Consultation, which is a semi-structured, telephone conversation covering a comprehensive range of potentials problems. The protocol also connects high-risk clients to existing available home- and community-based services. Results demonstrate that components of proven evidence-based interventions are feasible to integrate into existing programs and services. This includes adapting a model for problem-identification and assessment based on a consumer-driven conceptual framework, a record keeping system to enhance consistency and fidelity of program delivery, and establishing a formal referral protocol to more seamlessly link clients to other available services.

AGE AND SITE DIFFERENCES IN PLANNED AND PERFORMED ACTIONS IN RESPONSE TO IDENTIFIED RISKS IN OLDER ADULTS

Deborah Finkel,[1] Linda Johansson,[2] Björn Westerlind,[3] Ulrika Lindmark,[4] and Marie Ernsth-Bravell[2], *1. Indiana University Southeast, New Albany, Indiana, United States, 2. Jönköping University, Jönköping, Jonkopings Lan, Sweden, 3. Linköping University, Linköping, Ostergotlands Lan, Sweden, 4. Karlstad University, Karlstad, Varmlands Lan, Sweden*

The Swedish health care system focuses on allowing older adults to "age in place"; however, that approach assumes that home health services are adequate to support health and prevent unnecessary decline. Data from the Senior Alert national quality register in Sweden were examined to compare the quality of care across care locations. First registration in Senior Alert was available for 2914 adults aged 57–109 (median age = 81): 3.6% dementia unit, 7.8% home health care, 4.4% rehabilitation unit, 62.8% hospital, 21.4% care home. There were significant differences across units in the number of identified risks in 4 categories: falls, malnutrition, oral health, and pressure ulcer. Individuals in rehabilitation units averaged 2.4 risks, individuals in dementia and care homes averaged 2.0 risks, and individuals in home health care and hospitals averaged 1.4 risks. For individuals with identified risks, the differences between planned and performed actions for each risk independently were greatest for those in home health care. Moreover, the correlation between total planned and performed actions in home health care was .79 for adults aged 65–80 years and .39 for adults aged 81 and over. The correlation did not differ across age for the other care units. Results suggest that individuals most in need of actions to address health risks (older adults in home health care) are least likely to have the actions performed. Training and support of workers responsible for home health care need to be improved if the "age in place" policy is to continue.

TRAJECTORIES OF HEALTH RECOVERY AFTER HIP FRACTURE IN OLDER ADULTS: A SCOPING REVIEW

Tingzhong (Michelle) Xue,[1] Jiepin Cao,[2] Leila Ledbetter,[3] Margaret Graton,[3] Yan Zhan,[4] Dingyue (Demy) Wang,[3] Youran Lee,[3] and Eleanor McConnell[3], *1. Duke University School of Nursing, Durham, North Carolina, United States, 2. NYU Grossman School of Medicine, New York City, New York, United States, 3. Duke University, Durham, North Carolina, United States, 4. Yale University, Orange, Connecticut, United States*

Hip fracture recovery outcomes in older adults are characterized by high mortality, lowered functional status, and feelings of being disrupted from a normal life. Studying recovery trajectories through the lens of resilience can provide novel perspectives for developing interventions targeting to promote recovery. However, the lack of knowledge of recovery trajectories and their variations in hip fracture patients impedes such efforts. This review aims to synthesize current evidence on how multiple health domains change longitudinally after hip fracture in older adults. The Joanna Briggs Institute scoping review methodology was followed, and seven databases were searched including Medline (PubMed), EMBASE, Web of Science Core Collection, CINAHL, Proquest Dissertations and Theses, Cochrane Central Register of Controlled Trials, and Cochrane Database of Systematic Reviews. No date limits were applied, and the final search resulted in 7,515 articles. Articles in English with participants aged 60 years and above who experienced a low-energy, nonpharmacological hip fracture in any health setting were selected. Results regarding multiple domains of health outcomes will be synthesized, including physical health (e.g. functional status, pain, nutrition, and mobility/physical performance), cognition, psychosocial health (e.g. depression, anxiety, social isolation, loneliness, and behavioral and psychological symptoms of dementia when individuals with dementia were included), and multidimensional outcomes such as health-related quality of life. Methodological challenges and limitations will be discussed. This review has important implications for clinicians and researchers to improve individualized treatment plans and research methodologies by providing a comprehensive, critical review of knowledge regarding health trajectories in older adults after hip fracture.

PHYSICAL SYMPTOM TRAJECTORIES OF OLDER ADULTS DURING THE COVID-19 PANDEMIC

Dylan Lee,[1] Soyoung Choun,[2] Hye Soo Lee,[2] Maria Kurth,[2] and Carolyn Aldwin[3], *1. Touro University Nevada, Henderson, Nevada, United States, 2. Oregon State University, Corvallis, Oregon, United States, 3. Oregon State University, Corvallis, Oregon, United States*

Older adults experience increased risk for morbidity and mortality during the COVID-19 pandemic (CDC, 2021). Social distancing and lockdown to prevent contagion may affected physical and mental health. We examined the fifteen physical symptom trajectories of older adults during the early months of the COVID-19 pandemic. We also examined age, gender, and marital status differences in each physical symptom trajectory. The sample consisted of 247 older adults (Mage = 71.1, SD = 7.3, 88.7% White, 73% women, 73.4% married), who participated in eight weekly longitudinal online surveys from April 28 to June 23, 2020. Random-effects logistic regression analysis controlling for age, gender, marital status, and depressive symptoms showed that the nine physical symptoms (headache, constipation/diarrhea, muscle soreness, shortness of breath, tightness of chest, backache, heart pounding, congestion, and sore throat) significantly decreased in the first few weeks, but then six symptoms (constipation/diarrhea, shortness of breath, tightness of chest, heart pounding, congestion, and sore throat) increased in later weeks of the study period.