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Social isolation and frailty are global public health issues that may lead to poor health outcomes. We tested the two following hypotheses: 1) changes in social isolation and frailty are associated with adverse health outcomes over two years, 2) the associations between social isolation and health vary across different levels of frailty. We estimated a series of latent growth models to test our hypotheses using data from the FRÉLE longitudinal study among 1643 Canadian community-dwelling older adults aged 65 years and over. Missing data were handled by pattern mixture models with the assumption of missing not at random. We measured social isolation through social participation, social networks, and social support from different social ties. We assessed frailty using Fried's criteria. Our results revealed that higher frailty at baseline was associated with a higher rate of comorbidity, depression, and cognitive decline over two years. Less social participation at baseline was associated with comorbidity, depression, and changes in cognitive decline. Less social support from friends, children, partner, and family at baseline was associated with comorbidity, cognitive decline, and changes in depression. Fewer contacts with grandchildren were related to cognitive decline over time. The associations of receiving less support from partner with depression and participating less in social activities with comorbidity, depression, and cognitive decline were higher among frail or prefrail than robust older adults over time. This longitudinal study suggests that intimate connectedness and social participation may ameliorate health status in frail older populations, highlighting the importance of age-friendly city policies.

Session 2150 (Paper)

Sexuality

AGING LGBT ADULTS' ACCESS TO SOCIAL RESOURCES ACCORDING TO LGBT IDENTITY AND SOCIODEMOGRAPHICS

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Research suggests that social resources positively influence the health and well-being of lesbian, gay, bisexual, and transgender (LGBT) aging adults, but their access to social resources may vary according to LGBT identity. Using data from Aging with Pride: National Health, Aging, and Sexuality/Gender Study (N=2,536), multivariate models tested how access to social resources varied by LGBT identity and whether the effect of LGBT identity showed additional variations by sociodemographic characteristics (i.e., age and education) among aging LGBT adults. Lesbian respondents had larger social networks than gay respondents, while gay respondents had smaller networks than transgender respondents. Lesbian respondents had more social support and community belonging than other identity groups. Bisexual male respondents and transgender respondents had less support than gay respondents and bisexual male respondents reported less

community belonging than gay respondents. Education and age moderated the association between LGBT identity and social support. Findings highlight the importance of considering social support separately from social network size with the understanding that large social networks do not necessarily provide ample social support and this distinction was particularly relevant for transgender respondents who had larger social networks, but less social support than gay respondents. Results also suggest that feelings of LGBT community belonging vary among LGBT identity groups. Health and human service professionals should not only consider the sexual and gender identity of their aging LGBT clients, but also consider the clients' additional sociodemographic characteristics when assessing their access to social resources.

COMPARISON OF TWO SURVEYS USING THE SEXUALITY ASSESSMENT TOOL (SEXAT) IN FLANDERS

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From 2015 it is mandatory in Flanders, Belgium, to develop a policy to deal with sexual abuse in elderly care. Residential Aged Care Facilities (RACF'S) try to focus on this mandatory, but should also pay attention to implement an overall Sex and Intimacy Policy. This study contains a Comparison of two surveys (Messelis & Bauer, 2020 and Vander Stichele, e.a. 2020) in Flanders, Belgium, both using the Sexual Assessment Tool (SeAT, Messelis & Bauer, 2017). Both studies aimed to assess how supportive residential aged care facilities are of residents' sexual expression. In the survey of Messelis & Bauer 750 aged care facilities were contacted in 2017-2018 and 69 (9,2%) completed the SexAT survey after three reminders. Vander Stichele e.a. contacted 100 aged care facilities managers in 2019. Twenty of them (20% response rate) completed the SexAT after three reminders. Findings of the Messelis & Bauer survey indicate that 70% of the facilities rated 'very good' to 'good' (score between 21-59/69), while Vander Stichele e.a. found a prevalence of 76% of this score. Both found no facilities were rated 'excellent' (score greater than 60/69). In the category 'improvement needed' (score less than 20/69), percentages were 30% and 23%; a difference of 7% (CI95% of difference in percentage includes zero, not significant). There is room for improvement in residential aged care facilities for the support of sexual expression of residents. The more recent study confirms results of the previous one, and no significant evolution was observed in two consecutive cross-sectional surveys.

SEXUAL EXPRESSION, POLICY, AND PRACTICES IN SKILLED NURSING FACILITIES: AN UPDATED ASSESSMENT IN THE STATE OF KANSAS

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Prior studies have reported barriers to meeting the sexual needs of older adults within skilled-nursing facilities, such as a lack of privacy, lack of supportive practices and policies, and judgement or discomfort on the part of the staff (Doll,

2013; Hajjar & Kamel, 2003). In 2008, Doll and colleagues assessed the scope of sexual behaviors, staff perceptions of and responses to such behaviors, and whether facilities had a sexual policy in place in SNFs in the state of Kansas (Doll, 2013). In the present study, an online survey was distributed to the same population to provide an updated assessment of sexual behaviors, policies, and practices. Of 60 survey respondents, 62.7% reported knowledge of individual sexual acts (e.g., masturbation) within the past year and 34.5% reported interactional (between two or more residents) sexual acts. When encountering a sexual event, staff were most likely to report the incident to an administrator (76.7%) and treat residents with respect (70.0%), while 35.0% and 41.7% were expected to respond with embarrassment and discomfort, respectively. Only 40% of administrators reported having a policy related to sexual expression. Findings indicate that staff are likely to respond differently to LGBTQ residents due to discomfort and those living with cognitive impairment due to concerns related to consent. The proportion of facilities in Kansas with policies related to sexual expression has increased from 26% to 40% in the past 12 years, but there remains a need for greater specificity of sexuality-related policies and trainings.

THE ROLE OF MINORITY STRESS AND SOCIAL RESOURCES IN THE HEALTHCARE UTILIZATION OF AGING LGBT ADULTS

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Research suggests that minority stress can influence the healthcare utilization of aging LGBT adults, and that social resources can buffer the effect of stress on healthcare utilization. Using data from Aging with Pride: National Health, Aging, and Sexuality/Gender Study (N = 2,560), multiple logistic regression assessed the associations between minority stress (i.e., internalized stigma and LGBT identity disclosure) and healthcare utilization (i.e., health screenings, emergency room use, routine checkups, and regular provider). We also examined the moderating effect of social resources, including social network size, social support, and LGBT community belonging, in these associations. Internalized stigma was negatively associated with having a routine checkup in the previous year (OR = 0.82, p = .038). Disclosure was positively associated with having a health screening within the past 3 years (OR = 1.52, p = .000) and having a regular provider (OR = 1.33, p = .021). Further, we found that social support moderated the association between disclosure and health screenings (OR = 1.52, p < .001); thus, having higher levels of social support and disclosure in tandem increased the likelihood of getting a health screening in the last three years. Health and human service professionals should provide information about internalized stigma and LGBT identity disclosure to educate their clients about the ways in which these minority stressors can impact their healthcare experiences. Providers should assess the social support of their aging LGBT clients and inform them about the added benefit that social support can have in their healthcare experiences.

Session 2155 (Symposium)

TRANSFORMING DEMENTIA CARE: IMPLEMENTATION CHALLENGES MOVING EVIDENCE-BASED PROGRAMS TO HEALTH CARE

Chair: Laura Gitlin

Co-Chair: Kenneth Hepburn

Discussant: Sara Czaja

Although evidence for dementia care programs continues to grow, families and health providers do not have ready access to programs, nor have they been widely disseminated and routinized in healthcare. Understanding implementation considerations when embedding evidence-based programs in healthcare systems can inform ways to effectively transform dementia care. This symposium will examine similarities and differences in implementation challenges encountered and strategies used when implementing four evidence-based programs being tested in different healthcare environments using distinct study designs. Dr. Gaugler et al., will discuss implementation challenges encountered with a staff-delivered intervention (ADS Plus) to support caregivers in adult day services that is being tested using a mixed methods hybrid trial design in >50 sites nationally. Dr. Hodgson et al., will discuss adaptations and their measurement to COPE, a home-based dyadic support program being embedded in 10 PACEs of a large healthcare system using a noninferiority trial testing staff training strategies. Dr. Forester et al., will examine implementation of the Care Ecosystem for dementia patients in a high-risk, integrated care management program using a pilot embedded pragmatic trial. Dr. Hepburn et al., will explore tactical challenges of implementing Tele-Savvy, an online caregiver psychoeducation program, within the context of a pilot pragmatic clinical trial. Drawing upon implementation science, themes discussed include balancing adaptations and fidelity, measurement of implementation outcomes and organizational readiness, and staff training implications. Also highlighted are research design considerations. Dr. Czaja, an expert in the design and implementation of dementia care interventions from in-person to technology-based will be the discussant.

ADDRESSING TACTICAL CHALLENGES IN EMBEDDING TELE-SAVVY IN A PILOT PRAGMATIC TRIAL

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This presentation describes how we plan to address the challenges of testing an evidence-based caregiver program in a real-world setting without the infrastructure and personal contact of a typical RCT. Instead of screening participants for eligibility, clinic staff will pre-identify participants whom clinicians then confirm. Each clinic will include Tele-Savvy as standard of care; we will thus be able to obtain IRB approval for a waiver of consent. By securing agreement from each clinic to incorporate a small set of standard instruments (e.g., Pearlin Caregiver Competence scale) into their standard operating procedure of routinely collecting caregiver data