PAD disease. In addition, there is a need for special interest in intervening metabolic conditions of female patients with PAD.

MULTIMORBIDITY PROGRESSION AMONG MEDICARE BENEFICIARIES IN THE HEALTH AND RETIREMENT STUDY (1992-2014)

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Older adults are at greater risk for developing and accumulating multimorbidity, defined as 2 or more chronic diseases. This study describes the characteristics of multimorbidity progression-based groups using Medicare claims chronic condition warehouse algorithms over a 24-year period. The HRS-Medicare linked data (1991-2015, N=17,895, age 67 years and older) were used in descriptive analyses presented as a Sankey flow diagram. We identified 1,293 (7.2%) beneficiaries who had not yet developed multimorbidity by the end of the observation period (no multimorbidity), 7,552 (42.2%) who started without but developed multimorbidity over the course of observation (incident multimorbidity), and 9,050 (50.6%) who had multimorbidity upon study entry (prevalent multimorbidity). There were notable differences between multimorbidity progression-based groups. Beneficiaries with prevalent multimorbidity were younger at baseline (73.1% in youngest age category [67-69] vs. 50.3% for incident and 66.7% for no multimorbidity), had proportionately higher levels of cognitive impairment (21.6% CIND/dementia vs. 15.4% for incident and 16.8% for no multimorbidity), and greater mean levels of functional impairment and healthcare utilization. Non-Hispanic Black beneficiaries were more represented in prevalent multimorbidity (15.4%) than in the incident (11.8%) and no multimorbidity groups (13.4%). Non-Hispanic White beneficiaries were more represented in the incident (83.5%) than the prevalent (77.2%) and the no multimorbidity (77.7%). Hispanic beneficiaries were more represented in the no (8.9%) than the prevalent (7.4%) and incident multimorbidity groups (4.7%). Results highlight beneficiaries who experience clinically-meaningful transitions to multimorbidity states in late life, allowing new insights and informing interventions to address burdensome changes to their chronic disease status.

OBESITY AND MULTIMORBIDITY IN THE USA: NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEYS 2005-2014

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Declining mortality rates and an aging population have contributed to increasing rates of multimorbidity (≥2 chronic conditions) in the United States. Obesity is an important risk factor for the development of chronic diseases. We evaluated the association between obesity and multimorbidity, and how the prevalence of concomitant obesity has changed over time. We used data from 8,883 individuals aged ≥60 years with data on body mass index (BMI) and self-reported comorbidities from the National Health and Nutrition Examination Surveys 2005-2014. Logistic regression was used to quantify the association between BMI categories (<18.5, 18.5-24.9, 25-29.9, ≥30 kg/m2) and multimorbidity (yes/no). Change in proportions of obesity coexisting with multimorbidity by year was tested through linear regression. All analysis used NHANES survey design and weighting to be representative of the US population. The overall proportion of individuals with concomitant multimorbidity and obesity was 75%. As compared to a normal BMI (18.5-24.9 kg/m2), older adults with obesity (BMI ≥30 kg/m2) had higher odds of multimorbidity (OR 1.78, 95% CI 1.49,2.12). Persons with obesity had higher odds of decline in physical (1.41 [1.06,1.88]), basic (1.56 [1.13,2.15]), and instrumental activities of daily living (OR 1.58 [1.03,2.40]). The proportion of individuals with obesity and multimorbidity increased over time, but did not reach significance ($\beta = 0.008$, $p=0.051$). These results emphasize the role of obesity as a contributing factor to the burden of multimorbidity among older adults and underscore the importance of identifying and addressing obesity and multimorbidity via interventions to decrease obesity prevalence.

PANDEMIC-INSPIRED STRATEGIES FOR CROSS-SECTOR COLLABORATION ON FOOD EQUITY ACROSS THE LIFESPAN

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Early during the pandemic, access to food by residents across the lifespan was problematic in many communities. We observed well-intentioned responses by community organizations but a lack of centralized coordination across sectors, even as donations and resources significantly increased. Most of the organizations were in various sectors and not aware of the efforts and capabilities of others causing duplication or gaps in services. To prepare for future emergencies, our team created a project to develop and pilot a user-friendly, evidence-based roadmap to guide communities through the process of developing and sustaining effective collaborative partnerships for food and nutrition-related problems they could address together. We will describe the process through which we developed the roadmap structure and recruited stakeholders and content experts for our advisory board. To determine the effectiveness of our interventions, we designed methods with which we can analyze the organizations willing to use the roadmap and participate in the collaborative partnership; how they implement the roadmap; and ways they cope with challenges they face during implementation using strategies in the roadmap. We will describe elements of an effective, efficient roadmap development process using as