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This study examined the association between metabolic syndrome (MetS) and frailty status in relatively healthy community-dwelling older adults. Participants included 19,114 individuals from the “ASpirin in Reducing Events in the Elderly” (ASPREE) trial. The diagnostic criteria for MetS were according to the International Diabetes Federation Task Force on Epidemiology and Prevention and the American Heart Association/National Heart, Lung, and Blood Institute (2009); and comprised any three of five parameters: waist circumference, triglycerides, fasting blood glucose, high-density lipoprotein cholesterol or hypertension. Frailty and prefrailty were defined using a modified Fried phenotype (FP) comprising exhaustion, body mass index, grip strength, gait speed and physical activity and a deficit accumulation frailty index (FI) of 66 items. The association between MetS and frailty was examined using multinomial logistic regression. At baseline, 51.1% of participants met the criteria of MetS; of those, 41.8% and 2.5 % were prefrail and frail, respectively, according to Fried phenotype, while 49.6% and 11.8 % were prefrail and frail, respectively, according to FI. MetS at baseline was associated with an increased likelihood of prefrailty (RRR: 1.25; 95% CI: 1.17, 1.33) and frailty (RRR: 1.60; 95% CI: 1.28, 2.01) compared to no frailty after adjustment for potential confounders according to Fried phenotype, while the association was stronger for prefrailty (RRR: 2.74; 95% CI: 2.55, 2.94) and frailty (RRR: 5.30; 95% CI: 4.60, 6.11) according to FI. Overall, at baseline, more than half of the participants had MetS, and the presence of MetS was significantly associated with pre-frailty and frailty.

TRANSPLANT CENTERS THAT MEASURE FRAILTY AS PART OF CLINICAL PRACTICE HAVE BETTER OUTCOMES

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Frailty predicts adverse outcomes for kidney transplant (KT) patients; yet the impact of clinical assessments of frailty on center-level outcomes remains unclear. We sought to test whether KT centers that measure frailty as part of clinical practice have better pre- and post-KT outcomes. We conducted a survey of US transplant centers (11/2017-4/2018), 132 KT centers (response rate=65.3%) reported frequencies of frailty assessment at candidacy evaluation and KT admission. Center characteristics and clinical outcomes were gleaned from the national registry (2017-2019). Poisson regression was used to estimate incidence rate ratios (IRRs) of waitlist mortality rate and transplantation rate in candidates and graft loss rates in recipients by frequency of frailty assessment. All models were adjusted for case mix and center characteristics. Given similar center characteristics, centers assessing frailty at evaluation had a lower waitlist mortality

rate (always=3.5, sometimes=3.2, never=4.1 deaths per 100 person-years). After adjustment, centers assessing frailty at evaluation had a lower rates of waitlist mortality (always IRR=0.91, 95% CI:0.84-0.99; sometimes=0.89, 95% CI:0.83-0.96) and transplantation (always IRR=0.94, 95% CI:0.91-0.97; sometimes=0.88, 95% CI:0.85-0.90) than those never assessing frailty. Centers that always assessed frailty at KT admission had 0.71 (95% CI:0.54-0.92) times the rate of death-censored graft loss than their counterparts never assessing frailty. Assessing frailty at evaluation is associated with lower transplantation rate but better waitlist survival; centers always assessing frailty at admission are likely to have better graft survival. Research is needed to explore how routine assessment of frailty in other clinical practices benefits broader patient populations.

VALIDATION OF PERCEIVED MENTAL FATIGABILITY USING THE CHINESE VERSION OF THE PITTSBURGH FATIGABILITY SCALE

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Background: Recently we validated the simplified-Chinese version of the Pittsburgh Fatigability Scale (PFS) Physical subscale. Next step is to validate the PFS Mental subscale in order to introduce a reliable measure of perceived mental fatigability among Chinese community-dwelling older adults. Methods: This cross-sectional study was conducted in an urban community in Beijing. Internal consistency of the PFS Mental subscale was evaluated by Cronbach's alpha. The participants were divided in half to evaluate the factor structure validity by exploratory factor analyses and confirmatory factor analysis. Convergent validity and discriminant validity were evaluated against cognitive function (assessed by MOCA) and global fatigue from FRAIL Scale. Results: Our study included 370 participants (mean=83.8 years). The simplified-Chinese version of PFS Mental subscale showed strong internal consistency (total Cronbach's alpha=0.82, each items Cronbach's alpha ranged from 0.78 – 0.83). The results of exploratory factor analysis showed all 10 items loaded on two factors: moderate to high and low intensity activities, which explained 60.8% of the total variance. Confirmatory factor analysis showed fit indices: SRMSR = 0.090, RMSEA = 0.120, CFI = 0.89. PFS Mental scores demonstrated moderate concurrent and construct validity against cognitive function ($r = -0.24$, $P < .001$). Additionally, the PFS Mental subscale had strong convergent validity, discriminating according to established cognitive impairment or FRAIL Scale fatigue testing cut points, with differences in PFS Mental scores ranging from 3.2 to 8.4 points. Conclusions: The PFS Mental subscale

simplified-Chinese version is a valid tool to assess perceived mental fatigability in Chinese-speaking older adults.

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Home Health Care

FAMILY CAREGIVER TRAINING DURING MEDICARE HOME HEALTH CARE: CLINICIAN PERSPECTIVES

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During Medicare home health care, providers often rely on family caregivers to help meet patients' care needs. Beginning in 2018, CMS requires home health agencies to provide training to family caregivers. This qualitative study is the first research to examine current patterns of family caregiver training, and related facilitators and barriers, during Medicare-funded home health care. We conducted semi-structured key informant interviews with home health nurses and physical therapists (n=19) from 4 diverse agencies, then performed thematic analysis of interview transcripts using a hybrid inductive and deductive coding approach. Clinicians described family caregiver education as a dynamic and cyclical process: simultaneously providing patient care, training family caregivers, and gathering additional information about patient needs and caregiver capabilities, then adjusting the care plan accordingly. We present a model of this cyclic process and describe its four major stages: Initial Assessment, Education, Reassessment, and Adjustment. Additionally, clinicians identified a range of structural, individual, and interpersonal factors which impact their ability to successfully train family caregivers. We define each factor and, using illustrative quotes from our interviews, elucidate its role as a facilitator and/or barrier to clinicians' educational efforts. Findings provide the first model of caregiver training during home health care and highlight policy and practice changes to better support clinicians in these efforts; including greater visit flexibility, access to more experienced clinical mentors, and standardized caregiver assessment tools designed for this unique care setting.

HOME HEALTH AGENCIES WITH MORE SOCIALLY VULNERABLE PATIENTS HAVE LOWER EXPERIENCE-OF-CARE RATINGS

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Little is known about the disparities in patient experience of home health (HH) care related to social vulnerability. This study examined the relationships of patient Medicare-Medicaid dual eligible status and race and ethnicity with patient experience of HH care. We analyzed national data from the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS), Outcome and Assessment Information Set, Medicare claims and Area Health Resources File for 11,137 Medicare-certified HH agencies (HHA) that provided care for Medicare beneficiaries in 2017. Patient-reported experience of care star ratings (1-5)

in HHCAHPS included 3 domains (professional care delivery, effective communication, and specific issues in direct patient care) with each dichotomized into high (4-5) and low (1-3) experience of care. The proportion of patients with dual eligibility and the proportion of racial/ethnic minorities were summarized at the HHA level. HHA with higher proportion of dual eligible patients were less likely to have high experience of care rating in professional care delivery (smallest Odds Ratio [OR]=0.514; 95% CI: 0.397, 0.665; p<0.001), effective communication (smallest OR=0.442, 95% CI: 0.336, 0.583; p<0.001), and specific direct care issues (smallest OR=0.697, 95% CI: 0.540, 0.899; p=0.006). HHA with higher proportion of racial/ethnic minorities were also less likely to have high patient experience of care rating across all three domains (smallest OR=0.265, 95% CI: 0.189, 0.370; p<0.001). Disparities in patient experience of HH care exist and they are associated with low income and racial/ethnic minority status, indicating substantial unmet needs among these socially vulnerable patients.

PATIENT-RATED PERFORMANCE OF HOME HEALTH AGENCIES AND HOSPITALIZATION RISK: A PROPENSITY-SCORE MATCHED ANALYSIS

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Home health care is the most commonly used home- and community-based service to older adults "Aging in Place". Patient experience of healthcare services is a critical aspect of patient-centered care. Indeed, policymakers have linked patient-rated quality of care to payment to healthcare providers. This study aimed to examine the association between patient-rated care performance of home health agencies and risk for hospitalization among Medicare beneficiaries. This study used several national datasets from 2016 and included 491,718 individuals from 8,459 home health agencies. Home health agencies' performance was measured using patient experience star rating from the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS). Propensity score matching was used to balance the differences in patient characteristics at baseline between those receiving care from high-performing home health agencies and those in lower-performing agencies. On average, patients were 80.5 years old, 65% female, 81% White, 10% Black, and 6% Hispanic, with 90% taking 5 or more medications. Patients had a mean score of 1.73 (SD=1.69) on the Charlson Index. Respectively, 10% and 16% of patients were hospitalized within 30 and 60 days of home health care initiation. Estimates of logistic regression after propensity score matching found that patients receiving care from lower-performing agencies were at similar risk for both 30-day (OR=0.99, p=0.817) and 60-day (OR=1.02, p=0.616) hospitalization following the start of home health care, compared to those in high-performing agencies. Our findings suggest discrepancies (or no relationship) between patient experience and objective outcomes of home health care.