

of community-living older adults with MCC and to highlight their recommendations for improving care delivery for this group. A qualitative interpretive description design was used. A total of 42 healthcare providers from two provinces in Canada participated in semi-structured interviews. Participants represented diverse disciplines (e.g., physicians, nurses, social workers, personal support workers) and settings (e.g., primary care and home care). Thematic analysis was used to analyze interview data. The experiences of healthcare providers managing care for older adults with MCC were organized into six major themes: (1) managing complexity associated with MCC, (2) implementing person-centred care, (3), involving and supporting family caregivers, (4) using a team approach for holistic care delivery, (5) encountering rewards and challenges in caring for older adults with MCC, and (6) recommending ways to address the challenges of the healthcare system. Healthcare providers highlighted the need for a more comprehensive integrated system of care to improve care management for older adults with MCC and their family caregivers. Specifically, they suggested increased care coordination, more comprehensive primary care visits with an interprofessional team, and increased home care support.

CHRONIC CONDITION PATTERNS IN THE U.S. POPULATION AND THEIR RELATIONSHIP WITH MORTALITY

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Using data from 372,933 participants age >18 years from National Health Interview Survey 2002-2014, we employed latent class analysis to develop latent classes or subgroups of participants based on their combination of 13 self-reported chronic conditions. Mortality linkage with National Death Index was performed through December 31st, 2015. Survival analyses were conducted to assess how the derived latent class membership predicted all-cause mortality and cause specific mortalities. Five latent groups were identified with 70.5% of the participants belonging to the “healthy group”. The other four groups represented various degrees and patterns of multi-morbidity and were labeled accordingly: “hypertensive group” 20%, “respiratory condition group” 3.9%, “heart condition group” 3.7%, and “severely impaired group” 1.9%. 32,609 deaths were identified with average follow-up time of 6.93 years. After controlling for survey design, age, gender, race, Hispanic origin, education, income, health insurance, BMI, smoking and alcohol drinking status, compared to the healthy group, participants in all four latent disease groups had elevated mortality risk: hypertensive group Hazard Ratio(HR) 1.57 (95% confidence interval [1.49, 1.65]); respiratory condition group (2.08 [1.93, 2.24]); heart disease group (2.27 [2.13, 2.42]); and severely impaired group (3.84 [3.55, 4.16]); all p-values <0.01). Patterns of the chronic condition classes were also strongly associated with the primary underline cause of death. Four multi-morbidity groups, comprising 29.5% of the US population were at significantly elevated risk of

mortality. Assessing patterns of disease co-occurrence in the US population may be useful for identifying individuals in need of targeted interventions to reduce mortality risk.

SELF-REGULATION STRATEGIES IN MANAGING MULTI-MORBIDITIES AMONG COMMUNITY-DWELLING PEOPLE AGING WITH ARTHRITIS

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Quantitative and qualitative evidence supported the self-regulation strategies of Selection, Optimization and Compensation (SR-SOC), used by people aging with single and multiple chronic conditions (MCCs) to adapt to chronic disabling symptoms and live well. This study investigated the SR-SOC Strategies in the self-management of community-dwelling people aging with arthritis and MCCs. 140 individuals aged > 50 completed the demographic questionnaire, Functional Comorbidity Index (FCI), Brief Health Literacy Screening, Lubben Social Network Scale, Patient-Healthcare Provider Communication Scale, Health Insurance Checklist, PROMIS Adult Self-Reported Health Measures, SOC Questionnaire, Arthritis Self-Efficacy Scale, Healthcare Service Utilization Questionnaire, and a visual analogue QOL scale. With the theoretical framework, multivariate hierarchical stepwise regression was used to predict SR-SOC Strategies, arthritis self-efficacy, healthcare utilizations and QOL. Majority of the sample were female (70%), with < Bachelor's degree (56%), White (34%) or African American (33%), with personal annual income < \$25,000 (52%). Thirty-seven percent reported fairly and 26% poorly adequate income. Number of FCI count ranged from 2 to 14 (Mean =3.8). The top four comorbidities were obesity, diabetes, visual impairment and degenerative disc disease. QOL ranged from 0.5 to 10.0 (Mean=7.2, SD=2.2). Age, physical symptom cluster (pain, fatigue and cognitive abilities) and healthcare provider communication quality significantly predicted SR-SOC strategies. Income adequacy, physical symptom cluster and SR-SOC strategies significantly predicted arthritis self-efficacy. FCI significantly predicted healthcare utilization total, inpatient healthcare utilization, clinician visit and hospitalization. With income adequacy, FCI significantly predicted home health visit and emergency room visit. Being African American and FCI significantly predicted prescriptions filled.

RACIAL-ETHNIC DIFFERENCES IN MULTIMORBIDITY PROGRESSION ACCORDING TO BODY-WEIGHT STATUS AMONG OLDER U.S. ADULTS

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