults. Literature is conflicting with regards to the relationship between frailty and SDOH. A retrospective, observational cohort of adults 65+ (n=44,548) identified as part of the Wake Forest Baptist Health (WFBH) accountable care organization was used to evaluate the association between ADI, eFI, and mortality between 1/1/2019 and 1/1/2020. A cox proportional hazard model was fit, adjusting for age, sex, race, and weighted Charlson Comorbidity Index. Sources of mortality data include claims data, the EHR at WFBH, and NC Vital Statistics. Block-level geographic identifiers (GEOID) were extracted and used to merge ADI national percentiles (Neighborhood Atlas), derived from U.S. Census 5-year American Community Survey estimates, which incorporates 17 SDOH measures (e.g., income, education, housing, employment.) Frailty was calculated by the WFBH eFI. 9216 (20.7%) were frail by eFI (eFI>0.21) and 235 (0.5%) died. The interaction between ADI tertile and eFI category was not significant (p=0.78). Being frail was associated with poorer survival when compared to the fit group; HR= 1.94 (95% CI =1.23, 3.08; p<0.01.) Survival did not differ between the maximum deprivation tertile and