both bilateral agreements and communication. Whereas reported care related issues related to challenges such as the assessment of care receivers' needs and the use of assistive devices in the provision of ADL-care. The inventoried challenges will be addressed in an ADL-quality standard for nursing staff.

PATTERNS OF PERFORMANCE ON QUALITY OF CARE AMONG U.S. HOME HEALTH AGENCIES, 2015-2017

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Home healthcare is a critical care source for community-dwelling older adults. As the fastest growing healthcare sector in the US, quality of home healthcare is under increasing scrutiny. The purpose of this study is to examine patterns of performance on quality of care among US home health agencies. This is a 3-year cohort study using 2015-2017 Home Health Compare data and Provider of Services (POS) Files. In the dataset, each HHA was assigned a star rating (1-5) to reflect the overall quality of care. This indicator was calculated based on two process measures (timely initiation of care and drug education) and six outcome measures (e.g., hospitalization). We examined 8,020 HHAs in the US. Over the 3-year period, the number of HHAs receiving a star rating of 4 or 5 increased from 27% in 2015, 31% in 2016, to 32% in 2017. Roughly, 32% of the HHAs received a lower star rating and another 32% received a higher star rating from 2015 to 2016. Similarly, 30% of the HHAs received a lower star rating and 29% of the HHAs received a higher star rating from 2016 to 2017. Hospital-based HHAs were less likely to receive a star rating of 4 or 5. Larger HHAs (OR 1.34; 95% CI, 1.13-1.59) and HHAs with ownership changes (OR, 1.38; 95% CI 1.20-1.59) were more likely to improve their star ratings overtime. Our finding indicates dynamic changes in the quality of care within the US home healthcare sector.

TRENDS IN HEALTHCARE COSTS AND UTILIZATION ASSOCIATED WITH HEARING LOSS DIAGNOSIS OVER 10 YEARS

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Hearing loss affects 38 million Americans and is associated with cognitive and physical decline. Moreover, hearing loss limits communication between patients and providers. In this study, we aimed to determine whether hearing loss diagnosis impacts healthcare cost and utilization. In the OptumLabs Data Warehouse insurance claims database (January 1, 1999 to December 31, 2016) we identified cases of age-related hearing loss (i.e. excluding conductive, ototoxic-induced, surgical-related hearing losses) in adults over the age of 50 years. Hearing loss cases were propensity-matched (nearest neighbor) to persons without hearing loss on multiple socioeconomic (income, region), demographic (age, sex, race, education), and health status (comorbidity count, cancer, dementia, baseline resource utilization) indices. There were 154,414, 44,852, and 4,728 subjects, respectively, at the 2-, 5-, and 10-year follow-up time points. We used regression modeling to examine healthcare cost (total expenditures), inpatient hospitalization, length of inpatient stay, outpatient visits, 30-day readmissions, and emergency department visits. Among 4,728 matched adults, hearing loss was associated with $22,434 (95% CI $18,219-$26,648) or 46% higher total healthcare costs over a 10-year period compared to those without hearing loss. Persons with hearing loss experienced more inpatient stays (Incident Rate Ratio, 1.47; 95% CI 1.29-1.68) and were at-risk (44% higher risk) for greater 30-day hospital readmission (Relative Risk, 1.44; 95% CI 1.14-1.81) at 10-years post index date. Similar trends were observed at 2- and 5-year time points across all measures. Importantly, these pathways may be amendable to hearing treatment via amplification which warrants future research preventative strategies.

EXPLORING THE IMPACT OF RACE-ETHNICITY ON RESPONSE TO WEIGHT-LOSS TREATMENT: RESULTS FROM THE POWR-UP STUDY

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Racial/ethnic differences in obesity prevalence and in responses to weight-loss treatment between Black and White women are well documented. Whether these differences influence responses to weight-loss treatment among older women is unknown. Therefore, we evaluated racial/ethnic differences among participants in a 6-month weight-loss study with traditional versus higher protein intake. Participants were obese (BMI ≥ 30 kg/m2) community-dwelling women, age 45 years or older, who self-identified as either Black or White. Change in body-weight, 6 minute walk test (6MWT), general health (SF-36), and satisfaction with life (SWL) were evaluated at 0, 4 and 6 months. Both racial groups reduced (ps < 0.01) body weight at 4 and 6 months, with a trend toward more weight loss among White women ($p = 0.07$), relative to Black women. Other racial/ethnic differences included greater improvements in general health ($p = 0.05$) and 6MWT ($p < 0.05$) for White versus Black women at 6 months; these differences persisted after adjusting for treatment group, age/education, and comorbidity. Although racial/ethnic differences in SWL were not observed, significant improvement was observed only among White women ($p < 0.01$). Interestingly, weight loss was associated with improved 6MWT only among Black women ($r = -0.66$, $p < 0.05$) and with general health only among White women ($r = -0.44$, $p < 0.05$). Overall, White women experienced greater improvements in health and physical function as a result of weight-loss than did Black women. Further research is needed to identify equitable intervention strategies for the treatment of sarcopenic obesity.

FUNCTIONAL INDEPENDENCE, ACCESS TO KIDNEY TRANSPLANTATION, AND WAITLIST MORTALITY

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Although functional independence is a health priority for patients with advanced CKD, 50% of those who progress to end-stage kidney disease (ESKD) develop difficulties carrying-out essential day-to-day activities. Functional independence is not routinely assessed at kidney transplant (KT) evaluation; therefore, it is unclear what percentage of candidates are functionally independent and whether independence is associated with access to KT and waitlist mortality. We studied a prospective cohort of 3,168 ESKD participants (1/2009-6/2018) who self-reported functional independence in basic Activities of Daily Living (ADL) and more complex Instrumental Activities of Daily Living (IADL). We estimated adjusted associations between functional independence (separately) and listing (Cox), waitlist mortality (competing risks), and transplant rates (Poisson). At evaluation, 92.4% were independent in ADLs, but only 68.5% were independent in IADLs. Functionally independent participants had a higher chance of listing for KT (ADL:aHR=1.55,95%CI:1.30-1.87; IADL:aHR=1.39,95%CI 1.26-1.52). Among KT candidates, ADL independence was associated with lower waitlist mortality risk (SHR=0.66,95%CI:0.44-0.98) and higher rate of KT (IRR=1.58,95%CI:1.12-2.22); the same was not observed for IADL independence (SHR=0.86,95%CI:0.65-1.12; IRR=1.01,95%CI:0.97-1.19). ADL independence was associated with better KT access and lower waitlist mortality; clinicians should screen KT candidates for ADL independence, and identify interventions to maintain independence to improve waitlist outcomes.

HEALTH, WORRY, AND FOOD INSECURITY IN LOW-INCOME U.S. ADULTS: AN EXPLORATION OF MIDLIFE VULNERABILITY

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Food insecurity, defined as the inability to afford and access nutritious foods to eat, is associated with poor health, higher healthcare costs, and increased risk of mortality (Gundersen et al., 2018). Moreover, food insecurity appears to accelerate aging processes. For example, food insecurity is associated with inadequate nutrition, which expedites the loss of muscle mass, increases mobility problems, increases financial worry, and increases the risk of frailty. While a good deal is known about food insecurity in later life, far less is known about midlife, which may be a time of unexplored vulnerability. We examined food insecurity in a sample (n=17,866; 2014 NHIS) of low-income (PIR<3) young, early-middle, late-middle, and older adults (18-84), focusing on health challenges (chronic conditions, functional limitations) and financial worry as predictors and whether their effects varied with age. Multinomial logistic regression was used to assess the association of predictors with food insecurity and determine whether associations differed by age group, adjusted for covariates (e.g., sex, race/ethnicity, education, social security). Food insecurity rates were highest in late- (37.5%) and early- (36.0%) midlife followed by young (33.7%) and older (20.2%) adults. Age moderated the relationship between food insecurity and risk factors ($p < .05$ for both) such that health was stronger- but financial worry was weaker- in midlife (due to higher food insecurity in low- and high- worry groups). Midlife is a period of increased vulnerability to food insecurity, particularly for those with health challenges. Research is needed to inform prevention strategies to help ensure optimal aging.

SESSION 2385 (POSTER)

HEALTH, MEDICAL AND SOCIAL SERVICES

FALL INJURY CHARACTERISTICS ASSOCIATED WITH EMERGENCY DEPARTMENT VISITS AND HOSPITALIZATIONS AMONG OLDER ADULTS

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Fall injuries and related healthcare use among older adults are increasing in the US. Based on the 2013-2017 US National Health Interview Survey public use data, this study examined fall injury characteristics that are associated with emergency department (ED) visits and hospitalizations among those aged ≥60 years who received medical attention for their fall injuries within a 91-day reference period (N=1,840). Our findings show that nearly a third of these older adults received care from emergency medical services (EMS), presumably for a "lift assist" to get off the floor and/or for ED or hospital transport; a little more than one-third had an ED visit only; and a little less than a fifth had an overnight hospital stay. Multivariable analysis showed that hip and head injuries, face injuries, and broken bones/fractures (from any type of injury) were likelier causes of hospitalization than injuries to other parts of the body. Fall injuries sustained inside the home, falls from loss of balance/dizziness, and living alone were also more likely to result in hospitalization, while fall injuries that occurred away from home and those with lung disease and memory problems were associated with higher risk of ED use only. These healthcare use data indicate the significant toll that fall injuries exact upon older adults and healthcare system. Fall prevention programs should target risk factors that are specific to serious injuries and be made more accessible. Strategies for implementing scalable, adaptable, and measurable fall prevention models by EMS providers and ED staff are also needed.

SEX DIFFERENCE IN EARLY FRAILTY TRANSITIONS, HEALTHCARE USE, AND MEDICARE PAYMENT IN OLDER MEXICAN AMERICANS

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