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

D. Diane Zheng,[1] Sharon L. Christ,[2] Byron Lam,[3] Kathryn McCollister,[1] Daniel J. Feaster,[1] and David J. Lee[1], *1. University of Miami, Miami, Florida, United States, 2. Purdue University, West Lafayette, Indiana, United States, 3. Bascom Palmer Eye Institute, Miami, Florida, United States*

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

Wenhui Zhang,[1] Kavita Radhakrishnan,[1] Heather Becker,[1] Gayle Acton,[2] and Carole K. Holahan[2], *1. School of Nursing, the University of Texas at Austin, Austin, Texas, United States, 2. The University of Texas at Austin, Austin, Texas, United States*

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

Anda Botoseneanu,[1] Sheila Markwardt,[2] Heather Allore,[3] Corey Nagel,[4] Jason T. Newsom,[5] David A. Dorr,[2] and Ana R. Quiñones[6], *1. University of Michigan, Dearborn, Michigan, United States, 2. Oregon Health & Science University, Portland, Oregon, United States, 3. Yale University, New Haven, Connecticut, United States, 4. University of Arkansas for Medical Sciences, Little Rock, Arkansas, United States, 5. Portland State University, Portland, Oregon, United States, 6. Family Medicine, Oregon Health & Science University, Portland, Oregon, United States*

Obesity and multimorbidity are more prevalent among underrepresented U.S. racial/ethnic minority groups. Evaluating whether racial/ethnic disparities in multimorbidity accumulation vary according to body-mass index (BMI) may guide interventions aimed at reducing multimorbidity burden in vulnerable racial/ethnic groups. We used 1998-2014 data from the Health & Retirement Study (N=8,635 participants, age 51-55 years old at baseline) and negative binomial models stratified by BMI category to evaluate differences in rates of accumulation of seven chronic conditions (arthritis, cancer, diabetes, heart disease, hypertension, lung disease, and stroke), focusing on differences between racial/ethnic groups [White (reference; 64.7%), Black (21.5%), Hispanic (13.8%)]. Overweight and obesity were more prevalent in Black (80.9%) and Hispanic (78.6%) than White (69.9%) participants at baseline; in all BMI categories, Black participants had higher rates of multimorbidity compared with White participants (normal BMI:β=0.304, $p<0.001$; overweight:β=0.243,$p<0.001$; and obese:β=0.135,$p=0.013$); initial burden of disease was similar between Whites and Hispanics in the normal and overweight categories, but significantly lower among Hispanics (vs. Whites) in the obese category (β= -0.180,$p=0.017$). We found no significant differences in rates of disease accumulation between the racial/ethnic groups in any of the BMI categories. There are substantial differences in initial disease burden between Black and White middle-aged/older adults, but not in the rate of accumulation of disease between the race/ethnic groups in the 3 main BMI categories. These findings suggest an opportunity to reduce racial disparities in multimorbidity by intervening early in the lifecourse to reduce the burden of chronic disease among vulnerable racial minorities prior to entering middle-age.

CHRONIC ILLNESSES AND FATIGUE IN OLDER INDIVIDUALS: A LITERATURE REVIEW

Maral Torossian,[1] and Cynthia Jacelon[1], *1. University of Massachusetts Amherst, Amherst, Massachusetts, United States*

In the United states, 60% of adults have one chronic disease and 40% have at least two chronic diseases. Fatigue is a commonly reported symptom in individuals with chronic illnesses, the prevalence of which ranges between 40-74%. It is associated with multiple risk factors and has a tremendous impact on quality of life, social functioning, mood, motivation and cognition. Despite its high prevalence, the relationship between fatigue and chronic illness has not been well explored. Accordingly, the focus of this synthesis of literature is to explore fatigue-associated factors and their relation to chronic disease. The databases searched were CINAHL, PubMed, PsychInfo and Web of Science, where the following keywords were used: "Chronic disease" OR "Chronic illness" OR "Chronic conditions", "Fatigue", "Elderly" OR "Older adults" OR "Seniors" OR "Geriatrics". The synthesis resulted in four themes: understanding the concept of fatigue, factors related to fatigue, activity and fatigue, and self-management of fatigue. There were some inconsistencies in the findings among research studies which were addressed, in addition to the strengths and weaknesses of some of the fatigue measurement scales used. This literature review integrates findings about fatigue in chronic illnesses in various aspects, in the population of individuals who are of 65 age or older. The four emerged themes are of value to individuals with similar characteristics as the selected population, as well as to health care providers and researchers who may address the inconsistent findings and provide a strong evidence for best practice.

SESSION 1400 (POSTER)

SOCIAL DETERMINANTS OF HEALTH

DIMENSIONS OF SOCIAL SUPPORT AND ASSOCIATIONS WITH HEALTH AMONG OLDER ADULTS

Samuel Asante,[1] and Eun-Jun Bang[1], *1. Northeastern State University, Broken Arrow, Oklahoma, United States*

Social support is fundamental to human survival, and is significantly involved in the attainment and maintenance of good health and wellbeing. Previous studies have often considered social support as a singular, non-dimensional construct. While this is important and enlightening, the method of adding up individual aspects to create a singular, non-dimensional construct has produced little understanding of these aspects/dimensions of social support and their implications for health. This study examined three dimensions or types of social support-affective, confidant, and instrumental support-and their associations with physical and mental health in older adults. Data for this study were obtain from Utah Fertility, Longevity, and Aging (FLAG) study. Participants involved 325 older adults, aged 50 years or older. Results showed a significant, strong positive correlation between affective support and physical and mental health, and weak association between confidant support and physical and mental health. The correlation between instrumental support and physical and mental health was moderate. After controlling for the influence of socio-demographic variables, affective and instrumental support significantly predicted physical and mental health. Confidant support was not a significant predictor of either physical or mental health. The findings suggest both affective and instrumental support might be relatively more important to the health and mental wellbeing of older adults than confidant support, underscoring the relative importance older adults attach to quality rather than confidant support, which essentially is quantity of social ties.

GRANDPARENTAL CAREGIVING AND CO-RESIDENCE, SOCIOECONOMIC STATUS, AND MORTALITY IN RHODE ISLAND CITIES AND TOWNS

Julia Broccoli,[1] Steven A. Cohen,[1] and Mary L. Greaney[1], *1. University of Rhode Island, Kingston, Rhode Island, United States*

Grandparents co-residing with their grandchildren is becoming increasingly more common, with over 1.5 million grandchildren living with their grandchildren in the U.S. Furthermore, the number of grandparents who are primary caregivers for their grandchildren has also increased, which can negatively effects the grandparents' physical and mental health, and increase social isolation and financial burden. However, the associations between grandparental caregiving and health outcomes are not well understood on a population