REFINING THE PROGRAMME THEORYCASE STUDIES IN CARE HOMES FROM THREE DISCRETE CARE ECONOMIES

A. Gordon[1], C. Goodman[2], S. Davies[2], M. Zubair[1], A. Mayrhofer[2], B. Bell[1], J. Jordan[3], H. Gage[3], *1. Division of Medical Sciences and Graduate Entry Medicine, University of Nottingham, Derby, Derbyshire, United Kingdom, 2. University of Hertfordshire, Hatfield, United Kingdom, 3. University of Surrey, Guildford, United Kingdom*

To further develop the programme theory, three geographically discrete areas were identified with models of health care emphasising respectively: expertise in care of older adults organised around the care home; incentive-driven care using general practitioners (GPs) as co-ordinators; and mixed provision typical of usual UK care delivery. 242 residents from 12 care homes had baseline health status described using the InterRAI-LTC and their healthcare resource use and associated costs over 12 months collated. Interviews and focus groups with 181 health and social care professionals, residents and families described the care received. Healthcare costs per resident were greatest where provision was ad hoc and mixed. GP contacts and costs were greater where incentives emphasised GP contact. The most positive accounts were of models which recognised the pivotal role of homes in healthcare delivery, supported effective relational working between health and social care staff and allowed GPs to focus on medical care.

A SYNTHESIS: WHAT WORKS TO DELIVER OPTIMAL HEALTH OUTCOMES FOR UK CARE HOME RESIDENTS

C. Goodman[2], A. Gordon[1], S. Davies[2], A. Mayrhofer[2], M. Zubair[1], T. Dening[1], J. Meyer[3], *1. University of Nottingham, Nottingham, United Kingdom, 2. University of Hertfordshire, Hatfield, United Kingdom, 3. City University, London, United Kingdom*

The detailed reviews, interviews and subsequent longitudinal case studies structured around a unifying realist analytical framework allowed us to establish a theory of commissioning for health care provision to care homes which proposes health services will work better when: staff are explicitly tasked to work with care homes at an institutional level as well as individual residents; healthcare and care home staff are empowered to co-design their working models; where explicit expertise in dementia care is available; the role of GP as a medical care provider is supported by access to a wider array of services; and they incorporate care management. There was no evidence from our study that a short term focus on avoiding admissions to acute hospitals from care homes added any value to service specification or care delivery.

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IMPROVING CARE IN MINORITY AND DIVERSE POPULATIONS

HYPERTENSION MANAGEMENT BY OLDER SLAVIC IMMIGRANT WOMEN IN THE UNITED STATES

C.R. Van Son[1], O. Stasyuk[2], *1. College of Nursing, Washington State University, Vancouver, Washington, 2. Ivan Franko National University, L'viv, Ukraine*

Older immigrants have a disproportionately higher incidence of hypertension (HTN) compared to their American-born counterparts. They experience frequent illness exacerbations and acute care utilization due to uncontrolled HTN. Interviews were conducted with a convenience sample of 25 older Slavic immigrant women with HTN. The analysis focused on describing the beliefs and behaviors surrounding HTN management decisions. A four-stage circular process emerged: 1) **Identification** of HTN symptoms ("feel bad" and/or headache); 2) **Assessment** of blood pressure (taking a blood pressure reading or recall of prior experiences); 3) **Intervention Initiation** (folk remedies used first) such as: a) herbs (rosehips, yarrow, hawthorn, fennel, and dill); b) dietary remedies (lemon, beets and raspberries); c) mineral substance (mumiyo); d) Slavic pharmaceuticals (Validol and Enap); and/or d) treatments (mustard plaster and hot or cold water therapy). 4) **Reassessment** of symptoms and/or elevated blood pressure reading. Based on reassessments, if symptoms continued and/or blood pressure readings remained elevated (definitions of elevation varied for each woman) then another folk remedy and/or prescribed medication would be implemented. Participant approach to managing their HTN was based on their belief it was an episodic and acute condition and was to be treated only in the presence of symptoms and/or elevated blood pressure measurement reading. Thus, a trial and error approach was used to manage their HTN resulting in an uncontrolled chronic condition. Older Slavic immigrant women continue to experience uncontrolled HTN and understanding beliefs and behaviors will support the development of culturally tailored blood pressure management interventions.

RACIAL AND ETHNIC DISPARITIES IN ADL DISABILITY AFTER HOSPITALIZATION AMONG OLDER HOME CARE RECIPIENTS

J. Chase[1,2], L. Huang[2], D. Russell[3], A. Hanlon[2], M. O'Connor[4], K. Robinson[2], K.H. Bowles[2], *1. University of Missouri, Columbia, Missouri, 2. University of Pennsylvania, Philadelphia, Pennsylvania, 3. Visiting Nurse Service of New York, Manhattan, New York, 4. Villanova University, Villanova, Pennsylvania*

Older adults who experience new or worsening difficulties performing activities of daily living (ADL) after hospitalization have poorer prognoses within a year after discharge. Past research suggests racial/ethnic disparities exist in the development and progression of ADL disability. However, little research exists examining ADL disability disparities among racially/ethnically diverse older adults after hospitalization. Understanding differences in ADL disability across racial/ethnic groups may lead to targeted interventions reducing disparities and promoting ADL performance. This study's purpose was to determine if differences exist in ADL disability trajectories among racially/ethnically diverse adults age 65 years and older receiving home care following hospitalization. We used 2013–2014 Outcome and Assessment Information Set data (n=21,473) from a large non-profit home care agency to examine overall change in ADL disability, which was measured by summing the difference of admission and discharge scores from nine individual ADL. Associations between race/ethnic groups and overall ADL change scores were examined using general linear regression models, adjusting for personal, environmental, and health-related factors from the International Classification